



10 Key Rules for Health Issuer Compliance

with Federal and State Legal Protections
for AI/AN Enrollees and Indian Health Care Providers

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The American Indian Health Commission

www.aihc-wa.com

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About Us

American Indian Health Commission

Pulling Together for Wellness

We are a Tribally-driven, non-profit organization providing a forum for the twenty-nine Tribal governments and two urban Indian health programs in Washington State to work together to improve health outcomes for American Indians and Alaska Natives.



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Today's Purpose

- The State of Washington requires health insurance carriers (managed care organizations, qualified health plans, Medicare, private issuers) to comply with all state and federal laws relating to the acts and practices of carriers and laws relating to health plan benefits.
- The purpose of today is to improve carrier compliance with laws and regulations regarding American Indians/Alaska Natives (AI/AN) and Indian health care providers(IHCPs).



Agenda

1. Important Definitions
2. Scenarios
3. Why Do These Rules Exist?
4. What Happens When These Rules Are Not Followed?
5. 10 Rule Overview
6. Game Time
7. Wrap-Up





Important Definitions and Acronyms



American Indians/Alaska Natives (AI/AN):



AI/AN means any individual who is: (a) a member of a federally recognized Tribe; or (b) eligible for the Indian Health Service.

RCW 43.71B.010



Indian Health Care Provider (IHCP)



Native Project, Spokane, WA

A health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in § 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603).



Health Insurance Issuer or Issuer

An insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a State and that is subject to State law that regulates insurance.

Issuers may also be referred to in Washington State statutes and regulations as “health carriers.”

45 C.F.R. § 144.103; RCW 48.43.005



Qualified Health Plan (QHP):

As defined in the Affordable Care Act (ACA), a QHP is an insurance plan that is certified by the Washington Health Benefit Exchange, provides essential health benefits (EHBs), follows established limits on cost sharing, and meets other requirements outlined within the application process.

See <https://www.cms.gov/marketplace/health-plans-issuers/qualified-health-plan-certification>



Qualified Health Plan Issuer

Qualified health plan issuer or QHP issuer means a health insurance issuer that offers a QHP in accordance with a certification from the Washington Health Benefit Exchange.

See 45 C.F.R. § 155.20



Scenarios



Scenario 1

X Tribe has a substance use treatment center located in a rural area. The treatment center serves 2000 native and non-native patients and is the only Indian health care provider (IHCP) in the service area. Recently, a health insurance issuer sent the treatment center a letter denying a total of 10 claims based on the following factors:

1. The treatment center does not have a contract with the issuer.
2. The treatment center has providers that are licensed out-of-state but not in Washington.



Scenario 2

Chelsea, a member of a Tribe located outside Washington State, is an enrollee of a Washington Qualified Health Plan (QHP). Chelsea has a household income under 300% of the federal poverty level. Recently, Chelsea had a visit with her cardiologist for her complications with AFIB. Her visit was the result of a purchase and referred care referral from her Tribe's health clinic.

The QHP issuer has sent Chelsea an explanation of benefits that indicated that Chelsea was responsible for 100% of the cost for this visit because the referral came from an out-of-network provider. The QHP issuer further informs Chelsea that while her Tribe's IHCP is out-of-network, there are several in-network IHCP providers she can choose from for future visits.



Scenario 3

X Tribe has an Indian health care provider (IHCP) facility with a funding agreement with the Indian Health Service. Under this agreement, the Tribe manages and delivers health care programs for their members in accordance with the Indian Self-Determination and Education Assistance Act.

The IHCP receives the following notice from a health issuer: “In order to have your provider remain on our online directory, you must complete a primary source verification via the credentialing process. Additionally, the National Committee for Quality Assurance (NCQA) also requires health plans to directly credential primary care providers. If your provider does not wish to continue credentialing with us, we will need to remove your provider from our directory and reassign any members to convert the provider from a primary care provider to a specialist.”



Scenario 4

X Tribe's Indian health care provider (IHCP) facility receives a notice from Y health issuer that the issuer will not provide the IHCP a contract because the health issuer requires the IHCP physicians to have hospital privileges. The IHCP physicians do not have hospital privileges. All the surrounding hospitals currently have hospitalists who admit patients in the hospital.



Why Do these Issuer Requirements Exist?



Foundations of Protections in Federal Laws

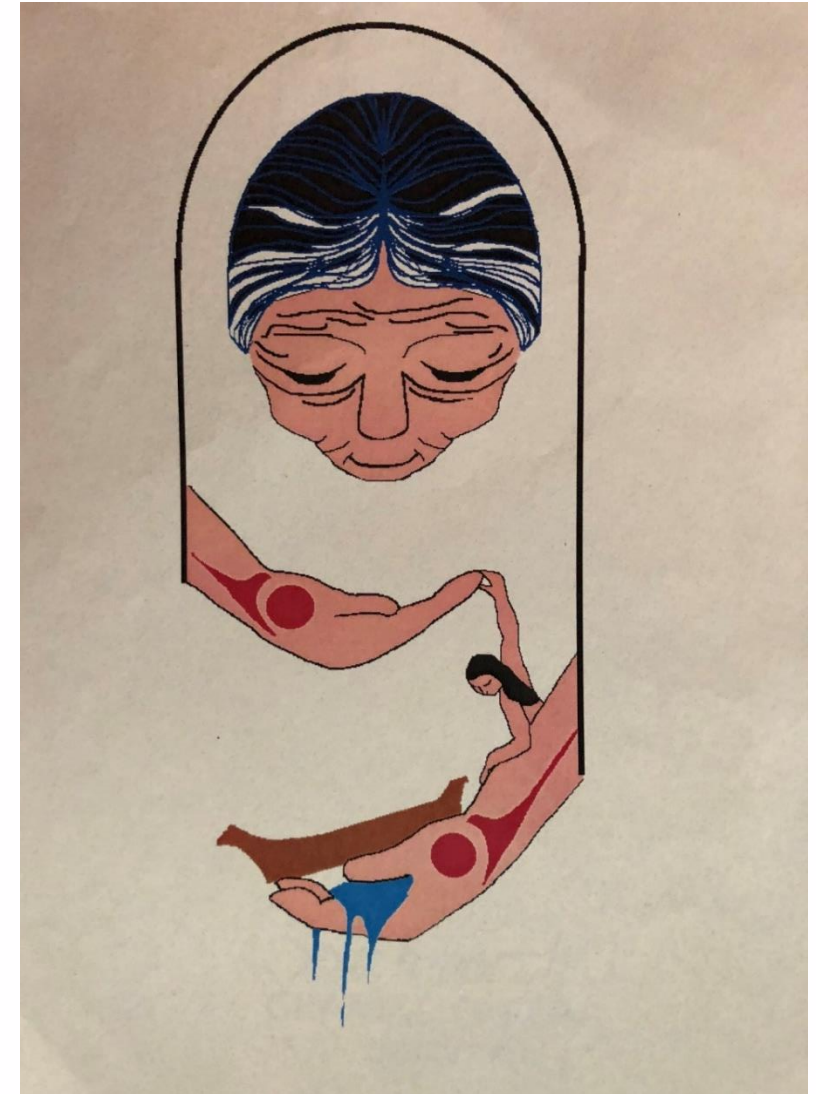


- Treaty Rights/Trust Responsibility
- Indian Health Care Improvement Act(IHCIA) of 1975
- Indian Self-Determination and Education Assistance Act (ISDEAA) of 1975
- Third Party Payments to Support Tribal Clinics



Treaty Rights

- Treaties are referred to in the Constitution as “the Supreme Law of the Land”
- Treaties include language about the provision of health services and vaccines
- In 1871, US Government passed 25 U.S.C. § 71:
“That hereafter no Indian nation or tribe within the territory of the United States shall be acknowledged or recognized as an independent nation, tribe, or power with whom the United States may contract by treaty: Provided, further, that nothing herein contained shall be construed to invalidate or impair the obligation of any treaty heretofore lawfully made and ratified with any such Indian nation or tribe.”





Federal Treaty Trust Responsibility to Provide Health Care To American Indians



“And the United States finally agree to employ a physician to reside at the said central agency, who shall furnish medicine and advice to their sick, and shall vaccinate them; the expenses of ...medical attendance to be defrayed by the United States, and not deducted from the annuities.”

Treaty of Point Elliot, 1855, Article 14



Trust Responsibility



Trust responsibility is a legally enforceable obligation of the United States to protect tribal self-determination, Tribal lands, assets, resources, and treaty rights, as well as carry out the directions of federal statutes and court cases.

SOURCE: Building Bridges for the New Millennium: Government-to-Government Implementation Guidelines, State-Tribal Workgroup, May 18, 2000.



Federal Statutory Responsibility to Provide Health Care to American Indians

Under the Indian Health Care Improvement Act (IHCIA), “[f]ederal health services to maintain and improve the health of the Indians are ... required by the Federal Government’s historical and unique relationship with, and resulting responsibility to, the American Indian people.”

25 U.S.C. § 1601(a)



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Indian Health Care Improvement Act § 1621

Indian Health Care Improvement Fund

(a) Use of funds: The Secretary, acting through the Service, is authorized to expend funds, directly or under the authority of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), which are appropriated under the authority of this section, for the purposes of—

- (1) eliminating the deficiencies in health status and health resources of all Indian tribes;*
- (2) eliminating backlogs in the provision of health care services to Indians; and*
- (3) meeting the health needs of Indians in an efficient and equitable manner.*

Originally Passed in January of 1975, permanently reauthorized in 2010 through ACA



Indian Self Determination and Education Act

§450 Congressional statement of findings

(a) Findings respecting historical and special legal relationship, and resultant responsibilities

The Congress, after careful review of the Federal Government's historical and special legal relationship with, and resulting responsibilities to, American Indian people, finds that...

...(2) the Indian people will never surrender their desire to control their relationships both among themselves and with non-Indian governments, organizations, and persons.

* Passed in 1975, Also known as PL 93-638 or the “638 Act”.



Impacts of “Bad” Federal Policy

**Inadequate funding
(32% level of
need)***

**Limited access &
fragmented care**

Health disparities



Complex Payer Requirements for AI/ANs and Tribes

Federal government fails to fund IHS adequately



Federal government requires AI/ANs to use other resources first*



Tribes/UIHPs forced to fill in the gaps



*42 C.F.R. § 136.61 – IHS is payer of last resort.



What Happens When These Laws Are Not Followed?



Lack of understanding of legal protections for American Indians/Alaska Natives (AI/AN) and Indian health care providers (IHCPs) can have detrimental impacts to Tribes, Tribal communities, and AI/AN individuals.



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For Example...

An insurance carrier's failure to recognize a Tribal health program as a licensed or certified facility can result in loss of funds for critically underfunded Indian health care providers.

A state court's failure to recognize a Tribal health program as licensed or certified facility can result in American Indians and Alaska Native unable to receive treatment from their Indian health care provider medical home.





How You (issuers and state/federal actors) Can Help...

Understanding and respecting federal and state legal protections for American Indian/Alaska Natives (AI/AN), Tribes, and Indian health care providers can bring about great improvements for Tribal nations and AI/AN people AND benefit the citizens of the State of Washington.





10 Key Rules for Compliance

with Federal and State Legal Protections for
American Indian/Alaska Native Enrollees and Indian Health
Care Providers



Who Do these Rules Apply to?

Health Carriers

- Managed Care Organizations (MCOs)
- Qualified Health Plans (QHPs)
- Medicare
- Private issuers



IMPORTANT DOC!!

Federal and State Legal Protections for American Indian/Alaska Native Enrollees and Indian Health Care Providers

Available at www.insurance.wa.gov/sites/default/files/documents/issuer-requirements-ai-an-ihcp_0.pdf



American Indian Health Commission

Federal and State Legal Protections for American Indian/Alaska Native Enrollees and Indian Health Care Providers

Requirements for Health Insurance Issuers

Last Updated: 8/26/24

The State of Washington requires health insurance issuers (hereinafter “issuers”) to comply with all state and federal laws relating to the acts and practices of issuers and laws relating to health plan benefits.¹ The purpose of this reference document is to assist issuers in complying with federal and state protections for American Indian/Alaska Native (AI/AN) enrollees and Indian health care providers, by consolidating the applicable state and federal statutes and rules in one place. Issuers, as referred to in this guidance, include entities defined as carriers under RCW 48.43.005 that are regulated by the Washington State Office of the Insurance Commissioner (OIC) and include issuers that offer qualified health plans (QHPs). This document will identify protections that apply to all issuers and those that may apply only to QHPs. This document does not address Medicaid or Medicare managed care organizations.

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8. Insurance and Indemnification
9. Confidentiality Requirements for Indian Health Care Provider Medical Quality Assurance Records
10. QHP Enrollment Periods for AI/AN



Rule 1: Access to Indian Health Care Providers

All issuers must maintain arrangements to ensure that all AI/AN enrollees enrolled in an issuer's plan have access to Indian health care providers for both medical and behavioral health services.

This rule applies even if an Indian health care provider is not a contracted network provider.

WAC 284-170-200(9) (emphasis added).



Rule 1: Access to Indian Health Care Providers Cont.

QHPs must include essential community providers (ECP) within their networks for QHPs and qualified stand-alone dental plans. Indian health care providers are considered ECPs. The issuer's QHP provider network must include access to 100% of Indian health care providers in its service area.

See WAC 284-170-310(1) and 3(b); 45 C.F.R. § 156.235(a); and WAC 284-170-200(9).



Rule 2: Cost of Services to American Indian/Alaska Natives

All issuers must ensure that all AI/AN enrollees can obtain medical and behavioral health services from an Indian health care provider “at no greater cost to the enrollee than if the service were obtained from network providers and facilities, even if the Indian health care provider is not a contracted provider.”

WAC 284-170-200(9)



Rule 2: Cost of Services to American Indian/Alaska Natives - QHPs

Zero Cost Sharing. If the Washington Health Benefit Exchange (WHBE) determines an AI/AN enrolled in QHP has household income under 300% of the federal poverty level, the QHP issuer must assign the individual to a zero-cost sharing plan variation. The issuer of the plan shall eliminate any cost-sharing under the plan. The zero cost sharing plan variation has no cost sharing (such as copays, deductibles, or coinsurance) for items or services provided:

- (a) directly by the IHCP or through referral under contract health services (currently referred to as “purchase and referred care”). The issuer of the plan may not reduce the payment to IHCP for such services or items; or
- (b) by any other QHP health care provider.

42 U.S.C. § 18071(d)(1)(B); 42 U.S.C. § 18071(d)(2); 45 C.F.R. § 156.410(b)(2)



Rule 2: Cost of Services to American Indian/Alaska Natives – QHPs Cont.

Limited Cost Sharing. AI/AN of any income can be enrolled in a QHP limited cost sharing plan, and such individuals shall have no cost sharing for essential health benefits received from an IHCP or through referral under contract health services (AKA purchased and referred care) from an IHCP.

42 U.S.C. § 18071(d)(2). See also Health Insurance Issuer Standards, 45 C.F.R. § 156.410(b)(3); ACA § 1402(d)(2) (codified at 42 U.S.C. § 18071(d)(2)).



Rule 3: Indian Health Care Provider Reimbursement

Right of Recovery Rule. All issuers must reimburse IHCPs for services they provide the “reasonable charges billed” or, if greater, the “highest amount” the issuer would pay for care and services furnished by nongovernmental providers. 25 U.S.C. § 1621e(a)

Right of Recovery Supersedes Issuer Contracts. No state law or issuer contract provision entered into or renewed after November 23, 1988, shall prevent or hinder the right of recovery under section (i) of this section. 25 U.S.C. § 1621e(c)



Rule 3: Indian Health Care Provider Reimbursement Cont.

No Reduction in Payment. QHPs shall not reduce the payment to an Indian health care provider by the amount of any cost-sharing that would be due from the AI/AN but for requirement under 42 U.S.C. § 18071(d)(2) that no cost sharing under the plan shall be imposed under the plan for such item or service.

ACA § 1402(d)(2)(B) (codified at 42 U.S.C. § 18071(d)(2)).



Rule 4: Indian Health Care Providers and State Licensure Requirements

Licensure of IHCP Professionals. An IHCP's employed health professionals are exempt from the Washington State licensure requirements if the professionals are licensed in another state and are performing the services described in the contract or compact of the Indian health program under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

25 U.S.C. § 1621t



Rule 4: Indian Health Care Providers and State Licensure Requirements Cont.

Credentialing - Issuers are not responsible for credentialing providers and facilities that are part of the Indian health system.

WAC 284-170-200(9).



Rule 5: Payer of Last Resort

IHCPs shall be the payer of last resort for services provided to eligible individuals. All alternate resources that are available and accessible such as Medicare, Medicaid, SCHIP, private insurance, etc. must be used before an IHCP's funds can be expended.

25 U.S.C. § 1623(b)



Rule 6: Enrollee Eligibility for Indian Health Care Provider Services

Issuers cannot require an IHCP to serve individuals who are ineligible for services from an IHCP.

IHCPs are established under federal law to serve their AI/AN community and/or other populations (including non-Indians). An individual shall not be deemed as subjected to discrimination by reason of his or her exclusion from benefits limited by federal law to individuals eligible for services from an Indian health program.

45 C.F.R. § 80.3(d)



Rule 7: QHP Contracting with IHCPs

QHP issuers must offer to contract with Indian health care providers who request a contract for reimbursement of covered health care services delivered to qualified enrollees under the QHP issuer's plan.

An Indian health care provider may seek a contract with an issuer at any time during a year.

WAC 284-170-310(5).



Rule 7: QHP Contracting with IHCPs Cont.

Good Faith Exception. If an IHCP requests a contract and a contract is not entered into, a QHP issuer must provide substantial evidence of good faith efforts on its part to contract with the IHCP.

WAC 284-170-310(5)(b)



Rule 7: QHP Contracting with IHCPs Cont.

QHPs are encouraged to use the [Model Washington State Indian Health Care Provider Addendum](#) to supplement the existing provider contracts when contracting with an IHCP.

WAC 284-170-310(5)(a).



Rule 8: Insurance and Indemnification

Federal Tort Claims Act (FTCA)

- IHCPs shall not be required to obtain or maintain professional liability insurance to the extent such Provider is covered by the FTCA.
- IHCPs shall not be required to acquire insurance, provide indemnification, or guarantee that the health issuer will be held harmless from liability.

[Model Washington State Indian Health Care Provider Addendum](#); See also, 28 U.S.C. §§ 2671-2680



Rule 9: Confidentiality Requirements for IHCP Quality Assurance Records

Under 25 U.S.C. § 1675(b), all medical quality assurance records created by or for an IHCP as part of a medical quality assurance program are confidential and privileged and may not be disclosed to any person or entity except under certain statutory exceptions. To the extent an issuer imposes any medical quality assurance requirements on an IHCP, any such requirements applicable to the IHCP shall be subject to this law.



Rule 10: QHP Enrollment Periods for AI/AN

QHP issuers must allow an AI/AN to enroll or change plans in Washington Healthplanfinder at any point during the year but not more than once-a-month.

45 C.F.R. § 155.420(d)(8).



OIC Enforcement



Enforcement of AI/AN and IHCP Legal Protections

The OIC has a formal complaint process for insurance enrollees, providers and others when issuers are not following state rules.

In general, complaints filed with the OIC include: insurance policies benefit coverage issues; insurance policy cancellations and renewals; medical necessity determinations by an insurer or their subcontractors; and payment claims delays, denials or disputes.



Enforcement of AI/AN and IHCP Legal Protections

Complaints can be filed with the Office of the Insurance Commission (OIC) online at: <https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status> or by mail, fax, email or chats with OIC staff.

Tribal governments and Indian health care providers may seek assistance from the OIC's tribal liaison in the filling of the complaint. Information is found here: <https://www.insurance.wa.gov/tribal-relations>



Game Time!



Game Time!

1. Spot the Issues
2. What's the Violation(s)?
3. Which Law/Regulation Applies?



Scenario 1

X Tribe has a substance use treatment center located in a rural area. The treatment center serves 2000 native and non-native patients and is the only Indian health care provider (IHCP) in the service area. Recently, a health insurance issuer sent the treatment center a letter denying a total of 10 claims based on the following factors:

1. The treatment center does not have a contract with the issuer.
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Scenario 2

Chelsea, a member of a Tribe located outside Washington State, is an enrollee of a Washington Qualified Health Plan (QHP). Chelsea has a household income under 300% of the federal poverty level. Recently, Chelsea had a visit with her cardiologist for her complications with AFIB. Her visit was the result of a purchase and referred care referral from her Tribe's health clinic.

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Questions? Thank you!

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