

Native American Health Care Reform Guide:

Implications of health care reform for Native
Americans in New Mexico

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Introduction

On March 23, 2010 President Obama signed the Patient Protection and Affordable Care Act. The new law puts changes in place that will hold insurance companies more accountable, lower health care costs, guarantee more health care choices, and enhance the quality of health care for all Americans. Perhaps the most important benefit for Native people is the immediate, permanent reauthorization of the Indian Health Care Improvement Act. This Act is designed to make it easier for the Indian Health Service (IHS) and Tribes to provide better health care to Native people.

A number of changes took place when the law was enacted in 2010, but the majority will take place in 2014 including the following:

- Nearly all Americans will be required to have health care coverage – ***Except for American Indians who will be exempt from this requirement.***
- Individuals age 19 and older, but less than 65, whose income is 133% of the federal poverty level (\$14,484 in 2011) will be eligible for Medicaid.
- Employers with 50 or more employees must offer health benefits or pay a penalty.
- States or federal government will create Health Insurance Exchanges or “one stop shopping” for individuals to access health care coverage.
- Individuals and families whose income is between 133% of the federal poverty level and 400% (about \$89,400 for a family of four) will receive financial help to pay insurance premiums and out of pocket insurance expenses

This guide is designed to help you understand the changes that will take place through health care reform and make sure that you benefit from the specific provisions of the new law that apply to Native Americans. It is also designed to assist Native communities and Tribal governments to recognize the opportunities to expand and strengthen Indian health systems through implementation of health care reform. Finally, this guide is supposed to be simple, concise, and easy to use. There are many additional details and complexities related to health care reform. If you have questions or need more detailed information, please contact:

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Immediate Changes

For Individuals with Health Insurance:

- Insurers can't impose a lifetime limit on your benefits, meaning you don't have to worry about your coverage maxing out when you most need it.
- Annual benefit limits are phasing out too, rising from \$750,000 to \$2 million per year before they are abolished in 2014.
- If you disagree with a benefit decision by your insurer, new independent appeals give consumers a standard, reliable way to dispute coverage decisions.
- Health insurers can't arbitrarily cancel your coverage if you get sick.
- You can now obtain preventive care such as annual exams and cancer screenings with no out-of-pocket costs.

For Children and Young Adults

- Children under age 19 can't be denied coverage because of their health status.
- Insurers can't exclude coverage for treatment related to a child's pre-existing condition.
- Children up to age 26 can remain on a parent's health insurance plan
- Your employer can't charge a different health insurance premium for your adult children than it does for your younger children.

Your child does not need to be financially dependent on you or live with you. He or she does not have to be unemployed, unmarried, or a student. Coverage of children up to age 26 does not extend to a spouse or a child of your adult child.

For People with Pre-Existing Health Conditions:

- Coverage is available through the new Pre-existing Condition Insurance Plan if you've been uninsured for at least six months and have been denied coverage because of a pre-existing condition.
- Premiums vary by age (but not by health status) and are tied to average rates for healthy individuals in your state.¹
- For more information about Pre-Existing Condition Insurance in New Mexico, go to: www.nmmip.org

For People on Medicare

- Traditional Medicare beneficiaries no longer have to pay any out-of-pocket costs for preventive services such as mammograms, colonoscopies, immunizations, and annual physical exams.

¹ Note: Premiums are not based on income, so a Pre-existing Condition Insurance Plan may still be unaffordable for some.

- If you fall into the “doughnut hole” and have to pay full price for your drugs, you will get a 50% discount on brand-name drugs and a 7% discount on generic drugs in 2011. These discounts will increase each year until the doughnut hole is completely eliminated by 2020.

Note: The Medicare “doughnut hole” is a gap in coverage that exists once you and your Medicare plan have paid \$2,930. Once you have spent \$4,700 out of pocket for the year, the coverage gap or “doughnut hole” closes.

Effective January 1, 2011, prescription drug costs paid by the IHS, an Indian tribe or tribal organization, or an urban Indian organization will count towards the out-of-pocket threshold (\$4,700).

For Small Employers

- Employers can receive a tax credit for up to 35% of what they spend on coverage for employees (25% for nonprofits). On Jan. 1, 2014, this tax credit increases to 50% (35% for nonprofits).²

Consumer Protections

- Starting in 2011, many insurance companies must publicly report how much they spend on health-care costs and on administrative costs.
- If you get your insurance through a large employer or other large group, your insurer must spend at least 85% of premiums on medical care or rebate the difference to you
- If you are covered through a small employer or buy insurance on your own, insurers must spend at least 80% of premiums on medical care.
- Rebates owed on 2011 premiums must be paid by August 2012
- Starting in 2011, insurers must publicly post and justify a rate increase of more than 10% for policies covering individuals or small businesses.
- States will determine whether the increase is unreasonable based on health-care costs and other factors. States can reject rates if their laws give them authority to do so. If states can’t make that determination, the federal government will.

Until 2014, when Medicaid eligibility is expanded to childless adults and the Health Insurance Exchanges are created, many Native Americans will continue to rely upon the Indian Health Service or Urban Indian Health Programs for no or low-cost health care services. It is critical that Native American consumers and policy makers understand that the Indian Health Service is not insurance or health coverage. It is a discretionary program that is funded at the will of congress. Currently, the congressional appropriation for the Indian Health Service is less than 55% of the actual funds needed for operations.

² Note: Businesses must have fewer than 25 full-time workers, pay average salaries under \$50,000, and cover at least 50% of the employees’ premiums.

Changes in 2014

Individual Mandate

Most individuals who can afford it will be required to obtain basic health insurance coverage or pay a fee to help offset the costs of caring for uninsured Americans. If affordable coverage is not available to an individual, he or she will be eligible for an exemption.

- ***American Indians are not required to obtain health insurance coverage.***
- ***There are many opportunities for tribes and Indian health programs to expand through increased revenue from people with health coverage. Even though American Indians do not have to obtain health insurance, it will be very important to acquire coverage in order to strengthen and expand the Indian health system.***

Employer Responsibility

Employers with at least 50 full-time employees are required to offer minimum essential coverage that satisfies the individual mandate. Employers that do not comply and whose employees receive a premium credit or cost-sharing subsidy will be subject to a penalty.

Tribal governments are not exempt from the employer requirement to offer minimum essential coverage.

Medicaid Expansion

Americans who earn less than 133% of the poverty level (about \$14,500 for an individual and \$29,700 for a family of four in 2011) will be eligible to enroll in Medicaid. States will receive 100% federal funding for the first three years to support this expanded coverage, decreasing to 90% federal funding in subsequent years.

States have significant authority over their Medicaid programs and may require cost sharing or co-payments for services. American Indians enrolled in Medicaid cannot be required to share costs if they are eligible for IHS services or have used IHS in the past.³

Health Insurance Exchanges

³ <https://www.cms.gov/smdl/downloads/SMD10001.PDF>

If your employer doesn't offer insurance, you will be able to buy it directly through a Health Insurance Exchange. An Exchange is a competitive insurance marketplace where individuals and small businesses can buy affordable and qualified health benefit plans. Individuals and small businesses will be able to compare health plans, get answers to questions, find out if they are eligible for tax credits for private insurance or health programs like Medicaid, and enroll in a health plan that meets their needs. In general, Exchanges must provide for an initial open enrollment, annual open-enrollment periods, and special enrollment periods following certain major life events.

Four levels of plans will be offered through the Health Insurance Exchanges. All the plans must offer a set of essential health benefits that will be specified in future federal regulations. The four plan levels vary in the total value of coverage they must provide. The "bronze" plan has an actuarial value of 60%, meaning that the insured person would be responsible for paying 40% of the costs of all covered benefits. The actuarial value for the "silver" plans is 70%, 80% for "gold" plans and 90% for "platinum" plans.⁴

- ***Health Insurance Exchanges must offer special monthly enrollment periods for American Indians.***
- ***If an insurance plan is purchased through an Exchange, co-payments and deductibles are waived for American Indians with incomes up to 300% of the federal poverty level (about \$32,670 for an individual).⁵***

Financial Assistance for Health Insurance

Two forms of financial assistance will be provided. A premium assistance tax credit will be provided monthly to lower the amount of premium an individual or family must pay for their health insurance coverage. Cost sharing subsidies will reduce the amounts (i.e., deductibles, coinsurance or copayments) that individuals or families pay out of pocket for their insurance plan.

Premium Tax Credits

To help the middle class afford insurance, tax credits will be available for those with income between 100% and 400% of the federal poverty level who are not eligible for other affordable coverage. (In 2011, 400% of the federal poverty level comes out to about \$43,500 for an individual or \$89,400 for a family of four.) The tax credit is received in advance on a monthly basis, so it can lower your premium payments each month, rather than making you wait for tax time. It's also refundable, so even moderate-income families can receive the full benefit of the credit.

⁴ <http://www.kff.org/healthreform/upload/8061.pdf>

⁵ Initially when the new laws were enacted, it was expected that health insurance premiums would also be waived, but it appears that the cost-sharing exemption applies to only to deductibles and co-payments.

If your income fluctuates during the year, it is possible that you could owe money for the tax credits you've received.

Cost Sharing Subsidies

People who qualify for the premium assistance tax credit will also be eligible for cost sharing assistance if they purchase a “silver” plan through a Health Insurance Exchange. This assistance will further reduce the limit on the out of pocket maximum that can apply to their coverage, with the amount of the reduction depending on income.

Remember, if your income is 300% of federal poverty level or less, you do not have to pay co-payments or deductibles if you purchase your plan through a Health Insurance Exchange – regardless of the type of plan, i.e. you can buy a bronze, silver, gold or platinum plan and still be exempt from cost sharing.

Basic Health Plans

The new law allows states to provide health insurance to individuals with incomes between 133% and 200% of the federal poverty level (In 2011, between \$14,484 and \$21,780). As their income fluctuates, people may have to move between Medicaid and private health insurance. A basic health plan could make it easier to ensure that people don't fall through the cracks and become uninsured.

- ***The State of New Mexico has not committed to creating a basic health plan***
- ***Basic health plans are not purchased through an Exchange, so the exemption from cost sharing for American Indians does not apply.***

Insurance Reforms

The law implements strong reforms that prohibit insurance companies from refusing to sell coverage or renew policies because of an individual's pre-existing conditions. Also, in the individual and small group market, it eliminates the ability of insurance companies to charge higher rates due to gender or health status

Implications of Reform for People Using the Indian Health Service

Health care presents a number of opportunities for Indian people to acquire affordable, high quality, health care coverage. The permanent reauthorization of the Indian Health Care Improvement Act enables the Indian Health Service to provide better more comprehensive services including:

- Establish comprehensive behavioral health, prevention, and treatment programs
- Provide or pay for hospice, assisted living, long-term, and home- and community-based care
- Create a Community Health Representative program for urban Indian organizations to train and employ Indians to provide health care services to Indian people living off the reservation

Implementation of the new law is taking time and appears dependent upon existing resources. It may be some time before the Indian Health Service determines how they will implement some of the elements of reform, e.g. long term care, hospice, etc.

The new law states that health programs operated by the Indian Health Service, Indian tribes, tribal organizations, and urban Indian organizations are the payer of last resort for services provided by them to Indians. This means that before the Indian Health Service, Tribal 638 or Urban Indian Health Program (I/T/U) will pay for services, individuals must seek assistance through other programs including Medicaid, Medicare, and local charity care programs.

Even though American Indians are not required to obtain health coverage, many I/T/Us will require people to apply for Medicaid and other programs before they pay for services.

Health care reform offers an unprecedented opportunity to strengthen and expand the Indian health system, but it is imperative that Indian people take advantage of every benefit available to them under the new laws. For the first time, hundreds of thousands of Indian people will be eligible for Medicaid and have incentives to purchase health insurance. When more Native people are covered, the Indian health system is better able to collect revenue from Medicaid, Medicare, and other health coverage plans. Increased revenues can be invested in infrastructure, workforce and other resources to provide more services.

Enrolling in Medicaid and/or Medicare or purchasing health insurance if it's affordable can strengthen and expand the Indian health system.

Implications of Reform For Native Communities

Health care reform offers many grant opportunities to expand health care services in Native communities. Among those reserved specifically for Native American populations are the following:

Maternal and Child Health

Section 2951 of the Affordable Care Act allows the Health and Human Services Department to make grants to tribes, tribal organizations and urban Indian organizations to develop and implement early childhood visitation programs. In New Mexico, several Native communities have been awarded funds through this program. For more information about the tribal home visiting grants, contact: tribal.homevisiting@hhs.gov. For more information about Native early childhood visitation programs in New Mexico, go to: www.nappr.org

Trauma Centers

Section 3505 allows the Health and Human Services Department to award grants to qualified, public, non-profit, Indian Health Service, tribal, and urban Indian trauma centers to defray costs of uncompensated care and to provide emergency relief to ensure continued and future availability of trauma services.

Strengthening Primary Care and Other Workforce Improvements

Section 5507 provides for grants to certain entities to conduct demonstration projects that are designed to provide low-income individuals with the opportunity to obtain education and training for occupations in the health care field. This section requires the Secretary of HHS, in consultation with the Secretary of Labor, to award at least three of these grants to Indian tribes, tribal organizations, or tribal colleges or universities.

There are many other grant opportunities that are not specific to Native communities, but require collaboration with many stakeholders including Native American organizations, tribes, and community members. Some examples include:

Consumer Operated and Oriented Plan Program

The Affordable Care Act calls for the establishment of the Consumer Operated and Oriented Plan (CO-OP) Program, which will foster the creation of qualified nonprofit health insurance issuers to offer competitive health plans in the individual and small group markets. For more information about this program, go to www.grants.gov and search by funding opportunity number OO-COO-11-001. For more information about a local group that has applied for funding, go to: www.nmhealthconnections.org

Community Transformation Grants

The Community Transformation grants program supports community-level efforts to reduce chronic diseases such as heart disease, cancer, stroke, and diabetes. By promoting healthy lifestyles, especially among population groups experiencing the greatest burden of chronic disease, these grants will help improve health, reduce health disparities, and control health care spending. The New Mexico Department of Health received a Community Transformation grant in the amount of \$1.5 million to serve the entire state minus its large counties. Bernalillo County was awarded nearly \$500,000 to build capacity to support healthy lifestyles for its entire population including the City of Albuquerque. For more information about the Community Transformation grants, go to: www.cdc.gov/communitytransformation/

Health Care Innovation Challenge

The Health Care Innovation Challenge will award up to \$1 billion in grants to applicants who will implement the most compelling new ideas to deliver better health, improved care and lower costs to people enrolled in Medicare, Medicaid and CHIP, particularly those with the highest health care needs. The due date for an application is January 27, 2012. For more information go to: www.innovations.cms.gov/initiatives/innovation-challenge/

Health Insurance Exchange Establishment Grants

New Mexico received about over \$34 million to develop and establish the New Mexico Health Insurance Exchange in 2012 and to meet the timelines for certification and operation by 2014. There may be opportunities to competitively apply for funds to ensure that the Exchange complies with the Indian specific provisions of the health care reform law and meets the needs of Native American consumers. Check the New Mexico Human Services Department website for more information at: www.hsd.state.nm.us/nhcr/nhcr1ao.htm

Check www.grants.gov regularly to identify grant opportunities for your organization or community.

Implications of Reform For Tribal Governments

There are numerous opportunities for tribal governments to strengthen and expand their health systems through health care reform and the permanent reauthorization of the Indian Health Care Improvement Act. The following are a number of examples:

Express Lane Agencies

The Express Lane option provides States with a strategy to ensure that children eligible for Medicaid or the Children’s Health Insurance Program (CHIP) have a fast and simplified process for having their eligibility determined or re-determined. The Express Lane option allows States to rely on findings from a designated entity to determine whether a child satisfies one or more factors of eligibility for Medicaid or CHIP. Section 2901(c) of the Affordable Care Act adds the IHS, an Indian Tribe, Tribal Organization or Urban Indian Organization as Express Lane agencies that are capable of collecting information and making a finding regarding one or more programmatic eligibility requirements for Medicaid and/or CHIP.

New Mexico has not designated any entities as Express Lane Agencies. It is critical that the State facilitate the enrollment of eligible Native children in Medicaid and CHIP.

Purchase Health Benefits for IHS Beneficiaries

Section 152 of the Indian Health Care Improvement Act authorizes tribes and tribal organizations to purchase health benefits coverage for IHS beneficiaries using appropriated health care dollars. This means that tribal governments or tribal organizations could use Indian Health Service dollars that are contracted or compacted to purchase insurance coverage for people who are able to receive services from the Indian Health Service. Increasing the number of tribal members who have health coverage potentially increases the amount of third party revenue generated by I/T/Us thus strengthening the Indian health system.

Access to Federal Insurance for Employees

Section 157 of the Indian Health Care Improvement Act allows a tribe or tribal organization carrying out a program under the Indian Self-Determination and Education Assistance Act (Tribal 638) and an urban Indian organization carrying out a program under Title V of IHCA to purchase coverage for its employees from the Federal Employees Health Benefits Program.

Essential Community Providers

A central goal of the Affordable Care Act is to ensure that all Americans, regardless of income or location, have access to a sufficient choice of health care providers. This is achieved, in part, by requiring “essential community providers... that serve predominantly low-income, medically-

underserved individuals” to be included in the networks of all health plans offered through the health insurance exchanges.⁶

Currently, it does not appear that I/T/Us are recognized as essential community providers. Tribal leaders should leverage the government-to-government relationship and tribal consultation process to ensure that I/T/Us qualify as essential community providers and are designated as such in any proposed regulations.

Creation of Subsidiary Health Insurance Exchanges

By 2014, each State must have an operating Health Insurance Exchange. States can structure their Exchange in their own way, e.g. as a non-profit entity established by the State, as an independent public agency, or as part of an existing State agency. In addition, States can choose to operate an Exchange in partnership with other States through a regional Exchange or it can operate subsidiary Exchanges that cover areas within the State.⁷ Any combination of these options can be approved. Exchanges will perform a variety of functions, including:

- Certify health plans as Qualified Health Plans (QHPs) to be offered in the Exchange.
- Operate a website to facilitate comparisons among qualified health plans for consumers.
- Operate a toll-free hotline for consumer support, provide grant funding to entities for consumer assistance, called “Navigators”, and conduct outreach and education to consumers regarding Exchanges.
- Facilitate enrollment of consumers in Exchange-qualified health plans.

States have substantial flexibility in determining how to perform these functions, but it may be appropriate to consider the feasibility of a tribally operated subsidiary Health Insurance Exchange. In the case of the Navajo Nation which spreads across Arizona, Utah, and New Mexico and has more than 300,000 enrolled tribal members, it may be more appropriate to form a subsidiary Exchange to reduce the complexity of enrolling eligible individuals in three different Medicaid programs. Further, Section 159 of the Indian Health Care Improvement Act authorized the Navajo Nation to explore the feasibility of administering its own Medicaid program which might serve as a foundation for the creation of a subsidiary Exchange.

Creation of Tribally Operated Managed Care Organizations (MCOs)

The Affordable Care Act offers a number of incentives for American Indians to enroll in Medicaid or purchase health insurance, but American Indians have historically been reluctant to enroll in Medicaid or purchase health insurance coverage for a number of reasons.⁸ A

⁶<http://www.nnaapc.org/publications/ITU%20Are%20Essential%20Community%20Providers%20DIST%202011-02-09a.pdf>

⁷ <http://www.healthcare.gov/news/factsheets/2011/07/exchanges07112011a.html>

⁸[http://www.insurenwemexico.state.nm.us/Inm/Native%20American%20Health%20FINAL%20REPORT%20\(2-3-06\).pdf](http://www.insurenwemexico.state.nm.us/Inm/Native%20American%20Health%20FINAL%20REPORT%20(2-3-06).pdf)

tribally operated managed care organization might be more effective in aggressively reaching out to Native consumers and ensuring that health coverage programs meet their needs. Moreover, a tribally-operated managed care organization might be designed to focus on improved health outcomes, better quality, and reduced costs with revenues used to invest in tribal health infrastructure, workforce development and other resources.

Because Medicaid is financed differently for American Indians who receive services in Indian Health Service facilities or through Tribal 638 programs, it is possible that a tribally operated managed care organization could become a new economic development opportunity for tribal governments. For example, Medicaid reimbursable services received in Indian Health Service facilities or through Tribal 638 programs are paid 100% by the federal government; there is no State match required.⁹ In addition, services are reimbursed at an all-inclusive rate that is typically much higher than reimbursement rates received by other providers. Finally, while States cannot mandate American Indians to participate in managed care programs without a waiver¹⁰, tribal governments are in a much more powerful position to encourage their tribal members to participate.

Strengthen and Expand Indian Health Systems

The Affordable Care Act offers many opportunities for tribes who have contracted their health care programs from the Indian Health Service. For example, Section 194 of the Indian Health Care Improvement Act authorizes Tribal 638 programs to provide health care services to non-IHS eligible beneficiaries as long as they pay for the services they receive and there is no reduction in services to those who are eligible for services through IHS. This section was designed to ensure that Indian health programs could take advantage of the new population of insured patients and benefit from reimbursements available for providing care.¹¹ This provision offers some intriguing possibilities for Tribal 638 programs. Specifically, tribes could operate health care facilities and provide services to IHS beneficiaries (who are typically American Indian consumers) and non-Indian patients. Given the Medicaid financing mechanism described above, it might be possible for tribal programs to have a competitive edge in their ability to become the provider of choice for the newly insured in 2014.

It might be beneficial for tribes and states to partner to construct Tribal 638 facilities on or off the reservation. For example, an enterprising tribe could build a health facility on or off reservation and provide health care services to IHS while reducing Medicaid costs for the State. In a study performed in 2006, Dr. Donald Warne found that investing in Tribal 638 facilities resulted in significant savings for state Medicaid programs.¹²

⁹ http://www.cmsttag.org/docs/cms_aian_strategic_plan_final.pdf?story=20060206203843764

¹⁰ <http://www.cbpp.org/cms/index.cfm?fa=view&id=2138>

¹¹ http://bingaman.senate.gov/policy/ppaca_ihcia.pdf

¹² http://www.acoihc.az.gov/userfiles/file/American_Indian_Healthcare_Facilities_in_Arizona_3.pdf

Another opportunity to explore is the establishment of contractual agreements with non-Indian providers and facilities to expand access to services for tribal members living off the reservation. For example, the Acoma Laguna Canoñito Service Unit currently contracts with the University of New Mexico to provide health care services at a local school-based health center. Because of the contractual relationship, the school-based health center functions as an “IHS look-alike” and is able to bill at the higher all-inclusive rate and services reimbursed by Medicaid are matched at 100% by the federal government.¹³ Revenues received from Medicaid are split between the ACL Service Unit and the school-based health center. Based on this precedent, it appears possible for a Tribal 638 to contract with a local entity to provide services to tribal members living off the reservation and bill Medicaid accordingly.

There are many opportunities for tribal governments to strengthen and expand their health care systems, but they are often tied to the ability of the tribe to contract or compact services from the Indian Health Service. It is understood that the decision to contract or compact services is a serious endeavor and has long-term implications for other tribes and individuals dependent upon Indian Health Service facilities and programs.

Strategic partnerships and collaborations between tribal governments, Native communities, and the State are most likely to lead to successful implementation of health care reform and ensure Native people benefit from the many opportunities presented by the Affordable Care Act.

¹³ Telephone Interviews with Dr. Martin Kileen, MD, ACL Service Unit and Lakhana Peou, UNM

Terms

Actuarial Value - The percentage of total average costs for covered benefits that a plan will cover. For example, if a plan has an actuarial value of 70%, on average, you would be responsible for 30% of the costs of all covered benefits.

Children's Health Insurance Program (CHIP) - provides free or low-cost health coverage for children up to age 19.

I/T/U – Indian Health Service/Tribal 638/Urban Indian Health Program

Managed Care Organization (MCO) - Managed care plans are health insurance plans that contract with health care providers and medical facilities to provide care for members at reduced costs. These providers make up the plan's network.

Medicaid – a Federal-State health insurance program for low-income and needy people. It covers children, the aged, blind, and/or disabled and other people who are eligible to receive federally assisted income maintenance payments.

Medicare - a health insurance program for people 65 or older, people under 65 with certain disabilities, and people with End-Stage Renal Disease (permanent kidney failure).

Medicare Part A - Hospital insurance that helps cover inpatient care in hospitals, skilled nursing facility, hospice, and home health care.

Medicare Part B – Covers medically necessary services like doctors' services, outpatient care, durable medical equipment, home health services, and other medical services.

Medicare Part C - A Medicare Advantage Plan offered by private companies approved by Medicare. The plan provides all of your Part A and Part B coverage and may offer extra coverage, such as vision, hearing, dental, and/or health and wellness programs. Most plans include prescription drug coverage (Part D).

Medicare Part D – Prescription drug coverage offered through Medicare

Minimum Essential Coverage – includes coverage under government sponsored programs, eligible employer-sponsored plans, plans in the individual market, certain grandfathered group health plans, and other coverage as recognized by regulation.

Payer of Last Resort - A payer of last resort is an entity that pays after any other primary programs have been billed. For examples, individuals must apply for Medicaid or other financial assistance programs before the Indian Health Service will pay for care through the contract health services program because the IHS is the payer of last resort.

Silver Plan - Four levels of plans will be offered through the Health Insurance Exchanges. All the plans must offer a set of essential health benefits that will be specified in future federal regulations. The four plan levels vary in the total value of coverage they must provide. The “silver” plan has an actuarial value of 70%, meaning that the insured person would be responsible for paying 30% of the costs of all covered benefits.

Tribal 638 – Refers to a program that has been contracted by a tribal government through Public Law 93-638

Urban Indian Health Program (UIHP) - The Urban Indian Health Program consists of 34 non-profit 501(3) (c) programs nationwide. The programs are funded through grants and contracts from the I.H.S., under Title V of the Indian Health Care Improvement Act. In New Mexico, First Nations Community Healthsource in Albuquerque is the only Urban Indian Health Program.