

# National Indian Health Board

## Legislative Tool Kit for Tribes and Their Advocates: How to Fix Definition of “Indian” in the Affordable Care Act

May 21, 2013

The definitions of the word “Indian” in the Patient Protection and Affordable Care Act (“ACA” or “Act”) are not consistent with the definition used for delivery of other federally supported health services to American Indians/Alaska Natives (AI/ANs) under Medicaid and Children’s Health Insurance Program (“CHIP”) program and through the Indian Health Service (“IHS”). The inconsistency will result in many AI/ANs being subjected to tax penalties from which they should be exempt, and not receiving the benefits and special protections (protection from cost sharing and special enrollment) intended for them consistent with the special trust responsibility the United States owes to AI/ANs. It will also create significant confusion since the application for Medicaid and participation in insurance exchanges are being integrated. It is imperative that Congress correct these problems.

Examples of AI/ANs who might be affected include:

- Children born into Tribes that do not permit enrollment until age 18 may be ineligible to be treated as Indian under the ACA, although they are correctly treated as such by IHS and by the Centers for Medicare and Medicaid Services (“CMS”) for Medicaid.
- California Indians who are entitled to IHS and Medicaid services as Indians will not be treated as Indian under the ACA.
- Many Alaska Natives who are too young to have enrolled in an Alaska Native Claims Settlement Act Corporation, which largely ended in the 1970s, may be denied the protections due Indians because they have not yet become shareholders which is mostly dependent on inheritance from a parent or grandparent who may still be living.

### What’s in the Tool Kit:

- NIHB Briefing Document for Capitol Hill staff
- Proposed definition for “Indian” in the ACA
- Reference guide of Related laws and regulations
- Press Coverage of Definition of Indian

### Actions Needed:

Tribal leaders and advocates need to contact their Members of Congress about this issue and recommend passage of new definitions of Indian described below. The ACA health exchanges begin enrollment October 1, 2013, so Congress must act to ensure that AI/ANs are not forced to pay unjust tax penalties, nor prevented from accessing benefits of the exchanges intended for them. Currently, the strategy is to get this included into any bill that is going to be passed through Congress. Examples include, the debt ceiling limit or a comprehensive tax package that the House is expected to consider in early summer.

*Please contact Caitrin McCarron, NIHB’s Manager of Congressional Relations, by phone (202-507-4085) or email ([cmccarron@nihb.org](mailto:cmccarron@nihb.org)) about all Congressional meetings you have on this issue, so that NIHB may follow-up with the appropriate offices.*



### Legislative Recommendation:

The National Indian Health Board, the National Congress of American Indians, the Tribal Technical Advisory Group to CMS, the Tribal Self-Governance Advisory Committee, Area Indian Health Boards, and many individual Tribes have officially endorsed amending the definition of Indian in the ACA provisions affecting cost sharing (ACA 1402), special enrollment (ACA 1311) and tax penalties (ACA 1501/IRC 5000A) to correspond to the definition of Indian adopted by CMS in regulation at 42 C.F.R. § 447.50. Initially, tribal advocates believed it could accomplish this by cross-reference to the CMS regulation; however, we understand there may be some concerns about referencing regulations in statute. In order to avoid any procedural or technical delays, we endorse putting the language of the CMS regulation into the statute (as updated to reflect statutory reference updates since it was adopted and with language that eliminates an internal regulatory citation). A copy of the proposed language is attached.

### Questions You May Be Asked:

*What about the Administration's views?* Members of Congress or their staff may inquire about the Administration position on the definition. The HHS Secretary and IRS have said in public forums with AI/ANs that they believe the definitions should be the same as the definition adopted in regulation by CMS.

*Do Tribal advocates and the Administration agree on the Congressional remedy?* Recently, HHS offered technical assistance to the Congress in which it proposed to amend Section 1402 (and by reference back to Sec. 1402, the two other critical provisions) of the ACA by adding a new definition of Indian. Although there were some concerns about the initial draft, the IHS Director responded to Tribal questions by committing that the intent was that the new definition be identical to the CMS regulation. Tribal advocates have agreed on the attached language, which achieves the same result as the CMS regulation. A copy of the CMS regulation and the provisions of law and relevant IHS regulations are attached. A comparison to our proposed statutory language shows that it has the same effect as the CMS regulation.

*Will this improve access to health care by AI/ANs?* By using the same definition of Indian for all federally funded health programs that rely on the same streamlined application (i.e. Medicaid, CHIP, and exchanges) and for avoiding tax penalties, all AI/ANs will be treated equally and fairly consistent with the special trust responsibility owed to them and improve their access to all the available programs.

*Are there other benefits?* Using a single definition of Indian for Medicaid and the exchanges will reduce the costs of managing the new streamlined application and minimize the likelihood of errors that will negatively affect individual AI/ANs and their families.

*Does this solve all definition issues?* Although there are other definitions of "Indian" in the ACA, we are advocating correcting only the exchange-related definitions because these most directly affect access to health care and, if they are not fixed, there will be a real and immediate negative effect on AI/ANs.

**If you have any questions on this matter, AND to update NIHB regarding any Congressional contact you have on this issue, please contact Caitrin McCarron, Manager of Congressional Relations at the National Indian Health Board, at (202) 507-4085 or [cmccarron@nihb.org](mailto:cmccarron@nihb.org).**

# National Indian Health Board



## THE DEFINITION OF “INDIAN” NEED FOR CONSISTENT DEFINITION FOR ACCESS TO FEDERALLY-SUPPORTED HEALTH CARE MAY 18, 2013

### *Background*

The definitions of the word “Indian” in the Patient Protection and Affordable Care Act (“ACA” or “Act”) are not consistent with the definition used for delivery of other federally-supported health services to American Indians/Alaska Natives (AI/ANs) under Medicaid and Children’s Health Insurance Program (“CHIP”) program and from the Indian Health Service (“IHS”). The inconsistency will result in many AI/ANs being subjected to tax penalties from which they should be exempt, and not receiving the benefits and other special protections intended for them consistent with the special trust responsibility the United States owes to AI/ANs. It will also create significant confusion since the application for Medicaid and participation in insurance exchanges are being integrated. It is imperative that Congress correct these problems.

The Center for Consumer Insurance Information and Oversight (CCIIO) has determined that the two exchange-related definitions (for exchange cost-sharing and enrollment protections) “operationally means the same thing.” With regard to Exchange Establishment Final Rule, 77 Fed. Reg. 18346, IRS has said informally that its definition section, which protects against tax penalties being applied to AI/ANs for not maintaining minimum essential coverage, has the same meaning as the definitions used for the exchange.

In response to requests from States for clarification about who an “Indian” is, CMS adopted Medicaid regulations that simplified the IHS eligibility rules. *See*, 42 CFR 447.50. There is broad agreement that this definition should apply equally to the exchanges.

### *Legislative Objective*

A uniform definition of “Indian” should be implemented for AI/AN access to federally-supported health care, including the ACA exchanges, Medicaid and CHIP, and IHS services. This can be accomplished by substituting a definition that has the same effect as the one found in 42 C.F.R. § 447.50 (as in effect on July 1, 2010) for the three definitions in the ACA that affect AI/AN access and special protections: special enrollment (ACA § 1311(c)(6)(D)); cost sharing protections (ACA § 1402(d)(1)); and exemption from individual responsibility and tax penalties (IRC § 5000A(e)(3)). A copy of an amendment that will achieve this outcome is attached.

The proposed definition of Indian incorporated into the amendment was provided to Tribes by the Indian Health Service Director as the language the Administration was offering Congress in response to requests for technical assistance.

### *Tribal Support for Using CMS’s Medicaid Regulations as the Uniform Definition of Indian*

National Indian Health Board (NIHB), the National Congress of American Indians (NCAI), the Tribal Technical Advisory Group to CMS (TTAG), and regional Tribal organizations have adopted resolutions supporting the use of the CMS Medicaid regulation at 42 C.F.R. § 447.50 for purposes of implementing the Indian-specific health access provisions of the ACA. Thus, this definition should be used to develop legislation to develop a uniform definition of Indian.



## ***Potential Consequences of Failing to Pass Legislation***

Failure to pass legislation creating a uniform definition of Indian will impede Medicaid, Exchanges, and Internal Revenue Service (IRS) staff in making accurate and consistent determinations of eligibility, and delay or completely deny access for many AI/ANs, the Indian-specific benefits and protections established for Indians under the ACA.

### **Who will be affected?**

- Children born into Tribes that do not permit enrollment until age 18 may be ineligible to be treated as Indian under the ACA, although they will continue to be treated as such by IHS and by CMS for Medicaid.
- California Indians who are entitled to IHS and Medicaid services as Indians will not be treated as Indian under the ACA.
- In Alaska, many Alaska Natives who are too young to have enrolled in an Alaska Native Claims Settlement Act Corporation, which largely ended in the 1970s, will continue to be eligible for IHS services but will be subject to the health insurance mandate tax penalty and may be denied the protections due Indians because they have not yet become shareholders which is mostly dependent on inheritance from a parent or grandparent who may still be living.

**What will the effect be?** If the technical correction legislation is not adopted, and one of the AI/ANs described above is determined to not be “Indian” under the statutory definitions currently in the ACA, there are many potential consequences.

- Unwarranted application of tax penalties is likely if the AI/AN is not income eligible for Medicaid and does not purchase health insurance.
- Reduced timeliness in processing the consolidated Medicaid and exchange applications will occur because different definitions will apply to AI/ANs depending on the health access they are seeking, which may make it impossible to use a single automated database (like the IHS beneficiary roster), hamper coordination between the two programs, and likely increase the administrative cost and burden on States and AI/ANs.
- Reduced accuracy in determinations of eligibility and tax penalties are virtually certain since the training for all the agencies and the people trying to help applicants will be much more complex because of the differing rules and documentation requirements.
- Disruptions in coverage for AI/ANs whose income increases so they are no longer eligible for Medicaid, but don’t qualify as an AI/AN for the health insurance exchanges.
- Different treatment of members of the same family is probable since depending on the members’ age and other factors, some will satisfy any of the definitions and some will only satisfy the current IHS and Medicaid definitions. This will create enormous confusion, resentment and unwarranted costs.
- Reduced involvement of AI/ANs in insurance options is probable. Even if the instances of an AI/AN being determined to be an “Indian” for IHS or Medicaid purposes, but not for others, constitute a small percentage of the total population (which we expect), whenever it does occur it will cast a shadow over AI/AN’s involvement in ACA implementation generally.

### ***Can’t this be fixed administratively?***

The Department of Health and Human Services (HHS) and the IRS have stated in innumerable Tribal consultations and in response to innumerable letters from tribes that because of the way the law is explicitly written, there must be a legislative fix.

### ***Who can I contact if I have more questions?***

For more information, please contact Caitrin McCarron, NIHB Manager of Congressional Relations, [cmccarron@nihb.org](mailto:cmccarron@nihb.org) or (202) 507-4085.

## A BILL

To correct inconsistencies in the definitions affecting health care services for Native Americans.  
*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

### SECTION 1. TECHNICAL CORRECTIONS ALIGNING THE DEFINITIONS OF INDIAN FOR HEALTH CARE PURPOSES.

(a) IN GENERAL.—Title I of the Patient Protection and Affordable Care Act is amended—

(1) in section 1311(c)(6)(D), by striking “(as defined in section 4 of the Indian Health Care Improvement Act)” and inserting “(as defined in section 1402(d)(4))”; and

(2) in section 1402(d)(1), by striking “(as defined in section 4(d) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(d)))”; and

(3) in section 1402(d), by adding a new paragraph (4) to read:

“(4) DEFINITION.—For the purposes of this subsection, ‘Indian’ means any individual defined at 25 U.S.C. 1603(13), 1603(28), or 1679(a), or who is of Indian descent belonging to the Indian community served by the local facilities and program of the Indian Health Service. This means the individual:

“(A) Is a member of a Federally-recognized Indian tribe;

“(B) Resides in an urban center or rural area and meets one or more of the following four criteria:

“(i) 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;

“(ii) Is an Eskimo or Aleut or other Alaska Native;

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

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

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

“(D) 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.”

(b) EXEMPTION FROM PENALTY FOR NOT MAINTAINING MINIMUM ESSENTIAL COVERAGE.– Section 5000A(e)(3) of the Internal Revenue Code of 1986 is amended by striking subsection (3) and inserting “(3) INDIAN.– Any applicable individual for any month during which the individual is an Indian as defined in section 1402(d)(4) of the Patient Protection and Affordable Care Act.”.

**Reference Guide: Related Law and Regulations for Definition of Indian in the Affordable Care Act**  
**May 21, 2013**

**CMS Regulation—42 C.F.R. 447.50 Cost sharing: Basis and purpose.** (b) Definitions. For the purposes of this subpart:

- (1) Indian means any individual defined at 25 USC 1603(c) [(13)], 1603(f), or 1679(b), 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:
    - (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.

**IHCIA Definitions—25 U.S.C. § 1603(13) [§ 1603(c)] Indians or Indian.** The term “Indians” or “Indian”, unless otherwise designated, means any person who is a member of an Indian tribe, as defined in subsection (14) hereof, except that, for the purpose of section 102 [25 U.S.C. § 1612] and 103 [25 U.S.C. § 1613], such terms shall mean any individual 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 Secretary.

**25 U.S.C. § 1603(28) [§ 1603(f)] Urban Indian.** The term ‘urban Indian’ means any individual who resides in an urban center, as defined in subsection (g) [(27)] hereof, and who meets one or more of the four criteria in subsection (c)(1) through (4) [(13)(1) through (4)] of this section.

**25 U.S.C. § 1679(a) [§ 1679(b)] Eligibility of California Indians.** (a) In general. The following California Indians shall be eligible for health services provided by the Service:

- (1) Any member of a federally-recognized Indian tribe.
- (2) Any descendant of an Indian who was residing in California on June 1, 1852, if such descendant--
  - (A) is a member of the Indian community served by a local program of the Service; and
  - (B) is regarded as an Indian by the community in which such descendant lives.
- (3) Any Indian who holds trust interests in public domain, national forest, or Indian reservation allotments in California.
- (4) Any Indian of California who is listed on the plans for distribution of the assets of rancherias and reservations located within the State of California under the Act of August 18, 1958 (72 Stat. 619), and any descendant of such an Indian.

**IHS Eligibility Regulation—42 C.F.R. § 136.12 Persons to whom services will be provided.** (a) In general.

- (1) 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. Services will also be made available, as medically indicated, to a non-Indian woman pregnant with an eligible Indian's child but only during the period of her pregnancy through postpartum (generally about 6 weeks after delivery). In cases where the woman is not married to the eligible Indian under applicable state or tribal law, paternity must be acknowledged in writing by the Indian or determined by order of a court of competent jurisdiction. The Service will also provide medically indicated services to non-Indian members of an eligible Indian's household if the medical officer in charge determines that this is necessary to control acute infectious disease or a public health hazard.
- (2) 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.

# National Indian Health Board



## Press Coverage of Definition of Indian May 21, 2013

### Huffington Post

[http://www.huffingtonpost.com/2013/05/15/health-care-reforms\\_n\\_3280336.html](http://www.huffingtonpost.com/2013/05/15/health-care-reforms_n_3280336.html)

## Health Care Reforms Penalize Some Native Americans

By GARANCE BURKE 05/15/13 04:29 PM ET EDT 

SAN FRANCISCO — When Liz DeRouen needs any kind of health care services, from diabetes counseling to a dental cleaning, she checks into a government-funded clinic in Northern California's wine country that covers all her medical needs.

Her care and the medical services for her children and grandchildren are paid for as part of the government's treaty obligations to American Indian tribes dating back nearly a century. But under President Barack Obama's health care overhaul, DeRouen and tens of thousands of others who identify as Native American will face a new reality.

They will have to buy their own health insurance policies or pay a \$695 fine from the Internal Revenue Service unless they can prove that they are "Indian enough" to claim one of the few exemptions allowed under the Affordable Care Act's mandate that all Americans carry insurance.

"I'm no less Indian than I was yesterday, and just because the definition of who is Indian got changed in the law doesn't mean that it's fair for people to be penalized," said DeRouen, a former tribal administrator for the Dry Creek Rancheria Band of Pomo Indians who lost her membership amid a leadership dispute in 2009. "If I suddenly have to pay for my own health insurance to avoid the fine, I won't be able to afford it."

The Affordable Care Act takes a narrow view of who is considered American Indian and can avoid the tax penalty, which will reach a minimum of \$695 when fully phased in. It limits

the definition to those who can document their membership in one of about 560 tribes recognized by the U.S. Bureau of Indian Affairs.

Yet more than 100 tribes nationwide are recognized only by states and not the federal government. Many tribes do not allow their members to enroll before they are 18, meaning some school-age children whose parents are American Indian might not be considered "Indian" under the definition in the act.

Other tribal governments have complicated blood-quantum requirements or rules that all members must live on the reservation, even though nearly two-thirds of American Indians and Alaska Natives now live in metropolitan areas, partly a legacy of federal relocation and adoption programs.

The definition of Indian in the Affordable Care Act is roiling emotions on reservations and in native enclaves across the country, but U.S. Department of Health and Human Services spokeswoman Erin Shields said the agency is powerless to change it without an act of Congress.

The problem is so new that the federal government is still seeking to establish how many people might be affected, although Indian health advocacy groups estimate it could be up to 480,000.

In California alone, about 21,000 people who currently receive free health care through Indian clinics are not recognized as Native American by the federal government and would have to pay the penalty, according to the nonprofit California Rural Indian Health Board.

"We have and will continue to encourage a robust dialogue with American Indian and Alaska Native communities about this matter, and welcome their input and ideas for solutions," Shields said in a statement to The Associated Press. "Under the law, it would require a legislative rather than regulatory change to address this matter. And as we consider approaches to the best possible solution, we are eager to work with Congress."

The IRS is working with the definition but has not yet decided how the agency will verify who qualifies as Indian or assess the penalty on tax returns, agency spokesman Eric Smith said. The IRS and U.S. Treasury have scheduled a May 29 public hearing on their proposed rules establishing who qualifies for an exemption from the insurance coverage requirement.

Republican Rep. Tom Cole, a member of the Chickasaw Nation in Oklahoma and one of just two federal legislators who are members of a federally recognized tribe, said he was aware of the concerns and would ensure that care for native people was not compromised as the health overhaul rolls out. He declined to comment about whether he would sponsor a bill to address the issue.

"This could lead to some tribal citizens being required to purchase insurance or face penalties even though they are covered by IHS," he said in a statement to The Associated Press, referring to the federal Indian Health Service. "I am watching the situation closely to ensure that those individuals already benefiting from care through IHS continue to receive it."

The 2010 Census found that nearly one-third of the 6.2 million people who self-identify as American Indian or Alaska Native lack health insurance and that 28 percent live in poverty.

The Indian Health Service, a division of U.S. Health and Human Services, oversees a network of clinics that are required to serve all patients of Indian ancestry, even if they cannot document their federal tribal status.

One of those is the clinic in Santa Rosa, north of San Francisco, where DeRouen, 49, has been seen since she was a little girl. Molin Malicay, who directs the Sonoma County Indian Health Project, estimates DeRouen is among roughly 2,000 of his patients who would face the penalty.

"In the clinics in Central and Northern California, we see many of us Indians who are not considered Indians in the eyes of the federal government because the government itself terminated their tribes," Malicay said. "We're trying to get some of these people covered for care under Medicaid, but there is still so much confusion in the pamphlets and videos about who is Indian (that) it makes it hard to give advice."

Several members of the main tribal advisory group to the Centers for Medicare and Medicaid Services said in a recent conference call with the agency that the definition contained in the Affordable Care Act raises concerns that the U.S. could renege on its obligation to provide all people of Indian ancestry with free health care. Budget cuts already are set to reduce basic federal health programs for Indians by up to 8 percent.

Some tribal elders who favor tighter restrictions on who gets to identify as Native American see it another way.

Mychal Eaglefeathers, a 34-year-old member of the Northern Cheyenne Nation in southeastern Montana, said several elders he spoke with believe that allowing only members of federally recognized tribes to avoid the individual insurance mandate was a positive step, especially as the already strapped Indian Health Service clinics are forced to slash services.

"Especially the elders I've talked to say as long as you're recognized, fine. But if you're not federally recognized, people shouldn't get nothing," he said.

Valerie Davidson, a senior director at the Anchorage-based Alaska Native Tribal Health Consortium, estimates that about one-third of the 140,000 Alaska Native population would

have to pay the health care penalty. That includes her nieces and nephews from the largely Yup'ik Eskimo region, comprised of tiny villages only accessible by plane or boat.

She raises the possibility that native people would have to get extra documentation to prove they qualify. People have historically been able to use their federal tribal blood-quantum cards to get IHS health services, but that alone is no longer enough to qualify for the tax exemption under the Affordable Care Act, she said.

In addition, many Alaska Natives who were born after December 1971 are prohibited from enrolling in their families' tribal corporations, even if all four grandparents are Alaska Native, she added.

"Are America's first people really being forced yet again to prove our Indian-ness?" she said through tears on a recent conference call with federal agencies. "Every single day in our own communities we have to fight to demonstrate that we are still here, that we do still exist. We should be believed that what your parents and grandparents say you are, you are."

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## **The Oklahoman**

<http://newsok.com/health-care-law-changes-could-affect-okla.-tribes/article/feed/541799>

### **Health care law changes could affect Okla. tribes**

OKLAHOMA CITY (AP) — As a policy advisor for the Choctaw Nation Health Services Authority, Melanie Fourkiller knows that documented Native Americans can access the tribe's health care services even if they are not members of the Choctaw Nation or any other federally recognized tribe.

But changes in how the government defines a Native American that are part of the Affordable Care Act could force some who are served by the Choctaw Nation to either purchase private insurance or pay an annual \$695 penalty to the Internal Revenue Service, once it's fully phased in.

"It causes all kind of chaos," Fourkiller said. "Members of my family would fall into the category. It just would be very confusing."

Tribal leaders from across Oklahoma are working with federal officials to restore the definition of which American Indians and Alaska Natives are exempt from the penalty to the one that has been used by the Indian Health Service for decades.

"There are different definitions of Indians floating around out there," said Dr. Charles Grim, deputy executive director of health services for the Cherokee Nation, which operates a hospital and eight outpatient clinics that serve about 150,000 people in northeastern Oklahoma.

Grim said there is concern among tribal governments that some people eligible to receive health care services through the IHS will not meet the ACA's definition for which American Indians are exempt from the penalty.

In Oklahoma, almost 483,000 of the state's 3.75 million residents identify themselves as Native Americans, or nearly 13 percent of the state's population, according to figures from the U.S. Department of Health and Human Services. Only California has a higher number.

Tulsa County has the largest number of residents who identify themselves as Native American — 61,000. Oklahoma County is home to almost 46,000 people who self-identify as Native American.

There are approximately 560 federally recognized tribes in the U.S., and 39 of them are based in Oklahoma. Tribal officials said Native Americans who are not citizens of one of the tribes could potentially be required to enroll in health insurance exchanges and carry insurance.

"It is a potential problem," Grim said.

Republican Rep. Tom Cole, a member of the Chickasaw Nation in Oklahoma, said he was aware of the concerns.

"This could lead to some tribal citizens being required to purchase insurance or face penalties even though they are covered by IHS," he said in a statement to The Associated Press. Cole is one of two federal legislators who are members of a federally recognized tribe. He would not say whether he would sponsor a bill to address the issue. Mickey Percy, executive director of health for the Choctaw Nation, said the solution involves making the new health care law's definition of American Indian consistent.

"They're messing with the definition of who's an Indian," Percy said. "It needs to stay what it is."

Percy said the Choctaw Nation, which serves about 50,000 people with a hospital and outpatient clinics in southeastern Oklahoma, will be able to adapt to the ACA's provisions.

"We can bend and roll with the Affordable Care Act," he said. But the changes could be costly for non-tribal patients who have been receiving tribal health care services.

"It negatively impacts lots and lots of folks with uncompensated care," he said.

## **Reno Gazette Journal**

<http://www.rgj.com/viewart/20130515/NEWS/305150087/Health-reforms-could-penalize-some-Nevada-Indians>

### **Health reforms could penalize some Nevada Indians**

*Written by MICHELLE RINDELS, Associated Press  
May 15*

rgj.com

LAS VEGAS (AP) — On one hand, Angie Wilson said she's looking forward to when the health care overhaul takes full effect in 2014 — it'll allow the northern Nevada tribal health clinic she directs to maximize its limited resources.

But on the other hand, the director of the Reno Sparks Tribal Health Center is worried about the federal government's plans to use a narrow definition of American Indian in the law — one that could mean an estimated one-third of her clinic's 7,000 regular clients will be hit with a \$695 annual fine for not carrying insurance, even if they continue to receive free care through the clinic.

"This is such a huge issue for us," Wilson said. "The question that I can already see coming is that our folks are getting fined for not having health coverage, but we're already born with the right to health care because of the treaties."

Advocates across the country are raising concerns about the law's proposal to define an American Indian as a member of a federally recognized tribe. People in that category will continue receiving free tribal health care and be exempt from the requirement to carry health insurance.

But clinics such as Wilson's in Reno serve a much broader population that includes descendants of federally recognized tribal members, and Wilson said the clinic plans to continue serving those people when the law takes effect. The difference will be that descendants who don't sign up for a separate insurance policy will face fines — ones that Wilson worries they won't be able to afford.

It's unclear exactly how many people in Nevada will be affected if federal officials adopt the narrower definition. The Census counts nearly 56,000 people in the state who self-identify as Indian, including 30,000 in Clark County and 11,000 in Washoe County.

But not all of them are official members of federally recognized tribes. Some don't meet "blood quantum" levels set by tribes that require potential members prove a minimum quantity of Indian blood to join. Sometimes that happens when a child has parents from two separate tribes, but not enough blood from a single tribe to qualify.

Others, like the Pahrump Paiute Tribe, belong to entire groups that have never been federally recognized. It numbers about 150 people and is concentrated southern Nevada's Pahrump Valley.

Tribal chairman Richard Arnold said his education was paid for through the Bureau of Indian Affairs, and the federal agency keeps track of the tribe. But the group's application for federal recognition that was filed in 1982 is still pending. It could be years before it moves forward.

"We always have fallen through the cracks," Arnold said. "One way or the other, we're survivors. We've been able to keep going."

While some Pahrump Paiute members use Indian Health Service because of intermarriage with members of federally recognized tribes, many are accustomed to living without the services that people who self-identify as American Indians enjoy.

As far as insurance, "it's something that the majority of people don't have, and the majority just go without," Arnold said.

He's concerned that the fines from the Affordable Care Act could be a burden for Pahrump Paiute families.

And Arnold questions whether certain tribal members want to take part in the modern health insurance system to begin with.

As a practitioner of traditional medicine, he responds to sick members with a holistic approach that blends physical and spiritual approaches passed down from his ancestors. Many Pahrump Paiutes don't depend on hospitals as often as the general population.

"They believe in it, they rely on it," Arnold said about traditional medicine. "Why go someplace else?"