



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

Requirements for Health Insurance Issuers

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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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¹ WAC 284-43-0140.

1. Definitions

- a) **American Indians/Alaska Natives (AI/AN):** The definition of AI/AN varies depending upon which statutory or regulatory provision the term “AI/AN” appears in:
- i) **Generally:** AI/AN means any individual who is: (a) a member of a federally recognized Tribe; or (b) eligible for the Indian Health Service.²
 - ii) **For enrollment period protection and cost sharing benefits³ under the Patient Protection and Affordable Care Act:** AI/AN means: “any person who is a member of an “Indian Tribe.” An “Indian Tribe” means “...any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688) [43 U.S.C. 1601 et seq.], which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.”⁴
- b) **Essential community provider** means providers listed on the Centers for Medicare and Medicaid Services Non-Exhaustive List of Essential Community Providers. This list includes providers and facilities that have demonstrated service to Medicaid, low-income, and medically underserved populations in addition to those that meet the federal minimum standard which includes Indian health care providers as defined below in subsection (c) below.⁵
- c) **Indian health care provider** means:
- i) The Indian Health Service, an agency operated by the U.S. Department of Health and Human Services established by the Indian Health Care Improvement Act (IHCA) § 601, 25 U.S.C. § 1661;
 - ii) An Indian Tribe, as defined in the IHCA § 4(14), 25 U.S.C. § 1603(14), that operates a health program under a contract or compact to carry out programs of the Indian Health Service pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA), 25 U.S.C. § 450 et seq.;
 - iii) A Tribal organization, as defined in the IHCA § 4(26), 25 U.S.C. § 1603(26), that operates a health program under a contract or compact to carry out programs of the Indian Health Service pursuant to the ISDEAA, 25 U.S.C. § 450 et seq.;

² RCW 43.71B.010.

³ For enrollment period benefits for AI/AN, the Patient Protection and Affordable Care Act (ACA) uses the AI/AN definition under the Indian Health Care Improvement Act § 4 (codified at 25 U.S.C. § 1603). For cost sharing benefits for AI/AN, the ACA uses the AI/AN definition under the Indian Self Determination and Education Assistance Act § 4(d) (codified at 25 U.S.C. § 5304(d)). Both definitions are virtually identical and have the same meaning.

⁴ 25 U.S.C. § 5304(d).

⁵ WAC 284-170-300.

- iv) An Indian Tribe, as defined in the IHCIA, § 4(14), 25 U.S.C. § 1603(14), or Tribal organization, as defined in the IHCIA § 4(26), 25 U.S.C. § 1603(26), that operates a health program with funding provided in whole or part pursuant to 25 U.S.C. § 47 (commonly known as the Buy Indian Act); or
 - v) An urban Indian organization that operates a health program with funds in whole or part provided by Indian Health Service under a grant or contract awarded pursuant to Title V of the IHCIA § 4(29), 25 U.S.C. § 1603(29).⁶
- d) **Health insurance issuer or issuer** means “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 (within the meaning of section 514(b)(2) of ERISA).”⁷ Issuers may also be referred to in Washington State statutes and regulations as “health carriers.” Under RCW 48.43.005, “health carrier” or “carrier” includes “issuers” as that term is used in the Patient Protection and Affordable Care Act (P.L. 111-148).⁸

2. AI/AN Access to Indian Health Care Providers

a) All Issuers.

- i) **Network Adequacy Rule.** All issuers must maintain arrangements to ensure that all AI/AN enrollees have access to Indian health care providers for both medical and behavioral health services.⁸ This rule, often referred to as the “network access” rule, requires that all AI/AN enrolled in an issuer’s plan have access to Indian health care providers even if an Indian health care provider is not a contracted network provider.⁹
- ii) **OIC’s Assessment of Access.** If the OIC determines that an issuer's proposed or current provider network is not adequate, the OIC may permit the issuer to propose changes sufficient to make the network adequate within a sixty-day period of time.¹⁰ The proposal must include a procedure to ensure that new enrollees have access to an open primary care provider within ten business days of enrolling in the plan while the proposed changes are being implemented. This requirement is in addition to enforcement action permitted under Title 48 RCW.¹¹

- b) **Qualified Health Plans (QHPs).** QHPs must include essential community providers (ECP) within their networks for QHPs and qualified stand-alone dental plans.¹² Indian health care providers

⁶ WAC 284-43-0160.

⁷ 45 C.F.R. § 144.103.

⁸ WAC 284-170-200.

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

¹⁰ WAC 284-170-340(3).

¹¹ WAC 284-170-340(3).

¹² WAC 284-170-310(1); *See also* 45 C.F.R. § 156.235(a).

are considered ECPs.¹³ The issuer's QHP provider network must include access to one hundred percent of Indian health care providers in its service area.¹⁴

3. Cost of Services to AI/AN

- a) **All Issuers.** 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.”¹⁵ See Section 4 below.
- b) **Qualified Health Plans (QHP).** Members of federally recognized Tribes or Alaska Native Claims Settlement Act (ANCSA) Corporation shareholders qualify for specific cost sharing benefits as outlined below when they enroll in a Washington Health Benefit Exchange (WHBE) QHP.¹⁶
- i) **Zero Cost Sharing.** If the WHBE determines an AI/AN enrolled in a QHP has a household income under 300% of the federal poverty level (FPL), 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.¹⁷ 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 Indian health care provider or through referral under contract health services (currently referred to as “purchase and referred care”) as defined in 25 U.S.C. § 1603(5). The issuer of the plan may not reduce the payment to an Indian health care provider for such services or items;¹⁸ or
- (b) by any other QHP health care provider.¹⁹

In Washington, these plans are referred to as “Cost-Sharing Reduction (CSR) Tier 2 plan variations.”

- ii) **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

¹³ RCW 43.71.065(1)(c); WAC 284-170-300(6); and 45 C.F.R. § 156.235(c).

¹⁴ WAC 284-170-310(3)(b).

¹⁵ WAC 284-170-200(9).

¹⁶ Under the ACA, individuals who are Indian descendants but not enrolled members of a federally recognized Tribe or ANCSA shareholder are not eligible for these cost sharing benefits.¹⁷ ACA § 1402(d)(1) (codified at 42 U.S.C. § 18071(d)(1)(B)).

¹⁷ ACA § 1402(d)(1) (codified at 42 U.S.C. § 18071(d)(1)(B)).

¹⁸ ACA § 1402(d)(2) (codified at 42 U.S.C. § 18071(d)(2)). However, per the Centers for Medicare and Medicaid (CMS), “If the QHP is a closed-panel HMO that does not cover services furnished by a provider outside of the network (i.e., cost sharing for services provided by an out-of-network provider is at 100 percent), the cost sharing for these non-covered services would not need to be eliminated for the zero cost-sharing plan variation, and should be entered as it would be for non-covered out-of-network services under the corresponding standard plan.” CMS [Addendum to 2018 Letter to Issuers in the Federally-facilitated Marketplaces](#), p. 49, footnote 52.

¹⁹ 45 C.F.R. § 156.410(b)(2). This rule is subject to the special rule for family policies set forth in 45 C.F.R. § 155.305(g)(3).

from an Indian health care provider or through referral under contract health services (currently referred to as “purchase and referred care”) as defined in 25 U.S.C. § 1603(5).²⁰ The issuer of the plan may not reduce the payment to an Indian health care provider for such services or items.²¹ In Washington, these plans are referred to as “Cost-Sharing Reduction (CSR) Tier 3 plan variations.”

- iii) **Payment by HHS Secretary.** The Secretary of Health and Human Services (HHS) shall directly pay the QHP issuer an amount necessary to reflect the increase in actuarial value of the plan required by the zero and limited cost sharing plans.²²

4. Indian Health Care Provider Reimbursement

a) All Issuers.

- i) **Right of Recovery Rule.** Pursuant to 25 U.S.C. § 1621e(a), an Indian health care provider shall have the right to recover from an issuer the reasonable charges billed by the Indian health care provider in providing health services through the Indian health care provider or, if higher, the highest amount the issuer would pay for care and services that are furnished by providers other than governmental entities, to any individual to the same extent that such individual, or any nongovernmental provider of such services, would be eligible to receive reimbursement for such charges or expenses if—

- (a) such services had been provided by a nongovernmental provider; and

- (b) such individual had been required to pay such charges or expenses and did pay such charges or expenses.²³

- ii) **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.²⁴

- b) **Qualified Health Plans (QHPs).** For services or items furnished directly by an Indian health care provider or through referral under contract health services,²⁵ 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

²⁰ 42 U.S.C. § 18071(d)(2). *See also* Health Insurance Issuer Standards, 45 C.F.R. § 156.410(b)(3). This rule is subject to the special rule for family policies set forth in 45 C.F.R. § 155.305(g)(3).

²¹ ACA § 1402(d)(2) (codified at 42 U.S.C. § 18071(d)(2)).

²² ACA § 1402(d)(3) (codified at 42 U.S.C. § 18071(d)(3)).

²³ Indian Health Care Improvement Act (IHCA) § 206(a) (codified at 25 U.S.C. § 1621e(a)).

²⁴ IHCA § 206(c) (codified at 25 U.S.C. § 1621e(c)).

²⁵ Contract health services is currently referred to as “purchase and referred care” as defined under 25 U.S.C. § 1603(5).

the plan shall be imposed under the plan for such item or service.²⁶

5. Indian Health Care Providers and State Licensure Requirements

- a) **Licensure of Indian Health Care Provider Health Professionals.** For all issuers, licensed health professionals employed by a Tribal health program shall be exempt, if licensed in any state, from the licensing requirements of the state in which the Tribal health program performs the services described in the contract or compact of the Tribal health program under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).²⁷
- b) **Credentialing.** “Issuers are not responsible for credentialing providers and facilities that are part of the Indian health system.”²⁸ As stated above, health professionals employed by an Indian health care provider do not have to have a Washington state license if they have a license in another state and are performing the services described in the contract or compact of the Tribal health program under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).
- c) **Licensure of Indian Health Care Provider Facilities.** A Federal health care program [e.g., Medicare, Medicaid, Children’s Health Insurance Program, Veterans Administration, Qualified Health Plans] must accept an entity that is operated by the Indian Health Service, an Indian Tribe, Tribal organization, or urban Indian organization as a provider eligible for reimbursement of health care services furnished to an AI/AN on the same basis as any other qualified provider under the program if the entity meets generally applicable state or other requirements for participation as a provider of health care services under the program.²⁹

Any requirement under a Federal health care program that an entity operated by Indian Health Service, an Indian Tribe, Tribal organization, or urban Indian organization be licensed or recognized under the state or local law where the entity is located shall be deemed to have been met if the entity meets all the applicable standards for such licensure or recognition, regardless of whether the entity obtains a license or other documentation under such state or local law.³⁰ A licensed or certified behavioral health agency in Washington State, includes an entity with a Tribal attestation that it meets state minimum standards for a licensed or certified behavioral

²⁶ ACA § 1402(d)(2)(B) (codified at 42 U.S.C. § 18071(d)(2)).

²⁷ IHCA § 221 (codified at 25 U.S.C. § 1621t). *See also* IHCA § 408(a)(2) (codified at 25 U.S.C. § 1647a(a)(2)): For Federal health care programs [e.g., Medicare, Medicaid, Children’s Health Insurance Program, Veterans Administration, Qualified Health Plans], “the absence of the licensure of a health professional employed by such an entity [an entity operated by the Service, an Indian tribe, tribal organization, or urban Indian organization] under the State or local law where the entity is located shall not be taken into account for purposes of determining whether the entity meets such standards, if the professional is licensed in another State.”

²⁸ WAC 284-170-200(9).

²⁹ IHCA § 408(a)(1) (codified at 25 U.S.C. § 1647a(a)(1)).

³⁰ IHCA § 408(a)(1) (codified at 25 U.S.C. § 1647a(a)(2)).

health agency.³¹

6. Payer of Last Resort

Health programs operated by the Indian Health Service, Indian Tribes, Tribal organizations, and Urban Indian organizations (as those terms are defined in § 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603)) shall be the payer of last resort for services provided by such Service, Tribes, or organizations to individuals eligible for services through such programs, notwithstanding any federal, state, or local law to the contrary.³² Therefore, all alternate resources that are available and accessible such as Medicare, Medicaid, SCHIP, private insurance, etc. are used before Indian health care provider's funds can be expended.

7. Enrollee Eligibility for Indian Health Care Provider Services

Indian health programs are established under the Indian Health Care Improvement Act (IHCA) to serve their AI/AN community and/or other populations (including non-Indians) pursuant to 42 C.F.R. Part 136 and § 813(a) and (b) of the IHCA (25 U.S.C. § 1680c). Pursuant to 45 C.F.R. § 80.3(d), 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.

8. Qualified Health Plan Contracting with Indian Health Care Providers

- a) **Requirement to Offer to Contract.** (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.³³ The rule does not place specific time requirements; therefore, an Indian health care provider may seek a contract with an issuer at any time during a year. This rule does not apply to non QHP issuers.
- b) **Good Faith Exception.** If an Indian health care provider requests a contract and a contract is not entered into, the QHP issuer must provide substantial evidence of good faith efforts on its part to contract with the Indian health care provider. Such evidence of good faith efforts to contract will include documentation about the efforts to contract but not the substantive contract terms offered by either the issuer or the provider.³⁴
- c) **Model Washington State Indian Health Care Provider Contract Addendum.** The Washington Indian Addendum was developed for issuers in contracting with Indian health care providers and to help issuers comply with federal laws governing Indian health care and to comply with

³¹ RCW 71.24.025,

³² ACA § 2901(b) (codified at 25 U.S.C. § 1623(b)).

³³ WAC 284-170-310(5).

³⁴ WAC 284-170-310(5)(b).

QHP certification standards set forth in 45 C.F.R. Part 156. QHP issuers are encouraged to use the current version of the Model Washington State Indian Health Care Provider Addendum, as posted on <http://www.aihc-wa.com> to supplement existing provider contracts when contracting with an Indian health care provider.³⁵ The OIC expects issuers to use the Addendum.³⁶

9. Insurance and Indemnification

- a) **Federal Tort Claims Act.** The Federal Tort Claims Act (FTCA)³⁷ allows parties claiming to have been injured by negligent actions of employees of the United States to file claims against the federal government and provides authority for the federal government to defend against such claims. Congress extended the FTCA to the negligent acts of Tribal employees acting within the scope of their employment and within the scope of the Tribe's contract or compact with the Indian Health Service.³⁸ The coverage also extends under certain circumstances to personal services contractors and independent contractors acting within the scope of their employment and within the scope of the Tribe's contract or compact with Indian Health Services. FTCA coverage is also included for Urban Indian Organizations who are Federally Qualified Health Centers under § 224 of the Public Health Service Act. Per the U.S. Department of Health and Human Services (HHS), since a claim under the FTCA is the exclusive remedy for actions against Indian health care providers that are covered by the FTCA, those entities are not required to obtain separate professional liability insurance.³⁹
- b) **QHP Indian Addendum Liability Provisions.** The [Centers for Medicare and Medicaid \(CMS\) Overview of the Model QHP Addendum for Indian Health Care Providers](#) and the [Model Washington State QHP Indian Addendum](#) provide the following requirements:
- (i) Indian health care providers shall not be required to obtain or maintain professional liability insurance to the extent such provider is covered by the FTCA;
 - (ii) Nothing in the QHP network provider agreement or any addendum thereto shall be interpreted to authorize or obligate such provider or any employee of such provider to operate outside of the scope of employment of such employee; and
 - (iii) Such provider shall not be required to acquire insurance, provide indemnification, or guarantee that the QHP will be held harmless from liability.

³⁵ WAC 284-170-310(5)(a).

³⁶ Concise Explanation Statement to R-2013-22, at page XX. However, please note that under existing state law, the OIC does not have authority to require issuers use the Addendum when contracting with Indian health care providers. State law also prohibits the Washington Health Benefit Exchange (WHBE) from adding new QHP certification standards without legislative approval. See RCW 43.71.080(10). The state legislature is the only entity that can establish requirements that issuers use the Indian Addendum when contracting with Indian health care providers.

³⁷ 28 U.S.C. §§ 2671-2680.

³⁸ 25 U.S.C. § 5321(d).

³⁹ [Centers for Medicare and Medicaid \(CMS\) Overview of the Model QHP Addendum for Indian Health Care Providers](#), p. 2-3.

10. Claims Format

All issuers are prohibited from denying a claim for benefits submitted by an Indian health care provider based on the format in which the claim is submitted if such format complies with the format required for submission of claims under title XVIII of the Social Security Act [42 U.S.C. 1395 et. seq.] or recognized under section 1175 of such Act [42 U.S.C. § 1320d-4].⁴⁰

11. Confidentiality Requirements for Indian Health Care Provider Medical Quality Assurance Records

All medical quality assurance records created by or for an Indian health care provider as part of a medical quality assurance program are confidential and privileged and may not be disclosed to any person or entity, including health issuers,⁴¹ except under certain statutory exceptions.⁴²

12. OIC Enforcement of Issuer Requirements

Issuers regulated by the OIC must comply with all state and federal laws relating to the acts and practices of issuers and laws relating to health plan benefits.⁴³ The OIC has a formal complaint process for insurance enrollees, providers and others when issuers are not following state rules. The complaint process applies to entities regulated by OIC including licensed insurers selling health insurance policies, including QHPs sold through the WHBE. It covers violations of the OIC network access rules set forth in WAC 284-170, Subchapter B – Health Care Networks. The complaint process does not cover complaints regarding Medicare, Medicaid, federal employee plans, or Indian Health Services. It also does not cover clinical care provided by licensed health care professionals, such as physicians, dentists, therapists and behavioral health professionals, who are regulated by provider-specific boards or commissions or the Washington State Department of Health.

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. Complaints can be filed online at: <https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status>. They also can be

⁴⁰ IHCA § 206(h) (codified at 25 U.S.C. § 1621e(h)).

⁴¹ Per Centers for Medicare and Medicaid (CMS): “Section 805 of the IHCA, 25 U.S.C. § 1675, facilitates internal medical program quality reviews; shields participants in those reviews; and restricts disclosure of medical quality assurance records, subject to the exceptions in 25 U.S.C. 1675(d), which provides that medical quality assurance records created by or for I/T/U providers may not be disclosed to any person or entity. These disclosure limitations are also applicable to anyone to whom the I/T/U provider discloses such medical quality assurance records under the authority of 25 U.S.C. 1675(d). Although restrictive, we expect these limitations will have limited applicability to QHPs because there will be few, if any circumstances, where such records may be disclosed to a QHP under the law.” See CMS, [Overview of the Model QHP Addendum for Indian Health Care Providers](#).

⁴² IHCA § 805(b) (codified at 25 U.S.C. § 1675(b)).

⁴³ WAC 284-43-0140.

filed by mail, fax, email or chats with OIC staff. The OIC has a complaint form that can be obtained online at the address above. The OIC Online Complaint Center allows persons to track the status of their complaint, get progress emails and upload documents needed for the complaint filing.

Once a complaint has been filed, the OIC will first determine if they have jurisdiction over the complaint matter. If they do not have jurisdiction, they will notify the person filing the complaint and refer the individual to the correct agency or entity. If the OIC has jurisdiction, they will send the complaint to the issuer and request a response. The issuer has 15 business days to respond to the complaint. Given the specifics of the complaint, OIC may ask for more information and will work with the issuer to address the issue. It takes approximately 22 days from the date of filing to get information from the issuer and to review the complaint and their response. The OIC will then provide an explanation of the issuer's response and OIC review of the response to the entity filing the complaint. 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>.

13. QHP Enrollment Periods for AI/AN

QHP issuers must allow an AI/AN⁴⁴ to enroll or change plans in Washington Healthplanfinder at any point during the year but not more than once-a-month.⁴⁵

⁴⁴ As defined in Section 1(a)(ii) above.

⁴⁵ 45 C.F.R. § 155.420(d)(8).