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NAIC/American Indian and Alaska Native Liaison Committee
Denver, Colorado
November 18, 2024

The NAIC/American Indian and Alaska Native Liaison Committee met in Denver, CO, Nov. 18, 2024. The following Liaison Committee members participated: Glen Mulready, Chair (OK); Trinidad Navarro, Vice Chair (DE); Lori K. Wing-Heier (AK); Dean L. Cameron (ID); Grace Arnold (MN); Chlora Lindley-Meyers (MO); Mike Causey (NC); Jon Godfread (ND); Scott Kipper (NV); Andrew R. Stolfi (OR); Larry D. Deiter (SD); Jon Pike represented by Tanji J. Northrup (UT); Mike Kreidler represented by Todd Dixon (WA); Nathan Houdek (WI); and Jeff Rude (WY).

1. Adopted its Summer National Meeting minutes.

Director Wing-Heier made a motion, seconded by Commissioner Rude, to adopt the Liaison Committee's Aug. 14 minutes (*see NAIC Proceedings – Summer 2024, NAIC/American Indian and Alaska Native Liaison Committee*). The motion passed unanimously.

2. Announced the Reaffirmation of its 2024 Mission Statement for 2025

Commissioner Mulready announced that the Liaison Committee conducted an e-vote that concluded Oct. 15 to reaffirm its 2024 mission statement for 2025. The motion passed unanimously.

3. Heard a Presentation from the University of Washington School of Medicine and Leavitt Partners on the AIMES Alliance

Bill Snyder (Leavitt Partners) said that as a South Dakota resident who worked with Medicaid, he saw the need for better health care first-hand. He said Leavitt Partners manages the American Indian Medical Education Strategies (AIMES) Alliance. Leavitt said the Alliance brings together voices from all sectors to collaboratively drive solutions forward that will bring graduate medical education (GME) to Tribal communities. He said there are numerous founding members that include health plans, associations, universities, health systems and tribes. Dr. LeeAnna Muzquiz (University of Washington School of Medicine) said this program is collaboratively advancing federal and Tribal solutions that expand GME opportunities in Indian Country through communications, outreach, and policy development to reduce physician shortages in Tribal medical facilities. She said the goal is to keep up to date on the latest policies, activities, and developments focused on reducing physician shortages and expanding GME in Tribal medical facilities by joining the AIMES Alliance community in providing broader medical access for American Indians and Alaska Natives (AI/ANs). Dr. Muzquiz said this is also important because it provides another avenue for outreach that states can use via a partnership with the AIMES system. She encouraged state insurance regulators to use their influence to help expand membership in the AIMES Alliance nationally, as it currently has members in only 19 states with seven tribal partners; 14 medical schools; four teaching hospital systems; one health plan; one residency program, and five physicians and medical education advocates.

Dr. Muzquiz said the diversity of the AIMES Alliance membership is its strength. She said AIMES Alliance members include those from Tribal nations, urban and rural Tribal organizations, medical institutions that grant Doctor of Medicine (MD) and Doctor of Osteopathic Medicine (DO) degrees, teaching hospitals, residency programs, and physician and workforce advocates.

Dr. Muzquiz said that despite the billions of dollars put toward training physicians, hardly any money goes to Tribal medical facilities even though they could benefit the most from improved staffing. She said AI/ANs suffer from some of the highest rates of avoidable deaths from preventable and treatable causes. For example, from 2020–

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2021, the U.S. rate of deaths before age 75 from preventable causes per 100,000 population was 231.9. For AI/AN individuals, however, that rate was more than double the national rate, at 478.9. In one state, the rate of preventable deaths was more than four-and-a-half times the national rate, at 1,394 deaths from preventable causes per 100,000 population. Snyder said the AIMES Alliance is working to accomplish its mission through communications, outreach, and policy development. Dr. Muzquiz said the AIMES Alliance envisions an environment where urban and rural Tribal members benefit from access to fully staffed medical facilities filled with physicians who provide high-quality and culturally appropriate care and invest in the communities they serve. She said the Alliance also envisions a medical education and training environment where allopathic and osteopathic physicians have extensive opportunities to benefit communities and further their education and training in urban and rural Indian Health Service (IHS), Tribal-administered, and other Indigenous clinics and facilities.

Dr. Muzquiz said Dr. Donald Warne leads the AIMES Alliance as its convener and is currently serving as co-director of the Johns Hopkins Center for Indigenous Health. She said Warne is an acclaimed physician, one of the world's preeminent scholars in Indigenous health, health education, policy, and equity, as well as a member of the Oglala Lakota Tribe from Pine Ridge, SD. She said Warne will also serve as Johns Hopkins University's new Provost Fellow for Indigenous Health Policy. Davis said that because Warne comes from a long line of traditional healers and medicine men and is a celebrated researcher of chronic health inequities, he is also an educational leader. Warne created the first Indigenous health-focused Master of Public Health (MPH) and Doctor of Philosophy (PhD) programs in the U.S. or Canada at North Dakota State University and the University of North Dakota, respectively. She said Warne previously served at the University of North Dakota as a professor of Family and Community Medicine and associate dean of diversity, equity, and inclusion (DE&I), as well as director of the Indians into Medicine and Public Health programs at the University of North Dakota School of Medicine and Health Sciences.

Dr. Muzquiz said Dr. Michael Toedt serves as the AIMES Alliance's senior advisor and is the founder and chief executive officer (CEO) of Toedt Health Solutions. She said Toedt is a North Carolina-licensed and board-certified family physician and the former chief medical officer (CMO) of the IHS, as well as their chief medical informatics officer (CMIO). Dr. Muzquiz said Toedt is a retired rear admiral with over 30 years of experience as a physician executive, public health expert, health information and technology expert, and flag officer in the U.S. Public Health Service Commissioned Corps. She said that Toedt, as a Uniformed Services University of the Health Sciences graduate, has first-hand experience serving in IHS, Tribal, U.S. Department of Defense (DoD), and U.S. Department of Veterans Affairs (VA) health care facilities. He has served on numerous U.S. Department of Health and Human Services (HHS) committees. She also said Toedt has experience working with local, regional, Tribal, state, and federal governments, emphasizing eliminating health inequity and improving health outcomes for vulnerable and underserved populations.

Snyder said GME is the period of training performed after medical school where physicians gain specific skills and experiences in a particular medical specialty (residency) or subspecialty (fellowship). This formal training must be completed to practice medicine in the U.S. He said GME is primarily funded by four federal programs and agencies (Medicare, the Health Resources and Services Administration [HRSA], the VA, and the DoD) and one joint federal-state program (Medicaid). Snyder said GME residents and fellows in Tribal medical facilities create an ecosystem of sustainable, high-quality care locally, reducing the need for travel, long waits, and paying for high-cost locum tenens positions (a locum, or locum tenens, is a person who temporarily fulfills the duties of another; the term is especially used for physicians. For example, a locum tenens physician is a physician who works in the place of the regular physician). Dr. Muzquiz said physicians invested in the community are more likely to provide consistent, accessible, and culturally appropriate care to Tribal members. She said that while IHS-operated medical facilities are frequently viewed by non-Tribal individuals as the most visible medical care provider in Indian Country, IHS is only part of the greater system that provides medical care to AI/ANs. She also said this system is referred to as the I/T/U in reference to the three categories of participating facilities: IHS, Tribal-operated, and Urban Indian

Organizations (UIOs). She said this system finds creative ways to help patients and GME provides an opportunity for this type of creative training.

Dr. Muzquiz said the goal was for medical students to go back home to do their residencies and post-graduate training; however, there are no training centers in those areas, so it is hard for new physicians to get back into serving their own communities during the GME training cycle. Snyder said a tool was released last week to help medical students find GME training in their native lands. Dr. Muzquiz said the University of Washington has started a program to rotate student training through the Flat Head organization and Pine Ridge Medical Center to address this situation. Dr. Muzquiz invited state insurance regulators to proactively engage with urban and rural Tribal nations and Tribal organizations in their state; let policymakers know that GME opportunities in Tribal communities are important to state insurance regulators and the organizations they represent; check out the Tribal GME opportunities tool on the AIMES Alliance website and share it with interested individuals and organizations in their networks; and encourage organizations interested in joining the AIMES Alliance to contact herself or Snyder.

4. Heard a Presentation from Tribal First on Producer Outreach to Tribal Members Providing Access to Affordable Insurance Products

Commissioner Mulready said the Liaison Committee has discussed outreach to tribal communities for many years; however, it has not heard from producers until now.

Brendan McKenna (Tribal First) said his presentation is designed to provide insight into the innovations being used to make affordable health care more accessible to all Native Americans and give tribal leaders the ability to self-govern the health care arena. He said tribes in the Pacific Northwest have been taking a more liberal approach to tribal self-governance recently by exercising self-governance to Deliver Health Care. At the turn of the century, he said there were 15 million native Americans. Over the past 35 years, the number of native Americans has been on the same path as the buffalo, in that both have dropped dramatically to almost extinct levels, with tribal members going from 250,000 to only 5,000 in recent years. McKenna said much of this decline has been the result of failed U.S. government policies, with over 2,500 treaties being broken—not by the tribes, but by the federal government. He said another big part of the decline was in the lack of proper medical care caused by reduced federal funding of tribal nations and the condensing of Indian Country into ever smaller areas of land on a per-person basis.

McKenna said that in 1994, Indian Country used Publication 638 to take authority for tribal self-governance to do what it needed to serve and meet the needs of its own people without relying on the federal government. He said the Indian Self Determination and Education Assistance Act identified the need and set forth plans to meet it. He said the Indian Health Care Improvement Act allowed the use of federal appropriations wherever and however tribal members needed it, whether it was to buy insurance plans on the open market; use federal funds to self-insure; or open their own medical facilities to serve their people. He noted that annual federal appropriation for general prison populations in 2024 is $11,400 per prisoner; however, it is only $4,500 per person for federal-recognized tribal members. McKenna said the Medicare Prescription Drug, Improvement, and Modernization Act finally allowed native Americans to access Medicare. He said the Patient Protection and Affordable Care Act (ACA) included AI/ANs for the first time and the Public Health Service Act included the 340 B Drug Pricing Program, which is the Tribal Healthcare Model Plan that tribes can now purchase as self-funded outside of state authority. McKenna said self-governance gives tribes the opportunity: 1) to promote tribal sovereignty to serve the needs of plan participants for generations without IHS or state oversight; 2) to secure PRC Program Authorities to collaborate across stakeholders (tribes, brokers, TPAs, Tribal First and Tribal Care), continue to pool appropriations, and exercise PRC authorities (to purchase health care services, deliver health care services, and enforce Payor of Last Resort rules); and 3) to promote strength in numbers to align efforts to serve Tribes/Pueblos across Indian Country and install best practices shared by all. He said the Prevention, Retention, and Contingency

(PRC) program provides short-term assistance to low-income families and individuals in need of emergency help. The program is run by the local County Department of Job and Family Services.

McKenna said Tribal Cost Management Resources through the Medicare Modernization Act and PRC Rates Rule allow Medicare-like rates which saves 75% of billed charges on hospital-based or professional medical claims; through Indian Self-Determination and Education Assistance Act (ISDEAA); Indian Health Care Improvement Act (IHCIA); Affordable Care Act (ACA); Marsh McLennan Agency (MMA); Public Health Services Act (PHSA) which provides the authority of sovereignty and self-governance for the purchase and delivery of health services; the Public Health Services Act with its 340B drug purchasing that saves 50% compared to the traditional PBM model and all plan participants are eligible; and by Exchange Sponsorship where fully-insured state exchange plans are purchased by tribes for their members on a monthly basis. McKenna said resource integration was the key as it included plan administration by the preferred TPA partner, PRC program coordination, SPD compliance, and reporting; stop loss via preferred carrier partners, premium reward program, SPD complaints, and reporting; and broker support with its account support services, vendor partner relations, and reporting.

5. Heard a Panel Discussion from Commissioner Glen Mulready (OK) and Director Lori K. Wing-Heier (AK) on How State Insurance Regulators Support Tribal Communities.

Commissioner Mulready and Director Wing-Heier joined Dr. Muzquiz, Snyder, and McKenna to answer questions from attendees.

Julia Juarez (CA) asked how California could partner with the AIMES Alliance for outreach to Tribal communities. Dr. Muzquiz said to contact her or Bill Snyder following the meeting at their contact information noted on their last presentation slide.

Director Wing-Heier said health care accessibility is a huge challenge in Anchorage and other rural areas, as the cost is excessive, and the governor is working with HHS and the DOI on potential solutions.

Dixon said Washington is publishing a 12-page document that provides insurers with a handbook to meet the requirements of federal Tribal rules about networks, care, medical practice, etc. He suggested it might be a good topic for a future NAIC meeting.

Commissioner Mulready said he would like to thank our speakers, panelists, committee members and their staff for helping to promote the outreach of our NAIC community to Native American communities today, especially since November is officially recognized by the federal government as Native American Heritage month.

Having no further business, the Liaison Committee adjourned.

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