Indian Health Service Recovery Efforts Are Overreach

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Darryl T. Landahl

Health plans across the country are increasingly receiving demands for payment from the Indian Health Service, tribal health programs (collectively "Indian Organizations") and the U.S. Department of the Treasury for services provided by Indian Organizations to commercial health plan members. These claims for recovery are premised on the fact that Indian Organizations are generally considered a "payor of last resort."[1] To effectuate this principle, federal law provides Indian Organizations with a right of recovery against certain third parties, including health insurers, for services provided to a health plan's members by an Indian Organization provider.[2] However, some Indian Organizations have apparently interpreted that right as unlimited.

A broad, unlimited interpretation of the recovery right does not appear to be supported by the plain language of the recovery statute, which specifically states that Indian Organizations can only recover "to the same extent" that the member or a nongovernmental provider would be eligible to receive reimbursement if a nongovernmental provider had provided and the member was required to pay for the medical services. The central question is the extent to which the statute's "to the same extent" provision limits an Indian Organization's recovery right, particularly in cases where a nongovernmental out-of-network provider would not be eligible to receive payment from a commercial health insurer due to a member's coverage restrictions.

Case law supports the position that certain health insurance policy limitations are enforceable against Indian Organizations that attempt to recover under 25 U.S.C. § 1621e(a). Courts that have applied this and other similar recovery statutes have found that enforceability hinges on whether the plan limitation is substantive or procedural. Generally, enforceable substantive plan limitations are those that limit the type, quantity or location of services covered under the plan. Examples include: out-of-network or prior authorization requirements, visit limitations and coverage exclusions. Conversely, unenforceable procedural plan limitations are those that effectively preclude any ability for recovery by an Indian Organization, such as a requirement that a claim is only payable if submitted by the member.

Although the IHS, the U.S. Department of Health and Human Services and other regulators may argue otherwise, there is no known legal support for the position that 25 U.S.C. § 1621e(a) preempts all plan limitations on Indian Organization

recovery claims, or that the statute was intended to provide unabated coverage for services provided by an Indian Organization. If true, it would effectively allow a health plan member to access Indian Organization facilities and providers without limitation, including for services or treatments not otherwise covered under the plan, such as noncovered cosmetic or experimental services. But, when the statute is strictly construed in accordance with its intent, substantive health plan coverage limitations (e.g., out-of-network, prior authorization, etc.) are permissible for Indian Organizations, just as they would for any other nongovernmental provider.

Before any private federal contractor attempts to collect against a health plan, the Indian Organization that provided medical services will typically send a demand for payment to the plan. A collection notice from an Indian Organization is just one of the preliminary steps in the federal debt collection process. Although the notice will typically threaten a civil suit, there are several interim steps that may be taken by the Indian Organization, and the consequences can be significant for the health plan if the debt notices are ignored.

Once the Indian Organization refers the matter to HHS, the department may send one or more demand letters to the health plan. Second, as a general proposition, once the debt is 180 days past due, and if there is no simultaneous administrative review of the debt, the debt is certified by HHS as legally enforceable. If HHS certifies in writing that the debt is valid and legally enforceable without any bars to collection, the debt is generally transferred to the U.S. Department of the Treasury's Bureau of Fiscal Service. Once the debt has been referred to the bureau it may send additional demand letters or refer the debt to private collection agencies hired by the federal government. At that stage, the bureau has a number of options available to it for collection, including the option of referring the debt to the U.S. Department of Justice for litigation against the health plan.

While not an exhaustive list, additional consequences of nonpayment may include: (1) suspension or revocation of the health plan’s licenses, permits or other privileges “for any inexcusable or willful failure” of the health plan to pay the debt (extends to federal programs or activities that are administered by the states on behalf of the federal government); (2) suspension of federal loans or prohibition from obtaining federal financial assistance in the form of a loan, loan insurance or guarantee; (3) interest on the outstanding debt from the first date of notice; (4) charges to cover the cost of processing and handling the debt collection; (5) charges sufficient to cover the full costs of debt collection services; (6) a penalty charge of not more than 6 percent per year for failure to pay a debt more than 90 days past due; (7) public dissemination of the health plan’s identity and the existence of nontax debt; (8) administrative offset of payments made to the health plan by federal agencies; and (9) reports to credit bureaus regarding the debt.

For these reasons, it is critical that a health plan address any recovery demand at the outset by disputing the debt. Furthermore, addressing each individual recovery demand by reference number is key, because those numbers are the only link connecting the health plan to the debt. Sending blanket dispute letters to HHS or IHS without reference numbers may produce uncertain and negative results. Simply

ignoring the demand may lead to debt collection efforts by the bureau, and ultimately limit the plan's options for disputing the attempted recovery. In all events, tracking the notices as they arrive at the health plan and ensuring that debts are disputed at the earliest stages of recovery is essential to the plan's overall ability to avoid adverse consequences and to move toward a favorable outcome with the federal government.

—By Darryl T. Landahl and Shelley C. Nordling, Brownstein Hyatt Farber Schreck LLP

Darryl Landahl is a shareholder in Brownstein Hyatt Farber Schreck's Denver office.

Shelley Nordling is an associate in Brownstein Hyatt Farber Schreck's Phoenix office.

[1] 25 U.S.C. § 1623(b); see also, 42 C.F.R. § 136.61.

[2] 25 U.S.C. § 1621e(a).