

National Indian Health Board



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October 31, 2011

CC:PA:LPD:PR (REG-131491-10)
Room 5203
Internal Revenue Service
PO Box 7604
Ben Franklin Station
Washington, DC 20044

RE: NIHB Comments on IRS REG-131491-10: Health Insurance Premium Tax Credit

The National Indian Health Board¹ (NIHB) is submitting the attached analysis and recommendations (Comments) to the Department of the Treasury (Treasury), Internal Revenue Service (IRS) in response to the notice of proposed rulemaking published August 17, 2011 in the *Federal Register* titled "Health Insurance Premium Tax Credit" (IRS REG-131491-10) (Proposed Rule). The Proposed Rule is primarily aimed at implementing the new Internal Revenue Code section 36B established under section 1401(a) of the Patient Protection and Affordable Care Act.²

¹ Established nearly 40 years ago, NIHB is an inter-Tribal organization that advocates on behalf of Tribal governments for the provision of quality health care to all American Indians and Alaska Natives. NIHB is governed by a Board of Directors consisting of a representative from each of the twelve Indian Health Service (IHS) Areas. Each Area Health Board elects a representative to sit on the NIHB Board of Directors. In areas where there is no Area Health Board, Tribal governments choose a representative who communicates policy information and concerns of the Tribes in that area with NIHB. Whether Tribes operate their entire health care program through contracts or compacts with IHS under Pub. L. 93-638, the Indian Self-Determination and Education Assistance Act, as amended (ISDEAA), or continue to also rely on IHS for delivery of some, or even most, of their health care, NIHB is their advocate.

² Refers collectively to the Patient Protection and Affordable Care Act (Pub. L. 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), and referred to herein as the Affordable Care Act or ACA. Section 36B, contained in section 1401 of the ACA, was subsequently amended by the Medicare and Medicaid Extenders Act of 2010 (Pub. L. 111-309), the Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011 (Pub. L. 112-9), and the Department of Defense and Full-Year Continuing Appropriations Act, 2011 (Pub. L. 112-10).



We appreciate the opportunity to comment on this Proposed Rule. Although the Proposed Rule itself does not make specific mention of American Indians and Alaska Natives, or of Indian Tribes, the policies and procedures established through this Proposed Rule will have a profound impact on the ability of AI/AN to access affordable health insurance coverage and to secure needed health care services from their providers of choice, particularly Indian Health Care Providers.³

This Proposed Rule, although released by Treasury/IRS, is interconnected with provisions administered by Centers for Medicare and Medicaid Services (CMS), Department of Health and Human Services (HHS). As such, NIHB is submitting these comments to both IRS/Treasury and CMS/HHS.

In this cover letter, we provide a summary of the primary recommendations included in the attached Comments.

Summary of Primary Recommendations

- Clarify, along with HHS, the eligibility requirements for premium tax credits, the eligibility requirements for purchasing health insurance coverage in the individual market through an Exchange, and the eligibility requirements for cost-sharing assistance. (ACA § 1312; ACA §§ 1401 and 1501; Proposed Rule § 1.36B-2; ACA § 1402)
- Modify the definition of the “applicable benchmark plan” and “the second lowest cost silver plan offered through an Exchange in the rating area where the taxpayer resides” to ensure that the lowest and second lowest cost silver plans referenced are qualified health plans that serve the area in which the taxpayer/enrollee resides. (ACA § 1401(a) / IRC § 36B(b)(3)(B); Proposed Rule § 1.36B-3)
- Confirm that premiums that may be made by Tribes, tribal organizations, and other entities on behalf of a taxpayer/enrollee will be counted for purposes of determining the number of “coverage months” in calculating the premium tax credit amount. (Proposed Rule §§ 1.36B-3(c)(1)(ii) and (c)(2))
- Retain the policy that eligibility for the Indian Health Service does not constitute eligibility for government-sponsored minimum essential coverage. (Proposed Rule § 1.36B-2(c)(2))
- Exempt AI/AN from the requirement to enroll in employer-sponsored coverage.

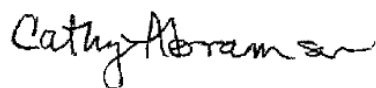
³ The term "Indian Health Care Provider" means the Indian Health Service (IHS), an Indian Tribe, tribal organization or urban Indian organization, and is sometimes referred to collectively as "I/T/U". The term "Indian Health Service" means the agency of that name within the U.S. Department of Health and Human Services established by Sec. 601 of the Indian Health Care Improvement Act (IHCIA), 25 USC §1661. The term "Indian tribe" has the meaning given that term in Sec. 4 of the IHCIA, 25 USC §1603. The term "tribal organization" has the meaning given that term in Sec. 4 of the IHCIA, 25 USC §1603. The term "urban Indian organization" has the meaning given that term in Sec. 4 of the "IHCIA", 25 USC §1603.

(Proposed Rule § 1.36B-2(c)(3))

- Provide, at least on an interim basis, a “safe harbor” exemption from the requirement to make a payment in the amount of any excess premium assistance payments made by the Federal government to a plan on behalf of an AI/AN to the extent that the initial determination of premium assistance was based on a good faith estimate of annual household income. (Proposed Rule § 1.36B-3(d))
- Clarify, along with HHS, that any payments of cost-sharing assistance made by the Federal government to a plan on behalf of an AI/AN or any other enrollee under ACA §§ 1402 or 1412 that may be subsequently evaluated to be in excess of the amount an individual is eligible to receive will not be required to be paid by the enrollee to the plan, Exchange, or to the Federal government. (ACA §§ 1402 and § 1412)
- Consider the attached presentation on the definition of Indian as IRS/Treasury proceeds to integrate implementation of the ACA with HHS.
- Engage in continued consultation with Tribes on these and other matters pertaining to the implementation of the Affordable Care Act in order to fully, efficiently and effectively carry out the Federal Trust Responsibility.

Thank you in advance for consideration of these recommendations as we jointly work to advance the health status of American Indian and Alaska Native individuals and communities across the United States.

Sincerely,



Cathy Abramson
Chairman, National Indian Health Board

- C: Dr. Donald Berwick, Administrator, CMS
Dr. Yvette Roubideaux, Director, Indian Health Service
Valerie Davidson, Chair, Tribal Technical Advisory Group to CMS
Kitty Marx, Director, CMS Tribal Affairs Group
H. Sally Smith, Chair, NIHB Medicare, Medicaid and Health Reform Policy
Committee (MMPC)
Stacy Bohlen, Executive Director, NIHB
Jennifer Cooper, Legislative Director, NIHB

Attachment: NIHB Analysis of and Recommendations on IRS REG-131491-01: Health Insurance Premium Tax Credit

National Indian Health Board



NIHB Analysis of Notice of Proposed Rulemaking: Health Insurance Premium Tax Credit (IRS REG-131491-10)

Analysis of and Recommendations on Proposed Rule by the National Indian Health Board¹ (Comments)

October 31, 2011

The National Indian Health Board (NIHB) appreciates the opportunity to provide these Comments on the Department of the Treasury (Treasury), Internal Revenue Service (IRS) Notice of Proposed Rulemaking, "Health Insurance Premium Tax Credit" published August 17, 2011 in the *Federal Register* (Proposed Rule). NIHB is providing these comments simultaneously to the IRS and the Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS).

In these Comments, NIHB provides analysis and recommendations on provisions specific to American Indians and Alaska Natives (AI/ANs) as well as to provisions generally applicable to all Americans. Furthermore, these Comments discuss the applicability to and impact on the Indian Health Service, Tribes and Tribal organizations, and urban Indian organization health care providers (which are referred to as Indian Health Care Providers or I/T/U).² The Patient Protection and Affordable Care Act³ as well as a host of other Federal

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laws and regulations govern Indian Health Care Providers and impact the structure and policies of such providers. These Federal laws and regulations (including, but not limited to, the Snyder Act, the Indian Health Care Improvement Act (IHCA),⁴ the ISDEAA, the Federal Tort Claims Act (FTCA) and the Anti-Deficiency Act⁵) also impact the range of functions, policies, and operations of an Affordable Health Insurance Exchange (Exchange) through which premium assistance will be accessed.

This Proposed Rule, although released by Treasury/IRS, is interconnected with provisions of the ACA administered by HHS, such as the eligibility determination functions performed by Exchanges. As such, NIHB is submitting these comments to both Treasury and HHS.

1. Background

Under subtitle E, part I, subpart A, section 1401 of the Affordable Care Act, a new section 36B was added to subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code. The addition of section 36B to the Internal Revenue Code is being codified at 26 CFR Part 1.

With the addition of section 36B to the Internal Revenue Code (IRC), health insurance coverage secured in the individual market through an Exchange is made more affordable to enrollees who have household income under 400 percent of the Federal poverty line⁶ by reducing an individual's premium costs. This is accomplished through premium tax credits provided by the Federal government, with the Exchange making an advance determination of credit eligibility for individuals enrolling in coverage through an Exchange and the amount of the advance payments. IRS provides the advanced payment of the premium tax credits directly to the Exchange plan selected by the taxpayer/enrollee(s).

Eligibility requirements for the premium tax credits are contained in ACA §§ 1401 and 1501. The provisions for calculating the premium tax credit amounts are found under ACA § 1401 / IRC § 36B. The procedures for applying the eligibility requirements from ACA §§ 1401 and 1501 determining eligibility for the premium tax credit (as well as for the cost-sharing reductions) are found under ACA § 1411.

Protection and Repayment of Exchange Subsidy Overpayments Act of 2011 (Pub. L. 112-9), and the Department of Defense and Full-Year Continuing Appropriations Act, 2011 (Pub. L. 112-10).

⁴ Pub. L. 94-437 was permanently reauthorized and amended March 23, 2010, by § 10221(a) of the ACA.

⁵ A more complete listing of the Federal laws and regulations affecting Indian Health Care Providers can be found in the Indian Addendum proposed by NIHB, the Tribal Technical Advisory Group to CMS (TTAG), and others to be used by Exchange plans when contracting with Indian Health Care Providers. (Refer to the letter and the attached draft Indian Addendum from TTAG to Dr. Donald Berwick dated April 13, 2011 titled "Indian Addendum for ACA Exchange Plan Provider Network Contracts".) Also, see the discussion on the value of an Indian Addendum on page 41900 of the Proposed Rule.

⁶ The "Federal poverty line" is defined in the Proposed Rule at § 1.36B-1(h).

Even without the provision of premium tax credits, the structuring of the Exchange itself, with the offering of multiple and comparable health plans, is intended to provide more affordable health insurance options than are generally available today.⁷

In addition to potential eligibility for premium tax credits, individuals enrolled in a health plan in the individual market through an Exchange may be eligible for cost-sharing assistance. For those taxpayers and their dependents with household income not greater than 400 percent of the Federal poverty line, cost-sharing reductions are provided according to a table found in ACA § 1402. Additional cost-sharing protections for AI/ANs are provided under ACA § 1402(d).

Eligibility for premium tax credits and for cost-sharing assistance requires enrollment in a health plan in the individual market through an Exchange. Eligibility for enrollment in a health plan in the individual market through an Exchange is established under ACA § 1312. Eligibility for enrollment in a health plan in the individual market through an Exchange is *not* dependent on eligibility for either premium tax credits or cost-sharing assistance.

Treasury and HHS, along with each Exchange, have responsibility for administering the various elements of the interrelated sections pertaining to eligibility determination, assistance calculations, and distribution and potential recapture of the assistance to enrollees and health plans.

2. Federal Trust Responsibility

The Federal government has a unique responsibility and obligation to American Indians and Alaska Natives. This Federal Trust Responsibility is enshrined in Federal law⁸ and guided by the government-to-government relationships between the Federal government and Tribes.⁹ Historically, the Federal Trust Responsibility to provide health care services to AI/ANs has been carried out through the Indian Health Care Providers. Facilitated by provisions in the IHCA, Medicare and Medicaid have become important additional means through which the resources to fulfill the Federal Trust Responsibility have been made available. Now, with the passage of the Affordable Care Act and the assistance to be provided to certain AI/ANs enrolled through an Exchange, Congress established an additional mechanism—although not a replacement mechanism—to fulfill the Federal Trust Responsibility and to achieve the national Indian health policy reconfirmed by Congress in § 103 of the Indian Health Care Improvement Act, which was enacted as part of the ACA.¹⁰

⁷ http://www.americanprogress.org/pressroom/releases/2011/06/states_exchanges_release.html

⁸ Most recently in Section 102 of the Indian Health Care Improvement Act (IHCA), as amended by Section 10221(a) of the ACA, (codified at 25 U.S.C. § 1602) (Congress declares a national Indian health policy “in fulfillment of its special trust responsibilities and legal obligations to Indians”).

⁹ *See*, 25 U.S.C. § 1602(6).

¹⁰ 25 U.S.C. § 1602.

It is critically important that the Affordable Care Act be implemented in a manner that is consistent with Congressional intent to establish a real and functional additional mechanism for carrying out the Federal Trust Responsibility. Through participation in a series of tribal consultation sessions conducted by HHS, Tribes and tribal organizations such as NIHB voiced concerns and recommendations on a host of matters pertaining to this Proposed Rule and other related proposed rules.¹¹ These comments and recommendations are offered as a supplement to the information exchanged through the tribal consultation process.

3. Tribal Consultation

The Federal Trust Responsibility and the requirement that all departments of the Federal government have a tribal consultation policy extends to Treasury and the IRS.¹² However, to our knowledge there was no Tribal consultation conducted by Treasury or IRS in the preparation of the Proposed Rule.¹³ Although the Proposed Rule does not specifically mention AI/ANs or Indian Health Care Providers, the Proposed Rule will have a profound impact on the availability and delivery of health care to AI/ANs who are among the most vulnerable people in our country.

The IRS Proposed Rule would benefit from greater coordination and synchronization between the IRS rules and the HHS rules in order to fully achieve the objectives of the ACA. For

Congress declares that it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians—

(1) to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy;

(2) to raise the health status of Indians and urban Indians to at least the levels set forth in the goals contained within the Healthy People 2010 initiative or successor objectives;

(3) to ensure maximum Indian participation in the direction of health care services so as to render the persons administering such services and the services themselves more responsive to the needs and desires of Indian communities;

(4) to increase the proportion of all degrees in the health professions awarded to Indians so that the proportion of Indian health professionals in each Service area is raised to at least the level of that of the general population;

(5) to require that all actions under this Act shall be carried out with active and meaningful consultation with Indian tribes and tribal organizations, and conference with urban Indian organizations, to implement this Act and the national policy of Indian self-determination;

(6) to ensure that the United States and Indian tribes work in a government-to-government relationship to ensure quality health care for all tribal members; and

(7) to provide funding for programs and facilities operated by Indian tribes and tribal organizations in amounts that are not less than the amounts provided to programs and facilities operated directly by the Service.

¹¹ The Department of the Treasury participated in the HHS tribal consultation sessions.

¹² “Memorandum for the Heads of Executive Departments and Agencies,” November 5, 2009, requiring implementation of Executive Order 13175, “Consultation and Coordination with Indian Tribal Governments,” November 6, 2000.

¹³ Treasury representatives did attend tribal consultation sessions held by HHS.

example, Congress chose tax credits as the mechanism for providing individual subsidies for health insurance premiums. The manner in which the IRS structures the system of tax credits will have a profound impact on whether the Federal subsidies actually reach the people for whom they are intended. Issues such as how determinations of eligibility are made are central to achieving the promise of the ACA. Related to this are what eligibility standards apply and what requirements, if any, there are on AI/ANs to make payments to the Federal government for any excess payments of premium tax credits made by the Federal government to Exchange plans on behalf of individual enrollees. These and other issues are critically important and require direct tribal consultation.

There are 565 Indian Tribes in the United States whose members receive their health care through the Indian Health Care Providers. This health care has been pre-paid through the ceding of lands from tribal governments to the Federal government through treaties. However, total funding to Indian Health Providers through direct Congressional appropriations and access to other funding sources that pay for medical care still leave the Indian health system funded at less than 60 percent of the level of need.¹⁴ The other resources that are made available (and accounted for in the calculation of the level of funding) include other Federally-funded programs including Medicare, Medicaid, State Child Health Insurance Programs (CHIP), the Department of Veterans Affairs, the Department of Defense, and now Exchange plans.¹⁵ Special provisions were put into the ACA to allow AI/ANs to more easily access these revenue sources for their health care and to permit the I/T/U to bill all health plans offered through (and outside) the Exchanges for services rendered to AI/ANs.

Again, the ability of AI/ANs and their Indian Health Care Providers to participate in Exchange plans, receive the benefits of premium tax credits and cost-sharing reductions, and not to be subject to detrimental liabilities created in the process are central to the promise of the Affordable Care Act serving as a positive vehicle for carrying out the Federal Trust Responsibility. We encourage Treasury to engage in tribal consultation on these and other matters pertaining to implementation of the Affordable Care Act and to coordinate more closely with HHS to assure that policies mesh more seamlessly.

4. Eligibility for Enrollment through an Exchange (ACA § 1312)

Eligibility for enrollment in a health plan in the individual market through an Exchange is established under ACA § 1312. Even without regard to the provision of premium tax credits, the structure of the Exchange itself – with the offer of multiple and comparable health plans – is intended to provide more affordable health insurance options than are generally available today. As such, the option created by the ACA for AI/ANs and others to enroll in a health plan in the individual market through an Exchange is of benefit to AI/ANs, and it is important that it be implemented in a manner that provides maximum access to this potentially more affordable coverage.

¹⁴ <http://www.ihs.gov/NonMedicalPrograms/Lnf/index.cfm>

¹⁵ IHCIA § 408.

If NIHB understands the ACA correctly, there are only three requirements that must be met for an individual to be eligible to secure health insurance coverage in the individual market through an Exchange. The individual —

- must reside in the State that established the Exchange,¹⁶
- not be incarcerated at the time of enrollment (other than while pending disposition of charges), and
- be a citizen or national of the United States or be lawfully present in the United States and be reasonably expected to be such for the entire period for which enrollment is sought.¹⁷

NIHB recommends that the preamble to the final rule emphasize this point and that IRS and CMS include this in educational materials that they may produce together or separately. The ACA is difficult for experts to parse through and laypeople are truly overwhelmed. Simple statements like that above can be helpful in assuring that everyone understands there is an opportunity for them to benefit.

5. Eligibility for Premium Tax Credits (ACA §§ 1401 and 1501; § 1.36B-2)

Although basic eligibility to enroll in an Exchange has few limitations, a much longer list of requirements apply in determining eligibility for premium tax credits under the ACA. Premium tax credits reduce the cost of securing health insurance coverage through an Exchange by covering a portion of an enrollee’s plan premium. As such, they are extremely important, especially for AI/ANs who experience higher than average rates of poverty and near poverty.¹⁸

Provisions establishing eligibility criteria for premium tax credits are found under ACA § 1401 “Refundable tax credit providing premium assistance for coverage under a qualified health plan” as well as in ACA § 1501 “Requirement to maintain minimum essential coverage.”

Based on ACA §§ 1401 and 1501, an individual is eligible to receive a premium tax credit for one or more months (referred to as “coverage months”) if the individual —

- is a taxpayer,
- has household income that exceeds 100 percent but does not exceed 400 percent of the poverty line,

¹⁶ The final rule should also make it clear that individuals may enroll in an Exchange established by CMS for those States that do not establish one for themselves.

¹⁷ ACA § 1312(f)(1) and (3).

¹⁸ U.S. Commission on Civil Rights, *Broken Promises: Evaluating the Native American Health Care System*, at 98 (Sept. 2004). <http://www.usccr.gov/pubs/nahealth/nabroken.pdf>

- is enrolled in a health plan in the individual market through an Exchange,
- pays the premium for coverage for each month,
- is not eligible (directly or through a family member) for minimum essential coverage through an employer that is affordable (*i.e.*, cost of single coverage is less than 9.5% of household income) and that meets minimum value requirements (*i.e.*, plan has at least a 60 percent actuarial value),
- is not enrolled in any employer-sponsored plan (even if coverage does not meet standards for affordability and value),
- is not eligible for certain other government sponsored programs,
- files joint tax return if married, and
- is a citizen or national of the United States or is lawfully present in the United States and is reasonably expected to be such for the entire period for which enrollment is sought.

In the following, NIHB provides comments on several of these eligibility requirements and related provisions affecting the eligibility for and calculation of premium tax credits.

5.1. Coverage Month Requires Payment of Premium by Taxpayer/Enrollee (§§ 1.36B-3(c)(1)(ii) and (c)(2))

Under ACA § 1401(a) / IRC § 36B(c)(2)(A)(ii), one factor for determining the number of countable “coverage months” is that the enrollee’s premium for the health plan secured in the individual market through an Exchange is paid for the month. The section reads, in part –

(ii) the premium for coverage under such plan for such month is paid by the taxpayer (or through advance payment of the credit under subsection (a) under section 1412 of the Patient Protection and Affordable Care Act).

This language is repeated in the preamble to the Proposed Rule¹⁹ and contained in the proposed § 1.36B-3(c)(1)(ii)²⁰ without further elaboration. However, in the proposed § 1.36B-3(c)(2), clarification is added that premiums may be paid by someone other than the taxpayer.

¹⁹ 76 Fed.Reg. 50933.

²⁰ 76 Fed.Reg. 50943.

(2) *Premiums paid for the taxpayer.* Premiums another person pays for coverage of the taxpayer, taxpayer’s spouse, or dependent are treated as paid by the taxpayer.²¹

NIHB supports the clarification that payments by some other person will be treated as a payment “by the taxpayer.” For purposes of AI/AN, the ability to credit coverage paid for on behalf of the taxpayer is important. Since AI/ANs are entitled to free health care through the Indian Health Care Providers, as a general rule, they are understandably reluctant to pay premiums directly. Consistent with § 402 of the IHCA, the Exchange Establishment proposed rule²² created an option to allow and facilitate the payment of premiums on behalf of AI/AN by Tribes or tribal organizations.

NIHB assumes that “person,” as it is used in proposed § 1.36B-3(c)(2), includes Indian tribes, tribal organizations, urban Indian organizations, and other entities that might choose to pay or subsidize payments. If this understanding is correct, we recommend that either a definition of “person” be added to clarify that it is defined broadly or some explanation be added to the preamble to the final rule. If the understanding is incorrect, then we recommend that (c)(2) be amended to make the current text clause (i) and that a new clause (ii) be added, to read:

(ii) Premiums an Indian tribe, tribal organization, or urban Indian organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act) or any other entity pays for coverage of the taxpayer, taxpayer’s spouse, or dependent who is an Indian are treated as paid by the taxpayer.²³

5.2. Definition of Dependent (§ 1.36B-2(b)(3))

In defining a dependent of a taxpayer, the proposed § 1.36B-2(b)(3) “Dependents” states that “an individual is not an applicable taxpayer if another taxpayer may claim a deduction for the individual for a taxable year” (emphasis added). We recommend that the word “may” be eliminated and the word “claim” be changed to “claims.” A person who lives in another person’s household may be considered a dependent, but they may also file their own taxes. If they choose to file their own taxes and are not claimed as a dependent for a deduction

²¹ *Id.*

²² CMS-9989-P, “Establishment of Exchanges and Qualified Health Plans,” published in the *Federal Register* July 15, 2011, page 41916 with discussion on page 41879.

²³ We have not included a citation to how “Indian” should be defined since we discuss this issue in extensive detail in “NIHB Analysis and Comment on Definition of ‘Indian’ in Proposed Rules to Implement Provisions of the Patient Protection and Affordable Care Act” that is attached here and was a supplemental submission to the NIHB comments on CMS-9989-P: Establishment of Exchanges and Qualified Health Plans. We are hopeful that consideration of the issues raised there will lead to resolution of what we believe to be inherent ambiguity in the Act that needs to be resolved by HHS and IRS in their final rules.

by another taxpayer, they should not be penalized by being denied access to tax credits for health insurance premiums.

5.3. Minimum Essential Coverage (§ 1.36B-2(c))

5.3.1. Government Sponsored Programs (§ 1.36B-2(c)(2))

Under ACA § 1501 / IRC § 1501A(f)(1)(A) “Government sponsored programs,” individuals are excluded from eligibility for premium tax credits if they are eligible for the following government sponsored coverage: Medicare, Medicaid, CHIP, TRICARE, certain veteran’s health care, or coverage related to Peace Corps volunteers. Eligibility for services from the Indian Health Service is not included as a government sponsored program for this purpose. For the reasons explained below, NIHB strongly supports Congress’s exclusion of eligibility for IHS services from the list of government sponsored programs.

We note that proposed § 1.36B-2(c)(2)(i), apparently relying on authority under ACA § 1501 / IRC § 1501A(f)(1)(E), permits the Commissioner to “define eligibility for specific government-sponsored programs further in published guidance.” NIHB recommends that such discretion not be exercised except in coordination with the Secretary of HHS, and that formal tribal consultation occur prior to publication of any proposed guidance or rule that would affect the status of individuals based on their being Indian or being eligible for the services of the Indian Health Service. In contrast to the comprehensive health insurance coverage to be provided for in health plans offered through an Exchange, IHS does not provide services or funding sufficient to guarantee timely access to a comprehensive and defined set of services such as that contained in the essential health benefits requirements of the ACA.²⁴

In September of 2010, NIHB provided extensive comments on a similar issue in the context of the Interim Final Rule for the Pre-existing Condition Insurance Plan Program (OCIIO-9995-IFC). One section of the comments is excerpted below –

*Census Bureau definition of health insurance coverage removed IHS programs.*²⁵

The Census Bureau collects data about different types of health insurance coverage and broadly classifies the types into either Private (non-government) coverage and Government-sponsored coverage. At one time, the “major categories of government health insurance” included programs operated by the IHS. The Census Bureau definition was subsequently revised, and for over a decade

²⁴ ACA § 1302.

²⁵ “Comments of the National Indian Health Board regarding Pre-Existing Condition Insurance Plan Program; Interim Final Rule; File Code OCIIO – 9995 – IFC”, September 28, 2010, page 5.

the definition of health insurance coverage used by the Census Bureau has not included programs operated by the IHS.

A footnote to the “CPS Health Insurance Definitions” reads: “After consulting with health insurance experts, the Census Bureau modified the definition of the population without health insurance in the Supplement to the March 1998 Current Population Survey, which collected data about coverage in 1997. Previously, people with no coverage other than access to the Indian Health Service were counted as part of the insured population. Subsequently, the Census Bureau has counted these people as uninsured. The effect of this change on the overall estimates of health insurance coverage was negligible.”²⁶

Due to the limitations on annual appropriations, the IHS does not provide guaranteed access to a defined set of covered services for the eligible population. As indicated above, the IHS is funded for only a fraction of the level required to provide guaranteed access to a standard set of covered services. As is the case with other health care programs operated by governments at the Federal, State or local level, health care programs that do not provide guaranteed access to a defined and comprehensive set of services—such as is the case with the IHS programs—should not be included in the definition of “creditable coverage” for purposes of implementing the PCIP.

Similarly, the Congressional Budget Office does not consider individuals served only by the Indian Health Service to be “insured”:

Because of staff shortages, limited facilities, and a capped budget, the IHS rarely provides benefits comparable with complete insurance coverage for the eligible population; as a result, estimates of the uninsured population in the United States do not treat the IHS as a source of insurance.²⁷

In fact, because of the funding shortfall, IHS estimated the extent of health service denials at \$130 million in 2008.²⁸ As a comparison, per capita spending for IHS medical care in 2003 was only slightly more than 50% of the per capita amount spent for Federal prisoners.²⁹

²⁶ <http://www.census.gov/hhes/www/hlthins/methodology/definitions/cps.html>

²⁷ Congressional Budget Office, “Key Issues in Analyzing Major Health Insurance Proposals,” at 127 (Dec. 2008).

²⁸ Indian Health Service, Fiscal Year 2011 Budget Justification, at CJ-95.

²⁹ U.S. Commission on Civil Rights, *Broken Promises: Evaluating the Native American Health Care System*, at 98 (Sept. 2004).

For a more extensive discussion of this issue, please refer to “Comments of the National Indian Health Board regarding Pre-Existing Condition Insurance Plan Program; Interim Final Rule; File Code OCIO – 9995 – IFC”, dated September 28, 2010.

5.3.2. Eligibility for Employer-sponsored Coverage Meeting Minimum Essential Coverage (Affordability and Value) Requirements (§1.36B-2(c)(3))

NIHB recommends that proposed §1.36B-2(c)(3) “Employer-sponsored minimum essential coverage,” be amended to explicitly exempt AI/ANs. The Proposed Rule states that if an individual, or a person eligible to enroll because of their relationship to an employee, could have enrolled in an employer-sponsored plan and they did not do so, then they will not be eligible for premium tax credits through the Exchange. In general, AI/ANs who have access to Indian Health Care Providers do not enroll in employer-sponsored health plans if doing so will subject them to contributing to the cost of the premiums. AI/ANs prepaid their health care through the ceding of lands through treaties. They are entitled to receive services at no cost from the Indian Health Service.

If AI/ANs are not exempted from the rule that would make them ineligible for tax credits if they did not enroll in employer-sponsored plans, then there will be AI/ANs who need the additional coverage that an Exchange plan can offer but who will not have the means to acquire it because they will be barred from the premium tax credit. This will effectively disenfranchise them from this important new Federal program.

5.3.3. Affordability of Employer-sponsored Coverage (§ 1.36B-2(c)(3)(v))

The determination of affordable coverage for an entire family based only on the cost of coverage for a single individual who is employed is not logical. It unfairly treats households with one or more dependents. It is not uncommon for the contribution amount for the employee to be quite reasonable, i.e. heavily subsidized by the employer, while the required employee contribution for spouses and children more closely approximate the actual cost of the coverage. In many cases, if the actual employee contribution for each family member was considered, instead of only the amount for the employee, the totals would exceed the allowable percentages and, more importantly, exceed any reasonable amount the individual could afford and still meet the other needs of his family. Also, it penalizes family members who may not have been enrolled in employer-sponsored health plans and are later deemed ineligible for tax credits because of this. This is illustrated in Example C.2. However, this example may, in fact, underestimate the problem for large families.

5.3.4. Safe Harbor for Initial Estimate of Annual Income (§ 1.36B-3(d))

NIHB concurs with the flexibility shown in the Proposed Rule at § 1.36B-2(c)(3)(v)(A)(2), to provide an “employee safe harbor” with regard to the determination of an employer-sponsored plan being unaffordable. Under this employee safe harbor, an

estimation of “unaffordability” at the beginning of the plan year is locked-in and applied to the entire year.

NIHB believes that Treasury and HHS may have the authority to provide similar flexibility with regard to a taxpayer’s/enrollee’s projected income for the year. See discussion and recommendation under “7. Reconciling the Premium Tax Credit with Advance Credit Payments” below.

The Proposed Rule justifies the creation of a safe harbor for employers, and subsequently for employees, with regard to determinations of the affordability of employer-sponsored coverage because it will, in part, provide greater predictability to employers and to employees. We believe this same rationale applies to the issue of estimated income for the year. In fact, the variability with regard to potential liabilities for premiums from a recalculation of income and the subsequent recalculation of the value of premium tax credits is much greater for taxpayers/enrollees than is the case for employers under the “affordability” determination.

In the preamble to the Proposed Rule there is a discussion of the concept of an employer safe harbor. The concern addressed is that an employer may not know that the insurance offered is unaffordable if it is based on percentage of household income rather than percentage of employee wages. The rules were written to give employers “a more workable and predictable method of facilitating affordable employer-sponsored coverage” so that they can avoid “an assessable payment under section 4980H(b).” It is warranted to give the same consideration to taxpayers so that they can lock-in the income amount that is used when the tax credit is calculated at the beginning of the year and not be at risk of a penalty later. The issue of predictability is even more important for the individual than it is for corporations, particularly when individuals are in low paying, part-time, or seasonal employment.

For example, the premium amounts owed by an employer may be \$2,000 per employee under one determination, \$3,000 per employee under a second determination, or an amount that is likely to be between \$2,000 and \$3,000 for the cost of providing an employer-sponsored plan for single coverage that is 60 percent of the actuarial value of the essential health benefits package. In contrast, taxpayers/enrollees can experience premium liabilities ranging from zero to one hundred percent, or \$4,500 for the cost of a typical health plan for single coverage, and multiples of that amount for family coverage.

As such, **we believe it would be consistent and warranted to provide, under § 1.36B-3(d), a safe harbor to taxpayers/enrollees from a recalculation of income that may be different from the initial projection of household income for the year.³⁰ If a permanent waiver cannot be provided, NIHB requests that a waiver on an interim basis (3-5 years) be provided.** This would allow adequate time for the various inter-related provisions of the

³⁰ See discussion and recommendation under “7. Reconciling the Premium Tax Credit with Advance Credit Payments”.

ACA to be implemented and the working of the advance credit to be refined. Providing this safe harbor for a taxpayer's / enrollee's estimated household income would ensure that there will not have to be a re-calculation and re-payment of tax credits that were paid to issuers of health plans if the individual's projected income differs from the end-of-year actual income.

5.3.5. Married Taxpayers Filing Separate Returns (§ 1.36B-4(b)(3))

NIHB appreciates the request for comments on whether rules should provide relief from the requirement that married taxpayers are entitled to premium tax credits only if they file a joint return.³¹ NIHB recommends that a hardship exemption be available under § 1.36B-4(b)(3). There are many circumstances in which filing a joint return is extremely difficult or even impossible. Certainly, the situations referenced in the preamble, such as pending divorce, domestic abuse and incarceration, should be *per se* situations in which hardship is deemed to be present. Often one spouse is a victim and that person should not be re-victimized with a tax penalty if filing joint returns is not practical.

6. Computing the Premium Assistance Credit Amount (§ 1.36B-3)

6.1. Computing the Premium Assistance Credit Amount (§ 1.36B-3)

NIHB recommends that IRS and HHS give consideration to simplifying the Proposed Rule on computing the premium tax credit amount. Although taxpayers/enrollees will have the assistance of the Exchange tools as well as Navigators³² in determining their eligibility for tax credits and the amount of the premium tax credit, these individuals will need to be able to compute their actual eligibility and tax credit amount on their annual tax filing the IRS. Every effort should be made to enable individuals to be able to use the most simplified tax forms and minimal calculations in order to minimize confusion and uncertainty on the part of taxpayers. For AI/ANs, we anticipate that the greater the degree of uncertainty and confusion around their eligibility for, and the amount of, the premium tax credit the lesser the likelihood that AI/ANs will be willing to access the premium tax credits by enrolling in comprehensive health insurance coverage through an Exchange.

To the extent that the final rules are not (perhaps, cannot be) simplified enough to be easily understandable at all levels of literacy, NIHB urges that IRS and CMS fund outreach and training in which tribal advocates can be trained and supported to assist AI/ANs to fully understand the rules.

6.2. Applicable Benchmark Premium: Determination of the Benchmark Plan Premium for Purposes of Calculating Premium Tax Credit (§ 1.36B-3(f))

³¹ 76 Fed.Reg. 50938.

³² ACA § 1311(i).

As referenced in the NIHB comments on the Exchange Establishment proposed rule,³³ NIHB is concerned that the “benchmark plan” defined in the Proposed Rule may not be for a qualified health plan (QHP) in the individual market through an Exchange that is actually available to the enrollee (*i.e.*, taxpayer). This issue is significant as the applicable benchmark premium will be used for purposes of determining the level of premium assistance that will be provided to eligible Exchange enrollees, if any. The amount of the premium tax credit is calculated pursuant to § 1.36B-3(d) of the Proposed Rule.

The term “applicable second lowest cost silver plan” is defined at IRC § 36B(b)(3)(B). The term is defined as –

(B) APPLICABLE SECOND LOWEST COST SILVER PLAN.—

The applicable second lowest cost silver plan with respect to any applicable taxpayer is the second lowest cost silver plan of the individual market in the rating area in which the taxpayer resides which—

(i) is offered through the same Exchange through which the qualified health plans taken into account under paragraph (2)(A) were offered, and

(ii) provides—

(I) self-only . . .

. . .

(II) family coverage in the case of any other applicable taxpayer.

. . .

In the Proposed Rule, at § 1.36B-3(f), the term “applicable benchmark plan” is similarly defined as –

[T]he second lowest cost silver plan (as described [in the ACA]) offered at the time a taxpayer or family member enrolls in a qualified health plan through the Exchange in the rating area where the taxpayer resides [for either single or family coverage]...

Both the statutory and regulatory definitions use the phrasing “in the rating area where the taxpayer resides.”

In the ACA, the term “rating area” is not defined. Under § 1.36B-1(n) of this Proposed Rule, “rating area” is defined as—

³³ NIHB Analysis and Comments on CMS-9989-P, “Establishment of Exchanges and Qualified Health Plans Implemented Consistent with Title I of the Patient Protection and Affordable Care Act,” October 31, 2011.

Rating area means an Exchange service area, as described in 45 CFR 155.20.

Under 45 CFR 155.20 (contained in the Exchange Establishment proposed rule issued by HHS),³⁴ “Exchange service area” is defined as –

Exchange service area means the area in which the Exchange is certified to operate, in accordance with the requirements specified in subpart B of this part.

As such, “the rating area in which the taxpayer resides” is defined to mean the overall service area of an Exchange in which the taxpayer resides. In States with no “subsidiary Exchanges”, there would be one Exchange serving the entire State. For States that choose to do so, they may establish one or more subsidiary Exchanges.³⁵ For States that choose to join with other States to form regional or multistate Exchanges, a single Exchange may serve more than one State.³⁶

Interestingly, when the IRS defined “rating area” in the Proposed Rule for purposes of establishing the benchmark plan premium for the second lowest cost silver plan in order to calculate the premium tax credit, the IRS referenced “Exchange service areas” as defined in the Exchange Establishment proposed rule.³⁷ IRS chose not to reference the term “rating area” as defined in the same Exchanged Establishment proposed rule. The term “rating area” is created in the Exchange Establishment proposed rule for the purpose of prohibiting discriminatory premium rates.³⁸ To the extent that they are created, the HHS-defined rating areas would each encompass a subset of the overall Exchange service area. In ACA § 1201 / § 2701(a)(2) of the Public Health Service Act (PHSA) (again as proposed by HHS in the Exchange Establishment proposed rule), “rating area” is defined as –

(2) RATING AREA.—

(A) IN GENERAL.—Each State shall establish 1 or more rating areas within that State for purposes of applying the requirements of this title.

(B) SECRETARIAL REVIEW.—The Secretary shall review the rating areas established by each State under subparagraph (A) to ensure the adequacy of such areas for purposes of carrying out the requirements of this title. If the Secretary determines a State’s

³⁴ Exchange Establishment proposed rule (CMS-9989-P), p. 41912.

³⁵ ACA § 1311(f)(2).

³⁶ ACA § 1311(f)(1).

³⁷ Exchange Establishment proposed rule (CMS-9989-P).

³⁸ ACA § 1201 / § 2701(a)(2) of the Public Health Service Act (PHSA).

rating areas are not adequate, or that a State does not establish such areas, the Secretary may establish rating areas for that State.

Given the lack of specificity in the defined “rating area” term in the Exchange Establishment proposed rule, it is understandable that the HHS proposed definition for the term “rating area” was not used by the IRS to define rating area for purposes of the premium tax credit calculation. Unfortunately, though, the IRS’s citing of the definition of “Exchange service area” for the purpose of defining “rating area” in this Proposed Rule did not provide any greater, or sufficient, specificity either.

The definition of a rating area cited by the IRS for purposes of identifying the benchmark plan refers to a geographic area in which the Exchange operates, not a geographic area for which QHPs offered through an Exchange operate.³⁹ The distinction between these two elements is that QHPs offered through an Exchange may have a service area that is less, or at least different, than the “area in which the Exchange is certified to operate.”⁴⁰ **This creates a real possibility that the applicable second lowest cost silver plan (as well as the lowest cost silver plan) “in the rating area in which the taxpayer resides” could actually be plans that do not serve the area in which the enrollee resides.** If the applicable benchmark plan is for a different region than that which the taxpayer actually resides, the premium tax credit amount calculated from this benchmark plan’s premium may be significantly different than what the lowest and second lowest cost silver plans in the individual market are for plans that have service areas that encompasses “where the taxpayer resides.”

Stated differently, NIHB is concerned that the premium tax credit amounts will be insufficient to secure coverage unless enrollees pay more than the premium cap “applicable percentages” under ACA § 1401(a) / § 1.36B-3(g) envision. There may not be sufficient affordable plan options in certain parts of a State given (1) the potential for a limited

³⁹ The authority for a QHP to serve an area that is not the entire Exchange service area is found in § 155.1000 of the Exchange Establishment proposed rule.

⁴⁰ More specifically, under § 155.1055 of the Exchange Establishment proposed Rule, the following requirements are established –

§ 155.1055 Service area of a QHP.

The Exchange must have a process to establish or evaluate the service areas of QHPs to determine whether the following minimum criteria are met:

- (a) The service area of a QHP covers a minimum geographical area that is at least the entire geographic area of a county, or a group of counties defined by the Exchange, unless the Exchange determines that serving a smaller geographic area is necessary, nondiscriminatory, and in the best interest of the qualified individuals and employers.
- (b) The service area of a QHP has been established without regard to racial, ethnic, language, health status-related factors listed in section 2705(a) of the PHS Act, or other factors that exclude specific high utilizing, high cost or medically-underserved populations.⁴⁰

number of health plans being offered, (2) the service areas of the plans that are offered being less than the full Exchange geographic area, and (3) the Federal premium assistance is tied to the premium of “the applicable second lowest cost silver plan with respect to the taxpayer” but that plan may have a service area that does not include the area where the enrollee resides. The core issues of concern may be highlighted by the use of a couple of examples.

Example 1: The State of California, for example, may establish one Exchange and two rating areas for the State (as is permitted under ACA § 1311 and ACA § 1201 / PHSA § 2701(a)(2), respectively). One rating area encompasses Southern California; the second rating area encompasses the remainder of the State north of the Southern California rating area. A taxpayer resides in Southern California. The “applicable second lowest cost silver plan” as defined under the Proposed Rule is a plan that solely operates in the Northern California rating area. No silver plan that is offered in the Southern California rating area offers a premium that is at or below the premium of the “applicable benchmark plan”. The individual would be required to contribute an amount above the applicable percentage caps as specified in ACA § 1401 / IRC § 36B(b)(3) and § 1.36B-3(g) of the Proposed Rule.

Example 2: Under a second example, again where the State of California establishes one Exchange and two rating areas for the State, the “applicable second lowest cost silver plan” is determined to be a plan that serves three suburban counties around San Jose, California. The taxpayer resides in a remote area of Northern California. Although the taxpayer and the applicable benchmark plan are in the same Exchange service area, and also in the same rating area (as defined by HHS at 45 CFR § 156.255(a), the taxpayer does not reside in the service area of the second (or first) lowest cost silver plan. In fact, no silver plan that does serve the area in which the taxpayer resides offers a premium that is near the premium of the applicable second lowest cost silver plan. Again, in order to secure coverage, this individual would be required to contribute an amount above the applicable percentage caps as specified in ACA § 1401 / IRC § 36B(b)(3) and § 1.36B-3(g) of the Proposed Rule.

Under the Exchange Establishment proposed rule, an Exchange may establish requirements that a QHP’s service area match an Exchange service area (such as serving an entire State). Theoretically, at least, this would ensure that the lowest and second lowest cost silver plans would actually serve the areas where each taxpayer resides. But in a discussion of the service areas of QHP contained in the same proposed rule, HHS seems to caution that this approach may not be practical. In acknowledging the discretion given Exchanges with regard to this matter, the proposed rule states, “we also seek to recognize that the capacity of health insurance issuers varies by region due to some factors that are outside of their control.”⁴¹ And in practice, health plans with highly integrated and coordinated provider networks, such as what is practiced by some health maintenance organizations (HMOs), may be confined to a primary service area that encompasses only

⁴¹ Exchange Establishment proposed rule (CMS-9989-P), p. 41894.

one region or sub-region of a State. It is these highly integrated plans with potentially narrower service areas and more restrictive networks that may offer lower premiums. If they then are identified as “the second lowest cost silver plan in the rating area in which the taxpayer resides”, the enrollee/taxpayer will not be able to secure coverage in a plan without paying additional premiums above the “applicable percentages” for the taxpayer’s income level. But, requiring these highly-integrated plans to serve an entire Exchange service area may damage the plan’s ability to offer a relatively affordable premium.

NIHB recommends that the Proposed Rule be modified to establish an additional qualifier to the determination of “applicable benchmark plan” under § 1.36B-3(f). The recommendation is to change § 1.36B-3(f)(2) to (f)(3), adjust all following annotation and references accordingly, and insert the following as a new § 1.36B-3(f)(2) –

(2) Service area of the benchmark plan does not encompass where the taxpayer resides. If the service area (as described in 45 CFR § 155.1055) of the lowest cost silver plan or the second lowest cost silver plan does not encompass where the taxpayer resides, the applicable benchmark plan shall be as provided for under paragraph (f)(1) or, if the cost is higher, the applicable benchmark plan shall be the second lowest cost silver plan offered at the time a taxpayer or family member enrolls in a qualified health plan through the Exchange in the rating area where the taxpayer resides based only upon silver plans that have service areas that encompass where the taxpayer resides.

(Bold indicates addition.)

7. Reconciling the Premium Tax Credit with Advance Credit Payments (§ 1.36B-4)

NIHB recognizes the provisions of the ACA, as modified, pertaining to the payment of premium tax credits if the amount of the advance credit payments is different from the amount of the credit allowed under section 36B. A taxpayer whose premium tax credit for the taxable year exceeds the taxpayer’s advance credit payments may receive the excess as an income tax refund. A taxpayer whose advance credit payments for the taxable year exceed the taxpayer’s premium tax credit owes the excess as an additional income tax liability. Nonetheless, **NIHB recommends that AI/ANs be provided an exemption from repayment of any excess premium credits made by the Federal government to an Exchange plan on behalf of an AI/AN.** This proposed exemption would be predicated on the initial determination of the advance credit amount being based on a good faith estimate of annual household income by the AI/AN enrollee/taxpayer.

Although we understand that an exemption from repayment of excess premium tax credits is not required by the Affordable Care Act, we believe it is permissible under the Affordable Care Act, and further, we believe providing the exemption to AI/AN would be consistent with other approaches contained in the Affordable Care Act with regard to carrying-

out the Federal Trust Responsibility. It would also be consistent with the approach taken, and the discretion employed, under the “employee safe harbor” provision locking-in a preliminary determination of the affordability of employer-sponsored coverage.^{42, 43}

Under the Affordable Care Act, AI/ANs are not provided an exemption from the requirement to secure minimum essential coverage, as were some individuals pursuant to ACA §§ 1501(d)(2), (3) or (4). For instance, a religious conscience exemption from the requirement to secure coverage is provided under § 1501(d)(2). However, under § 1501(e)(3), AI/AN are exempt from payment of a tax penalty for not securing minimum essential coverage. For those who are subject to the penalty provision, payment of the penalty is to be made to the Federal government through the tax filing process.⁴⁴

As just stated, under § 1501(e)(3), AI/AN are exempt from payment of a penalty for *not securing* minimum essential coverage. But if they do secure coverage and miscalculate their income, they run the risk of a liability, or tax penalty, being assessed.

In the case of AI/AN, we believe it is accurate to describe any requirement for payment of excess advance payments by AI/ANs as a “penalty” for the following reasons –

- First, it is important to remember that the Federal Trust Responsibility as articulated by the Federal government through the ACA and other laws holds that it is the Federal government’s responsibility to provide health care to AI/AN persons.⁴⁵
- Second, the demands on the direct Federal appropriation to the Indian Health Service is lessened by AI/AN securing needed health services elsewhere and/or IHS and other I/T/U providers being reimbursed from health plans covering AI/AN for health services provided to AI/AN. As such, any advance credit payments made by the Federal government to an Exchange health plan on behalf of an AI/AN is as much or more a payment on behalf of meeting the Federal government’s obligation as it is to being an obligation of the AI/AN.
- Third, any penalty amount would come from the personal resources an AI/AN may be able to access, and not from a “repayment” of excess amounts paid to an individual AI/AN, as the original “excess payment” is to be paid to the health plan.
- Fourth, the ACA clearly indicates that the excess advance payment will be levied against the individual’s taxes as would any penalty under §1501 / IRC § 5000A(b)(3),

⁴² Proposed Rule § 1.36B-2(c)(3)(v)(2).

⁴³ See discussion at “5.4 Safe Harbor for Initial Estimate of Annual Income” above.

⁴⁴ IRC § 5000A.

⁴⁵ Most recently in Section 102 of the Indian Health Care Improvement Act (IHCIA), as amended by Section 10221(a) of the ACA, (codified at 25 U.S.C. § 1602) (Congress declares a national Indian health policy “in fulfillment of its special trust responsibilities and legal obligations to Indians”).

in that “the tax imposed by this chapter for the taxable year shall be increased by the amount of such excess.”⁴⁶

If an exemption is not granted to AI/AN from a tax penalty in the amount of any excess advance payments, this will likely have a significant and damaging impact on the willingness of AI/AN to secure comprehensive coverage through an Exchange. Rather than AI/AN being rewarded for taking an action that furthers the goals and assists in meeting the obligations of the Federal government and its Federal Trust Responsibility (by an AI/AN offering to contribute to the cost of securing health insurance coverage through an Exchange in an amount determined at the time of enrollment to be the premium amount required), an AI/AN could end up with an additional financial liability at year’s end.

Simply put, **the recommendation NIHB is making here is to lock-in the estimated premium obligation for the AI/AN as determined at the time of enrollment, provided that the initial determination of the advance credit amount is based on a good faith estimate of the AI/AN’s household income for the year, and waiving any requirements for payment of excess advance credits. This could be accomplished by adding a provision under § 1.36B-3(d) providing for such a lock-in.**

Such a lock-in would provide a similar protection as the “safe harbor for employees” contained in § 1.36B-2(c)(3)(v)(2)).⁴⁷ As with the safe harbor under § 1.36B-2(c)(3)(v)(2)), we believe the Secretaries of HHS and Treasury have the needed authority to provide this waiver or exemption of, or safe harbor from, the tax penalty for excess advance payments. For instance, under ACA § 1401(g), the Secretary of the Treasury is directed to prescribe such regulations as may be necessary to carry out the provisions of this section (§ 1401), including regulations which provide for the coordination of the credit allowed under § 1401 with the program for advance payment of the credit under section 1412 of the Patient Protection and Affordable Care Act.

We believe our recommendation is permissible and consistent with the approach in the ACA pertaining to AI/AN securing health insurance coverage (*i.e.*, securing coverage is permitted for AI/AN, through an Exchange or otherwise, but there is no requirement to pay a penalty for failing to do so.)

A second argument and rationale for IRS and HHS taking the requested action is that any excess advance payments can be considered excess advance payments from the Federal government on behalf of the Federal government (in carrying out its Federal Trust Responsibility) and not a liability of an individual AI/AN. As such, an AI/AN would not be required to compensate an Exchange or the IRS for any overpayment of premium assistance that may be provided. A similar approach is taken at 42 U.S.C. 18084 pertaining to the

⁴⁶ ACA § 1401(a) / IRC 36B(f)(2)(A).

⁴⁷ Please refer to the “Employee Safe Harbor” (§ 1.36B-2(c)(3)(v)(2)) section above for additional discussion of this topic.

determination of eligibility for Federal and Federally-assisted programs, as authorized under § 1415 of the ACA.

As an alternative recommendation, if a permanent waiver cannot be accommodated, NIHB requests that a waiver on an interim basis (3 – 5 years) be provided, which would allow adequate time for the various inter-related provisions of the ACA to be implemented and the workings of the advance credit to be refined. This temporary waiver would provide a tremendous help in eliminating an initial uncertainty, and possible fear, that will be felt by AI/AN as they figure out whether to attempt to navigate this new avenue for carrying out the Federal Trust Responsibility knowing that they could end-up with a financial liability at the end of the year.

8. Cost-Sharing Reductions

8.1 Eligibility for Cost-sharing Reductions (ACA § 1402)

The ACA provides significant cost-sharing protections for certain individuals enrolled in a health plan in the individual market through an Exchange, with one set of protections applicable to the population in general and a second, additional set of cost-sharing protections applicable to AI/ANs.

Based on ACA § 1402, individuals in general are eligible to receive cost-sharing assistance under the ACA if an individual:

- is enrolled in a silver plan through an Exchange,
- has household income that exceeds 100 percent but does not exceed 400 percent of the poverty line, and
- is lawfully present in the United States.

The additional cost-sharing protections applicable to AI/ANs are contained at ACA § 1402(d). Based on ACA § 1402(d), an individual is eligible for the additional cost-sharing protections available to AI/ANs that are provided for under the ACA, thereby eliminating all cost-sharing requirements under a plan offered through an Exchange, if the individual:

- is enrolled in any qualified health plan in the individual market through an Exchange,
- is determined to be an “Indian”,
- has household income that is not more than 300 percent of the poverty line, and
- is lawfully present in the United States.

It is important to note that, pursuant to the Affordable Care Act, cost-sharing assistance is not dependent upon eligibility for premium tax credits (or vice versa.)⁴⁸ And as discussed earlier in these Comments, eligibility for enrollment in a health plan in the individual market through an Exchange *is not* dependent on eligibility for either premium tax credits or cost-sharing reductions. Eligibility for premium tax credits and cost-sharing assistance *is*, though, dependent upon enrollment in a health plan in the individual market through an Exchange.

NIHB recommends that the preamble to the final rule emphasize this point and that IRS and CMS include the list of eligibility requirements in educational materials that they may produce together or separately. The ACA is difficult for experts to parse through and laypeople are truly overwhelmed. Simple statements like that above can be helpful in assuring that everyone understands where there is an opportunity for them to benefit.

8.2 Excess Payment of Cost-sharing Assistance (§§ 1402 and 1412)

NIHB requests that IRS and HHS clarify that any payments of cost-sharing assistance provided under § 1402 and provided to AI/AN specifically under § 1412 that may be subsequently evaluated to be in excess of the amount an individual is eligible to receive will not be required to be paid by the enrollee.

For purposes of any “overpayments” of cost-sharing assistance, the Secretary should consider any cost-sharing reduction payment allowed under section 36B that is made pursuant to §§ 1402 or 1412 to be treated as made to the qualified health plan in which an individual is enrolled and not to that individual. As such, an individual would not be required to compensate an Exchange or the IRS for any overpayment of cost-sharing assistance that may be provided. Similar language is used at 42 U.S.C. 18084 pertaining to the exclusion of this assistance in determining eligibility for Federal and Federally-assisted programs, as authorized under § 1415 of the ACA.

9. Information Reporting by Exchanges (§ 1.36B-5)

Under § 1.36B-5(b) “Time and manner of reporting,” NIHB recommends that taxpayers should be able to go to the Exchanges at any time (electronically or in-person) and print out a record of the tax credits that they have received. Exchanges should also have a simple way to recalculate premiums and tax credits for people whose circumstances change and for people who stop their insurance or re-enroll in Exchange coverage. For example, if an AI/AN enrolls, disenrolls, and later reenrolls in health plans offered through an Exchange as permitted during the Special Enrollment periods⁴⁹, the individual’s tax credits should be recalculated by the Exchange and a running total of advance payments made should be available to the taxpayer and IRS at any time. The Exchange should be able

⁴⁸ In fact, in subtitle E, Part I, subpart A “Premium Tax Credits and Cost-sharing Reductions”, there are repeated references to, for example, “eligibility and amount of tax credit **or** reduced cost-sharing” (ACA § 1411(a)(1); emphasis added).

⁴⁹ ACA§ 1311(e)(6)(D).

to synchronize advance payments with enrollment and premium payments on a real-time basis. IRS should provide sufficient numbers of computers to community libraries, community centers, tribal offices and clinics and IHS clinics, so that low-income people can readily access this information.

10. Definition of Indian

Although these rules do not address the definition of Indian, it has certainly been discussed in tribal consultations at which IRS has been present. We attach “NIHB Analysis of and Comment on Definition of ‘Indian’ in Proposed Rules to Implement Provisions of the Patient Protection and Affordable Care Act” for IRS consideration as it proceeds to integrate implementation of the Affordable Care Act with HHS.

Attachments: “NIHB Analysis of and Comment on Definition of ‘Indian’ in Proposed Rules to Implement Provisions of the Patient Protection and Affordable Care Act,”
October 31, 2011

National Indian Health Board



National Indian Health Board

-- Supplemental Submission --

**Analysis of and Comment on Definition of “Indian” in Proposed Rules to Implement
Provisions of the Patient Protection and Affordable Care Act¹
 (“Analysis and Comment”)**

Attachment to NIHB Comments on CMS-9989-P, Exchange Establishment

Attachment to NIHB Comments on CMS-9974-P, Exchange Eligibility

Attachment to NIHB Comments on IRS REG-131491-10, Premium Tax Credit

October 31, 2011

The National Indian Health Board (“NIHB”) is vitally interested in all aspects of the implementation of the Affordable Care Act, which includes special benefits and protections for American Indians and Alaska Natives (“AI/ANs”) that have the potential to further the efforts to achieve the national Indian health policy declared by Congress in § 103 of the Indian Health Care Improvement Act (“IHCIA”)² as part of its enactment of the ACA. The

¹ The Patient Protection and Affordable Care Act (Pub. L. 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152) is referred to herein as the Affordable Care Act or ACA.

² 25 U.S.C. § 1602. The IHCIA, Pub. L. 94-437, was permanently reauthorized and amended March 23, 2010, by § 10221(a) of the ACA.

Congress declares that it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians—

(1) to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy;

(2) to raise the health status of Indians and urban Indians to at least the levels set forth in the goals contained within the Healthy People 2010 initiative or successor objectives;

(3) to ensure maximum Indian participation in the direction of health care services so as to render the persons administering such services and the services themselves more responsive to the needs and desires of Indian communities;

(4) to increase the proportion of all degrees in the health professions awarded to Indians so that the proportion of Indian health professionals in each Service area is raised to at least the level of that of the general population;



ACA special benefits and protections in which the implementation of the definition of “Indian” is of greatest concern relate to special enrollment,³ cost sharing protections,⁴ and protection from tax penalties.⁵

The Department of Health and Human Services (“HHS”), principally on behalf of the Centers for Medicare and Medicaid Services (“CMS”), and other Federal agencies are in the midst of publishing a number of proposed rules to implement the new Affordable Insurance Exchanges (“Exchanges”) consistent with Title I of the ACA. This analysis (“Analysis and Comment”) is intended to address comprehensively the issues surrounding the definition of “Indian” as it appears in the ACA and in the various proposed rules already noticed and anticipated.

NIHB requests that this Analysis and Comment be incorporated by reference into the comments that it has prepared in response to CMS-9989-P, “Establishment of Exchanges and Qualified Health Plans Implemented Consistent with Title I of the Patient Protection and Affordable Care Act;”⁶ as an attachment to its comments in response to CMS-9974-P, “Patient Protection and Affordable Care Act; Exchange Functions in the Individual Market; Eligibility Determinations; Exchange Standards for Employers;”⁷ and as an attachment to its comments in response to the Department of the Treasury, Internal Revenue Service’s notice of proposed rulemaking published August 17, 2011 in the *Federal Register* titled REG-131491-10, “Health Insurance Premium Tax Credit.”⁸

1. Statement of the Problem.

Each of the categories of special benefits and protections afforded to “Indians” under the ACA refers to a different statutory definition of “Indian” or fails to include any definition. Specifically, the opportunity for special enrollment periods for Indians found in ACA § 1311(c)(6)(D) relies on the definition of Indian in § 4 of the IHCA;⁹ reduced cost

(5) to require that all actions under this Act shall be carried out with active and meaningful consultation with Indian tribes and tribal organizations, and conference with urban Indian organizations, to implement this Act and the national policy of Indian self-determination;

(6) to ensure that the United States and Indian tribes work in a government-to-government relationship to ensure quality health care for all tribal members; and

(7) to provide funding for programs and facilities operated by Indian tribes and tribal organizations in amounts that are not less than the amounts provided to programs and facilities operated directly by the Service.

³ ACA § 1311(c)(6)(D).

⁴ ACA § 1402(d).

⁵ ACA §§ 1411(b)(5)(A) and Internal Revenue Code (“IRC”) § 5000A(e)(3), as enacted by ACA § 1501(b).

⁶ Hereafter referred to as “Exchange Establishment NPRM” or CMS-9989-P.

⁷ Hereafter referred to as “Exchange Eligibility NPRM” or CMS-9974-P.

⁸ Hereafter referred to as “Premium Tax Credit Proposed Rule” or IRS REG-131491-10.

⁹ 25 U.S.C. § 1603.

sharing for Indians under ACA § 1402(d) relies on the definition of Indian in § 4(d)¹⁰ of the Indian Self-Determination and Education Assistance Act (“ISDEAA”);¹¹ and exemptions from individual responsibility and tax penalties under ACA § 1411(b)(5)(A) refers only to “Indians” with no definition provided, while the related tax provision, IRC § 5000A(e)(3), as enacted by ACA § 1501(b) refers to “[a]ny applicable individual for any month during which the individual is a member of an Indian tribe (as defined in section 45A(c)(6)).”

In tribal consultations, Federal representatives from CMS, IHS, and IRS have indicated that HHS does not have authority to do more than merely restate the statutory definitions into rules implementing the ACA. As we discuss in more detail in Section 5 of this Analysis and Comment, NIHB disagrees with this conclusion. Moreover, while the proposed rules themselves merely restate the law, the explanatory preambles to the proposed rules go much further. The preamble to the Exchange Establishment NPRM states that “Section 4 of the IHCA defines “Indian” as a member of a Federally-recognized tribe.”¹² Similarly, the preamble to the Exchange Eligibility NPRM states that the definition of Indian in § 4(d) of the ISDEAA “means an individual who is a member of a Federally-recognized tribe.”¹³ As is discussed in Section 3, neither of these interpretations is consistent with the plain language of the statutes they cite and both would dramatically limit the number of AI/ANs to which the special benefits and protections for Indians are extended.

The ambiguity and the references to three separate, distinct statutes (albeit identical in meaning in NIHB’s view) will make it difficult for State Medicaid agencies, fledgling Exchanges, and other parties responsible for implementing the ACA to determine eligibility for Indian-specific protections and benefits. The ambiguity would result in many individuals being treated as “Indians” for the purposes of Medicaid cost-sharing exemptions, but not for the Exchanges cost-sharing protections, which would create confusion contrary to the ACA’s requirement of streamlining Medicaid eligibility by integrating Medicaid and Exchange applications.¹⁴ Also, most State officials and employees, Exchange plan and qualified health plan (“QHP”) staff, and AI/ANs themselves are unlikely to be familiar with the three statutes and their terms.¹⁵ This will lead to erroneous denials and delays in services and benefits and protections to which AI/ANs are entitled based on faulty or inconsistent eligibility determinations. That this potential confusion is virtually certain is proved by the erroneous statement in the preambles that at least two of the definitions of “Indian” in the ACA are restricted to “members of Federally-recognized tribes.”¹⁶

¹⁰ 25 U.S.C. § 450b(d).

¹¹ Pub. L. 93-638, as amended, 25 U.S.C. § 450 *et seq.*

¹² 76 Fed. Reg. 41884.

¹³ 75 Fed. Reg. 51205.

¹⁴ Both ACA § 1413(a) and proposed 42 C.F.R. § 155.405(a)(4) require a “single streamlined application to determine eligibility and to collect information necessary for enrollment” for Medicaid and the Exchanges.

¹⁵ This is particularly true in the context of AI/ANs inquiring into their own eligibility, some of whom may lack education or who may speak English as a second language.

¹⁶ 76 Fed. Reg. 14884 and 51205.

More simply put,

- mere restatement of statutory definitions into the final rules is insufficient for effective implementation of the ACA;
- indicating that the statutory definitions are limited to “members of Federally-recognized tribe” is a misstatement of the statutory definitions cited in the ACA;
- failure to use the same interpretation of the definition would create unnecessary confusion and unwarranted inconsistencies in determining who is “Indian”.

2. Recommended Solutions.

First, and most basically, HHS and other Federal agencies implementing the ACA should amend the statements in the preamble to the Exchange Establishment NPRM and the preamble to the Exchange Eligibility NPRM to make it clear that being Indian is not limited to members of Federally-recognized Tribes.

Second, and at a minimum, the final regulations should recognize that the definitions of “Indian” under the ISDEAA (applicable to reduced cost-sharing) and IHCIA (applicable to special enrollment periods) are operationally the same.

Third, the exemptions for Indians from individual responsibility requirements and related penalties for those who are not exempt under IRC § 5000A should be operationalized to include all Indians entitled to special enrollment benefits and cost sharing protections, which rely on the IHCIA and ISDEAA definitions respectively. This is appropriate and lawful since it is only one piece of the larger regulatory scheme to (1) establish Exchanges and (2) streamline the application and eligibility process for the Exchanges and Medicaid. These objectives cannot be achieved if the same individual is treated as an Indian for one purpose, but not for others.

Finally, the statutory definitions should be operationalized in the final rules so that people not steeped in Indian law can easily determine whether an individual is an Indian for the purposes of the ACA, preferably and most correctly, as the definition is set forth in 42 C.F.R. § 447.50.¹⁷ CMS promulgated Section 447.50 to implement the AI/AN-specific

¹⁷ This definition of “Indian” is:

any individual defined at 25 USC 1603(c)[IHCIA Sec. 4(13)], 1603(f) [IHCIA Sec. 4(28)], or 1679(b) [IHCIA Sec. 809], or who has been determined eligible as an Indian, pursuant to Sec. 136.12 of this part. This means the individual:

- (i) Is a member of a Federally-recognized Indian tribe;
- (ii) Resides in an urban center and meets one or more of the following four criteria:

Medicaid cost-sharing exemptions in § 5006 of the American Reinvestment and Recovery Act (“ARRA”).¹⁸ Section 447.50 is a comprehensive and inclusive definition that is consistent with the IHCIA, the ISDEAA and the IRS definitions of “Indian” referenced in the ACA. It is also consistent with the Federal trust obligation to provide health care to Indians and with the Snyder Act, which provides fundamental authorization for Federal health care programs to meet the needs of AI/ANs. Tracking the definition from § 447.50 in the ACA regulations would promote coordination of ACA programs with Medicaid. It would also be consistent with HHS administration of health care programs for Indians. Finally, it is written clearly and comprehensively so that a layperson can read it and understand whether or not an individual is an “Indian.”

Reliance on § 447.50 to implement the various definitions of Indian under the ACA has been endorsed by the National Congress of American Indians (“NCAI”), the National Indian Health Board, the Tribal Technical Advisory Group to CMS (“TTAG”), and the Tribal Self-Governance Advisory Committee (“TSGAC”), among others.¹⁹

3. The Definitions of “Indian” in the ACA Are Not Limited to Members of Federally-Recognized Indian Tribes.

The current NPRMs have set out interpretations of the definitions of “Indian” that are narrower than the statutory provisions upon which they rely and are therefore incorrect.²⁰ The

(A) Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;

(B) Is an Eskimo or Aleut or other Alaska Native;

(C) Is considered by the Secretary of the Interior to be an Indian for any purpose; or

(D) Is determined to be an Indian under regulations promulgated by the Secretary;

(iii) Is considered by the Secretary of the Interior to be an Indian for any purpose; or

(iv) Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.”

¹⁸ Pub. L. 111-5.

¹⁹ NCAI Res. # ABQ-10-080, November 2010, NIHB Res. 10-01, October 2010; TTAG October 2010; and TSGAC February 2011.

²⁰ 76 Fed. Reg. 41884 (“Section 4 of the IHCIA defines “Indian” as a member of a Federally-recognized tribe.”) and 51205 (“For purposes of determining eligibility for cost-sharing provisions, we propose to codify the definition of “Indian” to mean any individual defined in section 4(d) of the Indian Self-Determination and Education Assistance Act . . . , in accordance with section 1402(d)(1) of

Internal Revenue Service (“IRS”) has not yet opined on this issue in any proposed rules, however representatives of IRS present at national Tribal consultation meetings did not contradict CMS representatives who repeated the statements in the Exchange Establishment NPRM and Exchange Eligibility NPRM that for the purposes of the implementation of the ACA, “Indian” meant only members of Federally-recognized Tribes.”²¹

These statements are not consistent with the ACA and the statutory definitions of “Indian” that it cites. We elaborate below.

3.1 The Plain Language of the Statutes Does Not Require Enrollment in a Federally-Recognized Indian Tribe.

Section 4(d) of the ISDEAA defines “Indian” as “a person who is a member of an Indian tribe.”²² Similarly, the IHCIA defines “Indian” as “any person who is a member of an Indian tribe, as defined in subsection [(13)] thereof.”²³ The IRC does not define “Indian,” but all of the references to the IRC are to a member of an Indian Tribe as defined in Sec. 45A(c)(6). These consistent references to “member of an Indian Tribe” beg the question about whether the definitions of Indian Tribe, relied upon in each of these statutory provisions, are different. They are not.

The term “Indian tribe” means any Indian tribe, band, nation, pueblo, 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, which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status of Indians.

IHCIA Sec. 4(14), ISDEAA Sec. 4(d), AND IRC Sec. 45A(c)(6)
IRC Sec. 45A(c)(6) only
IHCIA Sec. 4(14) only

The definition of “Indian tribe” includes redundancies to assure that it is comprehensive and not misunderstood. The differences among the three definitions of “Indian Tribe” are without meaning, especially when one considers that the HHS regulations implementing the ISDEAA actually includes “pueblos,” although they are not expressly referenced in the

the Affordable Care Act. This definition means an individual who is a member of a Federally-recognized tribe.”).

²¹ Tribal Consultation in Seattle, Washington, August 22, 2011.

²² 25 U.S.C. § 450b(d).

²³ Subsections (c) “Indians or Indian” and (d) “Indian tribe” of the IHCIA were redesignated as paragraphs (13) and (14) by Section 104(3) of S. 1790 as reported by the Senate Committee on Indian Affairs (“SCIA”), which was incorporated by reference into the ACA pursuant to § 10221.

statutory definition.²⁴ It should be noted that pueblos are also considered to be Indian Tribes, nations, organized groups, and communities recognized as eligible for the special programs and services provided by the United States to Indians because of their status of Indians. To further support our contention that these definitions are not in fact different, dropping the word “pueblo” from the definition would not exclude pueblos.

The plain language of these definitions includes no reference to “Federally-recognized Tribes.” Instead, they all include “organized groups and communities” including Alaska Native regional and village corporations.

3.1.1 Other Organized Groups and Communities – Alaska Native Regional or Village Corporations.

The Alaska Native Claims Settlement Act (“ANCSA”)²⁵ was enacted in 1971 in order to settle land claims by Alaska Natives. Although ANCSA had the effect of extinguishing the Indian reservations in Alaska²⁶ and transferring title of selected lands to Alaska Native regional and village corporations, it did not eliminate the special trust relationship of the United States to Alaska Natives.

One consequence of ANCSA was, however, that tribal identity in Alaska began to be defined by reference to Alaska Native Corporations (“ANCs”) as well as, and often to a greater degree than, enrollment in a Tribe. In recognition of this, all three definitions of Indian used in the ACA treat the “regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act [cit.om.]” as “Indian tribes” for the purposes of defining who is an “Indian,” although they are certainly not “Federally-recognized Indian tribes” as that term is often employed.²⁷ Nor is the inclusion of ANCs limited by the final clause referencing eligibility for special programs and services provided by the United States for Indians because of their status as Indians.²⁸

²⁴ 25 C.F.R. § 900.6 (HHS and Department of the Interior (“DOI”) Title I), 25 C.F.R. § 1000.2 (DOI Title IV), 42 C.F.R. § 137.10 (Title V). These regulatory definitions also include “rancherias and colonies.”

²⁵ Pub.L. 92-203, § 2, 85 Stat. 688, codified as amended at 43 U.S.C. § 1603 *et seq.*

²⁶ The exception to the extinguishment was the Metlakatla Indian reservation in Southeast Alaska.

²⁷ *E.g.*, in the Preamble to the Exchange Establishment NPRM, the phrase “Federally-recognized tribes” is treated as synonymous with the list of Tribes as defined “in the Federally Recognized Indian Tribe List Act of 1994, 25 U.S.C. 479a.”

²⁸ *Cook Inlet Native Ass’n v. Bowen*, 810 F. 2d 1471, 1474 (9th Cir. 1987) (“Regional corporations appear to be included specifically in the Self-Determination Act definition, yet CINA contends they are excluded by the eligibility clause. CINA asserts that the clause modifies ‘regional corporation’ and therefore, to be a tribe, the corporation must ‘be recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.’ 25 U.S.C. § 450b(b). CIRI is not eligible for special programs because of its status. However, the statute should not be interpreted to render one part inoperative . . .”).

Limiting the definition of “Indian” to members of Federally-recognized Tribes disregards these individuals outright in violation of the statutes’ plain language and underlying directives. It is critical that CMS retract its reliance on Federally-recognized tribal membership, lest it essentially write Alaska Natives out of the scope of the law.

3.1.2 Other Organized Groups and Communities – California Indians.

As a result of a series of destructive Federal actions and policies specifically pertaining to California Indians,²⁹ thousands of “California Indians” are not members of Federally-recognized Indian Tribes. They do continue to be “recognized as eligible for special programs and services provided by the United States for Indians because of their status as Indians,” and therefore to fall within the definitions of Indian under the ACA.³⁰ For example, in 25 U.S.C. § 1679,³¹ Congress mandated the provision of health care to a variety of California Indians. The Indians to be served include:

- (1) Any member of a federally recognized Indian tribe.³²
- (2) Any descendant of an Indian who was residing in California on June 1, 1852, but only if such descendant--
 - (A) is living in California,
 - (B) is a member of the Indian community served by a local program of the Service; and
 - (C) is regarded as an Indian by the community in which such descendant lives.³³
- (3) Any Indian who holds trust interests in public domain, national forest, or Indian reservation allotments in California.³⁴
- (4) Any Indian in California who is listed on the plans for distribution of the assets of California rancherias and reservations

²⁹ We note that in the reference to the IHCIA definition of Indian all of § 4 of the IHCIA is referenced. Contained within § 4 is not only a definition of “Indian,” but also of “California Indian.” *See*, § 4(3). Had Congress intended to exclude these “Indians,” it could easily have done so by referencing only § 4(13). It did not.

³⁰ NIHB is grateful to the California Rural Indian Health Board (“CRIHB”) for sharing its analysis of the status of California Indians and encourages HHS and other Federal agencies to consider CRIHB’s more detailed comments on the status of California Indians.

³¹ 25 U.S.C. § 1679 is § 809 of the IHCIA, as amended, and is referred to in the definition of “California Indian” at § 4(3).

³² These Indians are, by definition, tribal members, and their eligibility therefore requires no further elaboration.

³³ Regardless of their formal enrollment status, all of these descendants are by definition part of the Indian “community” and are eligible for the “special . . . services provided by the United States to Indians” because of their status as Indians. They therefore meet the portion of the definitional test that requires them to being members of a “tribe. . . or other organized group or community.”

³⁴ Each of these Indians has an interest in land held in trust by the United States for that individual. As such, they are receiving the benefit of services provided by the U.S. because of their status as Indians. If not, the land could not be held in trust and administered by the U.S. for that individual Indian’s benefit.

under the Act of August 18, 1958 (72 Stat. 619) and any descendant of such Indian.³⁵

California Indians who are not necessarily members of Federally-recognized Tribes are also able to contract Federal programs under the ISDEAA under certain circumstances.³⁶

Congress did not indicate any intention to exclude California Indians from special benefits and protections for Indians under the ACA. CMS should not administer the ACA in a manner that creates such a result.

3.1.3 Other Organized Groups and Communities – Urban Indians.

In keeping with the Federal government’s obligation to provide services to AI/ANs and its policy of Indian self-determination, Title V of the IHCA established the use of Indian controlled, non-profit corporations to serve as the surrogate over the welfare and special health programs for the benefit of Indians in certain defined metropolitan areas. The principle of Indian self-determination was at the core of this approach by providing that the responsibility to aid urban Indians was to be fulfilled by an Indian community-represented Board of Directors. To assure that the welfare of Indians was paramount in this transformation, the Board is required to be representative of the community by assuring that the majority of Board members are of AI/AN heritage. In order to ensure a broad scope of urban Indian eligibility, Congress created a more inclusive definition³⁷ taken from the 1934 Johnson-O’Malley Indian Education Act.

³⁵ Virtually all of the rancherias and reservations that were terminated under that Act have been reinstated. Thus, the Indians falling under this provision are part of an organized “group or community” which was and is now recognized as eligible for the programs provided by the United States for Indians “because of their status as Indians.” Congress recognized that these individuals are part of the Indian community eligible for services provided by the U.S. for Indians because of their status as Indians when Congress included them as a category of Indians eligible for services from IHS.

³⁶ The federal regulations implementing the ISDEAA define the term “Indian Contractor” as follows:

- (1) In California, subcontractors of the California Rural Indian Health Board, Inc., or subject to approval of the IHS Directors after consultation with the DHHS Office of General Counsel, subcontractors of a Indian tribe or tribal organization which are:
- (i) Governed by Indians eligible to receive services from the Indian Health Service;
 - (ii) Which carry out comprehensive IHS service programs within geographically defined services areas; and
 - (ii) Which are selected and identified through tribal resolution as the local provider of Indian health care services.

25 C.F.R. § 900.181.

³⁷ This definition includes individuals who (1), irrespective of whether he or she lives on or near a reservation, is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member, or (2) is an Eskimo or Aleut or other Alaska Native, or (3) is considered by the Secretary of the Interior to be an Indian for any purpose, or (4) is determined to be an Indian under regulations promulgated by the

Both the IHCIA and the ISDEAA were crafted under the broad national policy of fulfilling the special trust responsibility of the United States to Indians and Indian self-determination, and in contrast to the policy of termination. The authors of these laws explicitly required efforts to encourage the maximum participation of Indian people in the management and operation of Indian benefits and programs.

3.1.4 The Courts Have Interpreted the Definitions of Indian to Include People Who Are Not Members of Tribes.

Courts have specifically held that the definition of Indian found in the IHCIA and ISDEAA is not limited to members of Federally-recognized Tribes. For example, courts have specifically held that this definition can under some circumstances include state-recognized tribes³⁸ and, in certain cases, even entities that are *not* eligible for special programs.³⁹

Moreover, an individual need not be enrolled in a tribe under certain circumstances to qualify as an “Indian” under the ISDEAA. At least one court has held that the phrase “other organized group or community” in the ISDEAA definition of “Indian tribe” refers to *a geographic area within which a tribe is located* so long as Indians in that community receive federal, Indian-specific assistance.⁴⁰ Because the state-recognized tribe at issue was located within the geographic area that received IHS services from an urban Indian organization, it was part of a “community” that was “recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.” As such, it fell within the ISDEAA definition.

The court supported this analysis by examining the purposes of the ISDEAA, the IHCIA, and federal precedents.⁴¹ The court found that “to conclude that [an individual who is] *a member of the recipient Indian community*, cannot qualify for an Indian preference would be contrary to the meaning of the Indian preference law and the rationale of the United States Supreme Court.”⁴² This interpretation of the phrase “other organized group or community” is correct as it ensures that individuals of Indian descent who live within an overall tribal community, but who are not members of an Indian tribe, be considered “Indians” for the purposes of the ACA.

Secretary. *See*, IHCIA § 4(28), 25 U.S.C. § 1603(28), in which references to subsections (g) “urban center” and (c) “Indians or Indian” of the IHCIA were redesignated as paragraphs (27) and (13), respectively, by Section 104(3) of S. 1790 as reported by the Senate Committee on Indian Affairs (“SCIA”), which was incorporated by reference into the ACA pursuant to § 10221.

³⁸ *Schmasow v. Native Am. Ctr.*, 968 P.2d 304 (Mont.1999).

³⁹ *Cook Inlet Native Ass’n v. Bowen*, 810 F. 2d 1471, 1474 (9th Cir. 1987).

⁴⁰ *Schmasow*, 978 P.2d at 304.

⁴¹ *Id.* at 308.

⁴² *Id.* (emphasis added).

The *Schmasow* court also emphasized that both the ISDEAA and the IHCA were intended to “provide federal benefits to non-reservation and non-federally recognized Indian communities.”⁴³ That same rationale applies in the instant case, as the Indian-specific provisions of the ACA, such as the special benefits and protections in the Exchanges, are aimed at expanding health services to AI/ANs and encouraging their participation in federal health care programs. The unnecessarily limited definition espoused in the proposed regulations would be contrary to this purpose.⁴⁴

Finally, reading the ACA definitions of “Indian” narrowly, and excluding anyone who is not member of a federally-recognized tribe, would violate the Indian canon of construction that ambiguities in the interpretation of treaties, statutes, regulations and other governmental-tribal agreements be construed in favor of the Indians,⁴⁵ and all “doubtful expressions [be given] that meaning least prejudicial to the interests of the Indians.”⁴⁶

3.1.5 Canons of Statutory Construction.

Finally, reading the ACA definitions of “Indian” narrowly, and excluding anyone who is not member of a Federally-recognized Tribe, would violate the Indian canon of construction that ambiguities in the interpretation of treaties, statutes, regulations and other governmental-tribal agreements be construed in favor of the Indians,⁴⁷ and that all “doubtful expressions [be given] that meaning least prejudicial to the interests of the Indians.”⁴⁸ Thus, the canons of statutory construction dictate that the definitions of Indian referred to in the ACA cannot be interpreted as applying only to members of Federally-recognized Tribes.

⁴³ *Schmasow*, 978 P.2d at 308.

⁴⁴ Further, “the concept of formal enrollment has no counterpart in traditional tribal views of membership.” FELIX S. COHEN, COHEN’S HANDBOOK OF FEDERAL INDIAN LAW §3.03, at 179 (Nell Jessup Newton *et al.*, eds. 2005 ed.).

⁴⁵ *See, e.g., Yakima v. Confederated Tribes and Bands of the Yakima Indian Nation*, 502 U.S. 251, 269 (1992) (“When we are faced with these two possible constructions, our choice between them must be dictated by a principle deeply rooted in this Court’s Indian jurisprudence: ‘[S]tatutes are to be construed liberally in favor of the Indians, with ambiguous provisions interpreted to their benefit.’” (citations omitted).

⁴⁶ *Nw. Bands of Shoshone Indians v. United States*, 324 U.S. 335, 362 (1945) (Murphy, J., dissenting).

⁴⁷ *See, e.g., Yakima v. Confederated Tribes and Bands of the Yakima Indian Nation*, 502 U.S. 251, 269 (1992) (“When we are faced with these two possible constructions, our choice between them must be dictated by a principle deeply rooted in this Court’s Indian jurisprudence: ‘[S]tatutes are to be construed liberally in favor of the Indians, with ambiguous provisions interpreted to their benefit.’” (citations omitted).

⁴⁸ *Nw. Bands of Shoshone Indians v. United States*, 324 U.S. 335, 362 (1945) (Murphy, J., dissenting).

Another well-established canon of construction is that a statute must not be read so as to render any portion inoperative.⁴⁹ The original proposed definition of “Indian tribe” in the ISDEAA was “an Indian tribe, band, nation, or Alaska Native community for which the federal government provides special programs and services because of its Indian identity.”⁵⁰ The phrase “other organized group or community” was not added until the bill’s final revisions before passage. Because the “Indian tribe” language had been included in the definition from the outset, though, “Indian tribe” and “other organized group or community” must be read as distinct concepts. As such, limiting “Indians” to individuals enrolled in a Federally-recognized Tribe would violate the canons of construction by equating the phrase “other organized group or community” with “any Indian tribe” wholesale, thus nullifying any purpose behind having added the “other organized group or community” language into the law’s final version. Although this legislative history may be unique to the ISDEAA, the conclusion must be the same with regard to interpretation of the virtually identical definitions in the IHCIA and IRC.

Other Indian-specific legislation recognizes the fact that the ISDEAA definition of Indian cannot be read to be limited to members of Federally-recognized Indian Tribes. For example, when Congress created the Museum of the American Indian in Washington, D.C., the enabling legislation’s originally proposed definition of the term “Indian” was “a member of an Indian tribe recognized by the United States Government, including an Alaska Native.”⁵¹ However, as enacted, the definition of Indian reads as follows:

(7) the term “Indian” means a member of an Indian tribe;

(8) the term “Indian tribe” has the meaning given that term in section 450b of Title 25.⁵²

So, rather than define Indian *specifically* as a member of a Federally-recognized Indian Tribe, Congress changed the definition to mirror that of the ISDEAA. There is no reason why Congress would substitute the comparatively simple “Federally-recognized Tribe” language for the more complicated citation to the ISDEAA if the two did not have different meanings. A similar logic must apply to the IRC and IHCIA definitions of Indian. If they were intended to be limited to members of Federally-recognized Tribes, Congress could have readily and more simply accomplished that by using language more like that originally proposed with regard to the Museum of the American Indian. It did not, which leads to the inescapable conclusion that the definitions cited in the ACA have broader meanings.

3.2 The Snyder Act.

⁴⁹ *Mountain States Tel. and Tel. Co. v. Pueblo of Santa Ana*, 472 U.S. 237, 249 (1985).

⁵⁰ H.R. 6372, 93d Cong. (1st Sess. 1973).

⁵¹ H.R. Rep. 101-340(I), 101st Cong. (1st Sess. 1989).

⁵² 20 U.S.C. § 80q-14(7)-(8).

The Snyder Act is the primary statute authorizing the Federal government to provide health care to Indians and implementing the unique Federal obligations to Indians. It directs and authorizes HHS⁵³ to “direct, supervise, and expend such moneys as Congress may from time to time appropriate, for the benefit, care, and assistance of the Indians throughout the United States” for the “relief of distress and conservation of health.”⁵⁴ The statute was enacted for the “special benefit of Indians and must be liberally construed in their favor.”⁵⁵

Congress and Federal courts have affirmed that the Snyder Act implements the Federal government’s trust obligation to Indians. For example, the House of Representatives’ report of April 9, 1976, published as part of the legislative history of the initial version of the IHCA, states that the Snyder Act’s directive for the Federal government to provide “for the relief of distress and conservation of the health of Indians” remains “the basic legislative statement of the Federal Government’s obligation to provide health services to Indians.”⁵⁶ Courts have found that the Snyder Act was enacted out of the Federal government’s “overriding duty of fairness when dealing with Indians, one founded upon a relationship of trust for the benefit of” AI/ANs.⁵⁷ Citing these principles, courts have held that IHCA implements and expands on the Snyder Act.⁵⁸ In fact, when examining the IHCA’s gloss on the Snyder Act, one court was “struck by Congress’ recognition of federal responsibility for Indian health care.”⁵⁹ Since ACA contains specific provisions for health care to Indians, including the permanent authorization of the IHCA as well as special treatment in the Exchanges and other ACA programs, there is no basis to conclude that the ACA does not also implement and expand on the Snyder Act.

This understanding of the Snyder Act and its relationship to the IHCA and other Federal laws for the benefit of Indian health are critical to correctly implement the definitions in the ACA. In an exchange regarding tribal concerns about how the proposed rules treat the definition of Indian, an HHS official commented that the regulations adopted by HHS to

⁵³ The responsibilities under the Snyder Act were transferred to the Secretary of Health, Education, and Welfare (the precursor to HHS) pursuant to the Act of August 5, 1954, Pub. L. 83-538, commonly referred to as the Transfer Act.

⁵⁴ 25 U.S.C. § 13.

⁵⁵ *Wilson v. Watt*, 703 F.2d 395, 402 (9th Cir. 1983).

⁵⁶ H.R. REP. No. 94-1026(I) (Conf. Rep.), at 2 (1976), *reprinted in* 1976 U.S.C.C.A.N. 2652, 2653.

⁵⁷ *Fox v. Morton*, 505 F.2d 254, 255 (9th Cir. 1974). *Accord Blue Legs v. U.S. Bureau of Indian Affairs*, 867 F.2d 1094, 100 (8th Cir. 1989).

⁵⁸ *See, e.g., McNabb for McNabb v. Heckler*, 628 F. Supp. 544, 547 (D. Mont. 1986), *aff’d*, 829 F.2d 787 (9th Cir. 1987). *Accord Hornell Brewing Co., Inc. v. Brady*, 819 F. Supp. 1227, 1236 n.9 (E.D.N.Y. 1993) (noting, with approval, the emphasis placed on the Snyder Act’s continuing viability in *McNabb*).

⁵⁹ *Malone v. Bureau of Indian Affairs*, 38 F.3d 433, 438 (9th Cir. 1994); *accord Zarr v. Barlow*, 800 F.2d 1484, 1493 (9th Cir. 1986). We note that the *Malone* court ultimately overturned the BIA regulations at issue for violations of the federal Administrative Procedure Act. This does not detract from or otherwise diminish the validity of the case’s interpretation of the Snyder Act.

implement protections for Indians under Section 5006 of ARRA”, which are favored by tribal leaders for implementation of the special protections related to implementation of the Exchanges, were adopted under the broad, general authority of the Snyder Act and were made possible because Section 5006 of ARRA contained no specific definition of Indian.

NIHB appreciated the clarification regarding the reliance on the Snyder Act. However, for the reasons discussed above, NIHB believes that the concern that they Snyder Act’s broad authority only applies in the absence of other definitions is misplaced. As courts have noted, the IHCIA expands on the Snyder Act; it does not limit it. To suggest that something permitted under the Snyder Act, i.e. delivery of health services to AI/ANs who may not be members of Federally-recognized Tribes, is not permitted under the IHCIA or the other statutory schemes that use virtually identical language turns the analysis of the Snyder Act on its head and should be reconsidered.

4. ISDEEA Definition Is Operationally Identical to that in IHCIA.

Whether HHS uses the ISDEEA definition or the IHCIA definition, the outcomes should be the same with regard to ACA regulations. HHS regulations implementing regarding who is eligible for services of the IHS provide that

Services will be made available, as medically indicated, to persons of Indian descent belonging to the Indian community served by the local facilities and program.

...

Generally, an individual may be regarded as within the scope of the Indian health and medical service program if he/she is regarded as an Indian by the community in which he/she lives as evidenced by such factors as tribal membership, enrollment, residence on tax-exempt land, ownership of restricted property, active participation in tribal affairs, or other relevant factors in keeping with general Bureau of Indian Affairs practices in the jurisdiction.⁶⁰

Efforts by HHS to restrict these IHS eligibility rules in the 1980s resulted in a Congressional moratorium that has not yet been lifted.

These rules apply equally to the ISDEEA. The ISDEEA broadly allows tribal health programs to redesign or consolidate programs, services, functions, and activities (or portions thereof) (“PSFAs”) included in a funding agreement under which the Tribe or tribal organization assumed responsibility for Federal PSFAs; however, it may not take any action that would diminish “eligibility for services to population groups otherwise eligible to be served *under applicable Federal law*.”⁶¹ One such “applicable federal law” is the IHCIA.⁶²

⁶⁰ 42 C.F.R. § 136.11(a). This same regulatory scheme defines “Indian” to “include[] “Indians in the Continental United States, and Indians, Aleuts and Eskimos in Alaska.” 42 C.F.R. § 136.1.

⁶¹ 25 U.S.C. § 458aaa-5(e) (emphasis added). *Accord* 25 U.S.C. § 450J(g) (“The contracts authorized under section 450f of this title and grants pursuant to section 450h of this title may include

Otherwise stated, the ISDEAA explicitly prohibits tribal health programs from reducing eligibility for services for which individuals would otherwise be entitled pursuant to the IHCA, including California Indians. Clearly, the ISDEAA definition of Indian cannot be read as requiring membership in a Tribe, Federally-recognized or otherwise, in order for an individual to count as an “Indian.”

Essentially, the concept of “Indian community” goes beyond a Tribe and encompasses members of the geographic “recipient Indian community.”⁶³ As a result, any individual of Indian descent belonging to an “Indian community,” as that term is used in 42 C.F.R. § 136 should be considered an “Indian” for the purposes of the ISDEAA, and therefore for the purposes of the Exchange-related provisions. And, in any case, as discussed earlier in this paper, the legislative history of the ISDEAA cannot be read as supporting an interpretation that it applies only to members of Federally-recognized Indian Tribes.

5. HHS (and Other Federal Agency) Regulatory Authority.

In tribal consultations regarding the ACA, HHS officials have responded to requests for more developed rulemaking regarding implementation of the definition of Indian by suggesting that they lack the authority to do more than to restate the various definitions of Indian as they specifically apply to particular provisions. This is incorrect.⁶⁴ HHS and other Federal agencies have the legal authority to implement the statutory definitions of “Indian” for the purposes of Exchange establishment and eligibility and related tax provisions, just as it did when it implemented ARRA.

HHS is responsible for the administration of Indian health programs and the fulfillment of the special trust responsibility owed to Indians, as well as administration of Medicaid, CHIP, and the Exchange plans. Clear definitions that actually describe which individuals may benefit from the Indian-specific provisions of the ACA are consistent with the statutory mandate to implement the Indian-specific provisions of the ACA as well the IHCA and other statutes governing Indian health care programs. Such definitions are also required to achieve the key purposes of administrative rulemaking – to resolve ambiguities that are inherent in complex legislation and provide regulatory detail to implement statutory generalities.

provisions for the performance of personal services which would otherwise be performed by Federal employees including, but in no way limited to, functions such as determination of eligibility of applicants for assistance, benefits, or services, and the extent or amount of such assistance, benefits, or services to be provided and the provisions of such assistance, benefits, or services, all in accordance with the terms of the contract or grant and applicable rules and regulations of the appropriate Secretary: *Provided*, That the Secretary shall not make any contract which would impair his ability to discharge his trust responsibilities to any Indian tribe or individuals.”).

⁶² *Id.* at § 458aaa-4(b)(2)(D).

⁶³ *Schmasowv. Native Am.Ctr.*, 968 P.2d 304(Mont.1999).

⁶⁴ We must also note that, as we discussed in Section 3 of this Analysis and Comment, the preambles to the NPRMs, in fact, did redefine Indian more narrowly than even the statutory definitions themselves.

5.1 The Transfer Act.

The Transfer Act provided

[t]hat all functions, responsibilities, authorities, and duties of the Department of the Interior, the Bureau of Indian Affairs, Secretary of the Interior, and the Commissioner of Indian Affairs relating to the maintenance and operation of hospital and health facilities for Indians, and the conservation of the health of Indians, are hereby transferred to, and shall be administered by, the Surgeon General of the United States Public Health Service, under the supervision and direction of the Secretary of Health, Education, and Welfare.⁶⁵

This extremely broad responsibility arising from both the trust obligations of the United States to Indians and the Snyder Act, was accompanied by expansive authority “to make such other regulations as [the Secretary] deems desirable to carry out the provisions of this Act.”⁶⁶ NIHB believes this authority carries over to HHS implementation of the Indian-specific provisions of the ACA, which can only be read as being intended to relate to the maintenance and operation of hospital and health facilities for Indians and the conservation of health of Indians. HHS should not ignore this authority.

5.2 Judicial Deference to Agency Regulations.

The courts have recognized broad agency authority to promulgate regulations that are consistent with congressional intent.⁶⁷ Courts have also recognized an agency’s power to adopt regulations that accommodate conflicting policies,⁶⁸ with one court noting that this requires upholding regulations that fall “within the universe of plausible approaches.”⁶⁹

⁶⁵ Pub. L. 83-568.

⁶⁶ Sec. 3 of Pub. L. 83-568.

⁶⁷ See, e.g., *Lacavera v. Dudas*, 441 F.3d 1380, 1383 (Fed. Cir. 2006) (“It was reasonable for the [Patent Trade Office] to interpret legal authority to render service as being a necessary qualification. Accordingly, it was reasonable for the PTO to enact regulations that limit an alien’s ability to practice before it to those activities in which the alien may lawfully engage. Therefore, the PTO did not exceed its statutory authority in promulgating the regulations in question.”).

⁶⁸ See, e.g., *Cent. Az. Water Conservation Dist. v. E.P.A.*, 990 F.2d 1531, 1541 (9th Cir. 1993) (holding that EPA regulations were entitled to deference against a challenge that they went beyond statutory authority “since the agency’s ‘choice represents a reasonable accommodation of conflicting policies that were committed to the agency’s care by the statute,’ which this court ‘should not disturb’ since it does not appear ‘from the statute or its legislative history that the accommodation is not one that Congress would have sanctioned.’” (citations omitted)).

⁶⁹ See, e.g., *Com. of Mass., Dep’t. of Pub. Welfare v. Sec’y of Agric.*, 984 F.2d 514, 522 (1st Cir. 1993) (“In terms of our analogy, the line drawn by [the agency], as the Secretary’s designee, seems to have been plotted sensibly, if not with perfect precision; that is, [the agency] chose a configuration consistent with statutory imperatives and well within the universe of plausible approaches.”).

Judicial deference is even required when the court disagrees with the agency's interpretation.⁷⁰

“[T]he case for deference is particularly strong when the agency has interpreted regulatory terms regarding which it must often apply its expertise.”⁷¹ Along with the BIA, IHS and other agencies within HHS have the greatest expertise in determining who is an “Indian” for purposes of programs serving Indians. As a result, courts would accord a higher level of deference to any reasonable regulatory definition of the term “Indian” that HHS promulgates.

This deference is illustrated in *Alaska Chapter, Associated General Contractors v. Pierce*,⁷² where the court gave substantial deference to another agency's definition of Indian even though it was alleged to go beyond the ISDEAA definition. In *Pierce*, the plaintiff challenged a regulation promulgated by the Department of Housing and Urban Development (“HUD”) that defined “Indian” for the purposes of the ISDEAA's Indian hiring preference requirement.⁷³ HUD interpreted the ISDEAA definition to include “any person recognized as being an Indian or Alaskan Native by a Tribe, the Government, or any state,” with a “tribe” then defined as “an Indian tribe, band, pueblo, group or community of Indians or Alaskan Natives.”⁷⁴ The court upheld the regulatory definition because it was “rationally related to the fulfillment of Congress' unique obligation toward Indians and Alaska Natives.”⁷⁵

A court would give a reasonable definition of “Indian” adopted by HHS or another Federal agency to implement the ACA at least as much deference as the court in *Pierce*. This is also a clear example of the fact that HHS has the inherent authority to promulgate such a regulation in the first instance.

5.3 Statutory Ambiguity Should Be Resolved by Regulations.

5.3.1 References to More Than One Statute Has Created Ambiguity for Those Charged with Implementing ACA.

⁷⁰ See, e.g., *Am. Radio Relay League, Inc. v. F.C.C.*, 617 F.2d 875, 881 (D.C. Cir. 1980) (“Had we been the rulemakers in this case, we might have been more hesitant in encroaching on the domain of the innocent amateur operators. Nonetheless, we cannot say that the agency abused its discretion in adopting the rules that it did.”).

⁷¹ *Wash. Urban League v. F.E.R.C.*, 886 F.2d 1381, 1386 (3rd Cir. 1989) (citations omitted). *Accord MCI Telecommunications Corp. v. F.C.C.*, 822 F.2d 80, 84-85 (D.C.Cir. 1987); *W. Union Tel. Co. v. FCC*, 541 F.2d 346, 351 (3rd Cir.1976).

⁷² 694 F.2d 1162 (9th Cir. 1982).

⁷³ See 42 U.S.C. § 450e(b)(i) (requiring that “preferences and opportunities for training and employment in connection with the administration of such contracts or grants shall be given to Indians”).

⁷⁴ 24 C.F.R. § 805.102.

⁷⁵ *Alaska Chapter*, 694 F.2d at 1170.

The decision in the proposed rules to merely repeat the statutory definitions of “Indian” and to let this constitute the entirety of the regulatory definition, rather than to more specifically spell out the meaning of the definitions creates ambiguity in the meaning of the ACA and for those charged with its interpretation. This is especially true given that the three statutory definitions are virtually identical, but not particularly susceptible to clear understanding without reliance on other regulations and materials of the agencies involved in carrying out the programs to which the definitions apply.

It is hornbook law that “judicial usage sanctions the application of the word ‘ambiguity’ to describe any kind of doubtful meaning of words, phrases or longer statutory provisions,”⁷⁶ and that ambiguity “exists when a statute is capable of being understood by reasonably well-informed persons in two or more different senses.”⁷⁷ The Indian-specific Exchange-related ACA provisions can be reasonably interpreted in a number of conflicting ways, and are therefore ambiguous under the landmark case of *Chevron U.S.A. v. National Resources Defense Council*,⁷⁸ which we discuss further in Section 5.3.2 of this Analysis and Comment.

The best evidence that reasonable people can interpret the statutory provisions differently appears in the Exchange Establishment NPRM and Exchange Eligibility NPRM themselves. Both preambles state that the definition of Indian in the IHCA and the ISDEAA mean that an Indian is a member of a Federally-recognized Tribe, contrary to the plain language of the statute, is a perfect example.⁷⁹ Also, persuasive is the fact that both CMS and IHS determined that they needed separate regulations and other guidance materials to assist Federal, Tribal and State officials about how to determine that a person falls within the statutory definition.⁸⁰ While these regulations and other materials demonstrate that the statutory definitions can be reconciled, mere restatement of the statutory language is not sufficient to actually do so.

The reliance on three different statutory references (or none) for the definition of “Indian” in the ACA creates an inherent ambiguity that requires resolution. For example, § 1311(c)(6)(D) of the ACA⁸¹ creates “special monthly enrollment periods for Indians (as defined in section 4 of the Indian Health Care Improvement Act).” By comparison, §

⁷⁶ Black’s Law Dictionary 88 (8th ed. 2004) (citation and internal quotation marks omitted).

⁷⁷ 2A NORMAN J. SINGER & J.D. SHAMBIE SINGER, STATUTES AND STATUTORY CONSTRUCTION § 45:2, at 13 (7th ed. 2007).

⁷⁸ 467 U.S. 837 (1984).

⁷⁹ See, Section 3 of this Analysis and Comment.

⁸⁰ IRS allows the employment tax credit under IRC § 45A to employees who are enrolled members of an Indian tribe, but states that “[e]ach tribe determines who qualifies for enrollment and what documentation, if any, is issued as proof of enrollment status. Examples of appropriate documentation . . . include a tribal membership card, *Certified Degree of Indian Blood (CDIB) card* . . .” IRS Form 8845 (emphasis added.) BIA issues CDIB cards to not only members of federally recognized tribes, but also to their descendants. Bureau of Indian Affairs, “Certificate of Degree of Indian or Alaska Native Blood Instructions,” OMB Control #1076-0153.

⁸¹ Codified as amended at 42 U.S.C. § 18031(c)(6)(D).

1402(d)(1) of the ACA waives cost-sharing for any individual whose family household income is below 300% of the Federal poverty level and who is “enrolled in any qualified health plan in the individual market through an Exchange [and] is an Indian (as defined in section 4(d) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(d)).” And, the protection from tax penalties applies to individuals who are members of Indian Tribes as defined in the IRC 45A. In the past, when Congress has cited to Indian-specific statutes within more general legislation, courts have found clear congressional intent as to its scope when, for example, “the incorporation of the ISDEAA was done with surgical precision.”⁸² Confusing citation to three separate statutes that nevertheless say the exact same thing hardly rises to this level of clarity, and therefore requires agency clarification.

This statutory ambiguity will become amplified in the implementation of the single streamlined application for Exchange plans and Medicaid,⁸³ if clarifying regulations about who is an “Indian” are not adopted. Cost-sharing protections for Indians are already available under Medicaid and the Children’s Health Insurance Program (“CHIP”).⁸⁴ They are available to Indians as defined at 42 C.F.R. § 447.50. It is impossible to imagine that ambiguity and confusion will not result if there is no definition of who is an “Indian” for the purposes of Exchange plan cost-sharing protections. And, even more, confusion will result if it is unclear whether a person is an Indian for the purposes of special enrollment, but perhaps not for Exchange plan cost-sharing or protection from tax penalties.

In the preamble to the Exchange Establishment NPRM, CMS acknowledges this problem by requesting “comment on how to distinguish between individuals eligible for assistance under the Affordable Care Act and those who are not in light of the different definitions of ‘Indian’ that apply for other Exchange provisions.”⁸⁵

Comment is also requested on the proposal regarding proposed § 155.350 regarding the best practices for accepting and verifying documentation related to Indian status.⁸⁶ The proposed language in the Exchange Eligibility NPRM is that the applicant be able to attest to being an Indian, but that the Exchange must verify the attestation.⁸⁷ The proposed rule goes on to indicate that absent other approved sources for verification that the Exchange should rely on “documentation provided by the applicant in accordance with the standards for acceptable documentation provided in section 1903(x)(3)(B)(v) of the Social Security Act, which allows for documents “issued by a federally recognized Indian tribe evidencing

⁸² *Navajo Nation v. Dep’t of Health and Human Servs.*, 325 F.3d 1133, 1139-40 (9th Cir. 2003).

⁸³ The single streamlined application is required by ACA § 1413(b)(1)A and proposed rule § 155.405.

⁸⁴ *See*, ARRA § 5006.

⁸⁵ 76 Fed. Reg. 41879 (regarding purchase of premiums under § 155.240(b)). It is important to note that NIHB does not accept the premise that the three definitions relied upon in the ACA regarding Exchanges are actually different from one another, although that appears to be the assumption made by HHS in the NPRMs. We addressed this issue comprehensively in Section 3 of this Analysis and Comment.

⁸⁶ 76 Fed. Reg. 51223.

⁸⁷ Exchange Eligibility NPRM § 155.315(c).

membership or enrollment in, *or affiliation with*, such tribe (such as a tribal enrollment card or *certificate of degree of Indian blood*).⁸⁸ Neither “affiliation with” nor a CDIB is equal to tribal membership. Both are more representative of the broader definition of Indian that HHS relies upon under ARRA and for the purposes of IHS programs. We support this approach, but it must be broader to accommodate the more expansive definition of “Indian” that HHS has adopted in its reasonable exercise of discretion § 447.50, and which should be used for implementation of the ACA.

5.3.2 The Ambiguity Should Be Resolved in Regulations.

The ambiguities in the ACA that are evident from the conflicting interpretations that even HHS has made regarding who will be an “Indian” for implementation of the various special benefits and protections for Indians demonstrate the ambiguity that justifies rulemaking under *Chevron* and that should be resolved in regulations. If HHS and other Federal agencies believe the definitions referenced in the ACA actually mean something different, then they should clearly define who is included in each so that the public has an opportunity to comment on their understanding. If the Federal agencies think they have the same meaning, as the actual statutory language suggests, then that should be stated and the States, Exchanges, and Tribes and others who will be affected by these regulations should have the benefit of knowing precisely who is it that is encompassed within the single definition.

There is no Congressional history that suggests Congress intended an ambiguous result. Rather, as Supreme Court Justice Antonin Scalia has noted, agency deference under *Chevron* is often warranted due to the fact that when crafting complex legislation that is dependent on precise usage of specific terms, “[i]n the vast majority of cases . . . Congress . . . didn’t think about the matter at all.”⁸⁹ The multiple definitions of “Indian” are likely a reflection merely of the complexity of the ACA and the fact that so many different individuals had a hand in crafting the law.

Chevron established the guidelines for when courts must defer to an agency’s interpretation of a statute it is charged with administering. This two-part inquiry is as follows:

- “First, always, is the question whether Congress has spoken directly to the precise question at issue. If the intent of Congress is clear, that is the end of the matter; for the court as well as the agency must give effect to the unambiguously expressed intent of Congress.”

⁸⁸ Codified at 42 U.S.C. § 1396b(x)(3)(B)(v). Emphasis added.

⁸⁹ Antonin Scalia, *Judicial Deference to Administrative Interpretations of Law*, 1989 DUKE L.J. 511, 517.

- “[I]f the statute is silent or ambiguous with respect to the specific question, the issue for the court is whether the agency’s answer is based on a permissible construction of the statute.”⁹⁰

Under this analysis, the present question is whether (a) Congress clearly expressed its intent as to who should benefit from the Indian-specific provisions in the ACA and, if not, (b) whether it would be reasonable for HHS to adopt regulations that more specifically identify who is an “Indian” in its implementing regulations. As discussed below, that answer to the first question is “no,” and is “yes” To the second question. In this circumstance, an agency is justified in adopting regulations.

As noted earlier, HHS officials have suggested that HHS may not adopt the definition in § 447.50 promulgated under ARRA for the purposes of the ACA because the agency’s regulatory authority under ACA is different than under ARRA. They note that ARRA did not specifically define “Indian” and suggest that the Snyder Act of 1921⁹¹ authorized HHS to craft the definition in § 447.50 to fill in the gap left by the statute. By comparison, these officials worry that Congress’s inclusion of statutory definitions of “Indian” in the ACA does not leave room for administrative interpretation, and that only Congress may reconcile the ACA’s multiple definitions of the term.

However, as discussed below (and in Section 3.2 of this Analysis and Comment), the Snyder Act is the primary statute authorizing the Federal government to provide health care to Indians and implementing the unique Federal obligations to Indians. Therefore, the Snyder Act applies with equal force to the ACA as it does to ARRA, and therefore CMS is empowered and obligated to supply a uniform definition of “Indian” for the latter statute just as it did under ARRA.⁹²

Several cases have held that when Federal agencies draft eligibility regulations for programs under the Snyder Act, because they are “for the ‘special benefit’ of all Indians[,] any ambiguities should be resolved in favor of *inclusion*” with regard to eligibility.⁹³ One such court favorably pointed to the IHCIA’s 1998 inclusion of California Indians as an example of this principle.⁹⁴ This is consistent with the Indian canons of construction, which require that ambiguities in the interpretation of treaties, statutes, regulations and other governmental-tribal agreements be construed in favor of the Indians,⁹⁵ and all “doubtful expressions [be given] that meaning least prejudicial to the interests of the Indians.”⁹⁶

⁹⁰ *Id.* at 842–843.

⁹¹ P.L. 67-85, 42 Stat. 208, codified as amended at 25 U.S.C. 13.

⁹² *Also see*, § 3 of the Transfer Act.

⁹³ *Malone v. Bureau of Indian Affairs*, 38 F.3d 433, 438 (9th Cir. 1994); *accord Zarr v. Barlow*, 800 F.2d 1484, 1493 (9th Cir. 1986). In fairness, it should be noted that the *Malone* court overturned the BIA regulations at issue for violations of the federal Administrative Procedure Act. This does not detract from or otherwise diminish the validity of the case’s interpretation of the Snyder Act.

⁹⁴ *Malone*, 38 F.3d at 438.

⁹⁵ *See, e.g., Yakima v. Confederated Tribes and Bands of the Yakima Indian Nation*, 502 U.S. 251, 269 (1992) (“When we are faced with these two possible constructions, our choice between them

Similarly, in *Morton v. Ruiz*,⁹⁷ the Supreme Court held that IHS was required to establish and consistently apply a reasonable standard for the allocation of its limited health services and facilities budget.⁹⁸ Subsequent courts have held that “the purpose of establishing a clear standard is to prevent arbitrary denials of benefits.”⁹⁹ While it is true that this rule applies to actual IHS funding determinations rather than regulatory definitions, its principle is nevertheless instructive. As discussed above, a narrow interpretation of the ACA definition of “Indian” could conceivably preclude California Indians, Alaska Natives, and other individuals who are otherwise eligible for IHS services from claiming “Indian” status for the purposes of the ACA’s Indian-specific protections. Allowing a drafting technicality in the ACA to produce such a disastrous result would be an arbitrary denial of statutory protections to which thousands of AI/ANs are entitled and inconsistent with the ACA and other laws governing Indian health care.¹⁰⁰

As a practical matter, the administration cannot wait for Congress to more perfectly align the definitions in ACA. There is a very tight timeframe for designing the streamlined Medicaid/Exchange application form, designing the eligibility software, and implementing other requirements to assure that Exchanges are functional by 2013, and this matter must be addressed quickly to assure that AI/AN receive the benefits to which they are entitled through ACA. Failing to clarify now the ACA definitions will interfere with the coordination of Exchanges and Medicaid.

ARRA § 5006 waives cost-sharing for Indians under Medicaid, and prohibits any reduction in payment that is due under Medicaid to the I/T/U or to a health care provider through referral under contract health services for furnishing an item or service to an Indian. As discussed, CMS applied a detailed and inclusive definition of the term “Indian” for the purposes of this benefit in 42 C.F.R. § 447.50. If CMS fails to clarify the ACA definitions, only enrolled tribal members may be found eligible for cost-sharing waivers in the Exchange. This will create a class of “sometimes Indians” who qualify for Medicaid cost-sharing waivers but not for Exchange cost-sharing waivers. These “arbitrary” denials of statutory rights for AI/ANs are precisely the type of injustices that *Morton* and its progeny specifically forbid.

5.3.3 Documentation Requirements Should Be Simple and Readily

must be dictated by a principle deeply rooted in this Court's Indian jurisprudence: “[S]tatutes are to be construed liberally in favor of the Indians, with ambiguous provisions interpreted to their benefit.” (citations omitted).

⁹⁶ *Nw. Bands of Shoshone Indians v. United States*, 324 U.S. 335, 362 (1945) (Murphy, J., dissenting).

⁹⁷ 415 U.S. 199 (1974).

⁹⁸ *Id.* at 230-31.

⁹⁹ *Rincon Band of Mission Indians v. Harris*, 618 F.2d 569, 572 (9th Cir. 1980).

¹⁰⁰ One court has rejected the diminution of Indian benefits under the Snyder Act when congressional intent to do so was ambiguous. *See Wilson v. Watt*, 703 F.2d 395, 402-03 (9th Cir. 1983).

Accessible.

AI/ANs are required to verify their status as Indians for a variety of purposes. When promulgating the expansive definition of Indian found in 42 C.F.R. § 447.50, CMS explicitly recognized that “administrative simplicity is very important” when it noted that for the purposes of verifying Indian status for Medicaid cost-sharing protections:

Documentation that an individual is an Indian could include Tribal enrollment and membership cards, a certificate of degree of Indian blood issued by the Bureau of Indian Affairs, a Tribal census document, or a document issued by a Tribe indicating an individual’s affiliation with the Tribe. The Indian health care programs and urban Indian health programs are responsible for determining who is eligible to receive an item or service furnished by their programs and so a medical record card or similar documentation that specifies an individual is an Indian as defined above could suffice as appropriate documentation. These documents are examples of documents that may be used, but do not constitute an all-inclusive list of such documents.¹⁰¹

A similar need is present under the ACA and the same kind of solution is appropriate and supported by law. While the most efficient approach would be to use attestation as the basis for determining who is Indian, NIHB recommends that when documentation of being Indian is required under any of the definitions, any of the documents referenced for verifying Indian status for Medicaid cost-sharing should apply equally under the IHCIA, ISDEAA, and IRC definitions. This could be addressed in the rules by setting out such language with regard to each of the special benefits or protections or by setting out an omnibus provision regarding documentation and applying it uniformly to the others.

6. Summary of Argument

The plain language of the statutory definitions referred to in the ACA does not limit the definition of “Indian” to members of Federally-recognized Tribes. HHS has authority to implement regulations that clarify who is included in the definition of “Indian” for the purposes of the ACA due to the inherent ambiguity in the statutory drafting. Under the authority of the Snyder Act, IHCIA and ISDEAA, it is appropriate and legally correct that a single reconciled definition incorporate each category of individual included in the definition of Indian found in 42 C.F.R. § 447.50.

The objectives of the ACA cannot be achieved, and ambiguity and confusion will result, if the application for Exchange plans and for Medicaid cannot be streamlined. A streamlined application for all applicants and efficient and consistent processing for AI/ANs

¹⁰¹ Medicaid Program; Premiums and Cost Sharing, 75 Fed. Reg. 30, 244, 30,248 (May 28, 2010).

will be impossible if who is Indian and how it can be documented is not clarified. Documentation permitted now under regulatory schemes that relies on the various statutory definitions does not require proof of enrollment in a Tribe, let alone a Federally-recognized Tribe.

If CMS does not modify its proposed rules related to the definition of Indian, it will have disastrous effects and be contrary to Federal law. First, there are numerous classes of individuals who are “Indians” for purposes of Medicaid, IHS eligibility, and other government benefits who may find themselves without benefits and protections to which they are entitled. Confusion will lead to Exchanges, States, IHS, Tribal health programs, urban Indian organizations, and individual providers, and patients changing the status of “Indian” between programs, procedures, or providers. When individuals move from State to State, their status could change if States are left to interpret the Federal definition of “Indian.” There will be billing problems for I/T/Us and QHPs regarding cost-sharing waivers. There will be many unnecessary and costly administrative appeals and legal challenges. AI/ANs, who are characterized by the experience of suffering some of the greatest health disparities, and to whom the United States owes a special duty, will find it difficult to access the resources that were intended by Congress through the ACA to provide them with special benefits and protections.

It is therefore absolutely essential any final rules be extremely explicit as to who CMS believes qualifies for benefits under each Exchange-related provision. Specifically, any final rules must lay out who qualifies as an Indian for the purposes of:

- Simultaneous application for enrollment in Medicaid or an Exchange (ACA § 1413(a), proposed 42 C.F.R. § 155.405);
- Special monthly enrollment periods for Indians (ACA § 1311(c)(6)(D), proposed 42 C.F.R. § 155.420(d)(8)).
- Payment of premiums by Tribes, tribal organizations, and urban Indian organizations (IHCIA § 402, proposed 42 C.F.R. § 155.240).
- Indian-specific cost-sharing waivers (ACA § 1402(d)).
- Waiver of IRS penalties.

CMS must provide a *detailed* explanation of *exactly* who counts as an Indian for the purposes of each Exchange-related regulatory provision that will directly affect AI/ANs. Merely citing the statutory provision that provides the definition of “Indian” is insufficient.