

National Indian Health Board



Via electronic transmission to: <<http://www.regulations.gov>>

October 4, 2010

Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
Attention: OCIO – 9989 - NC
P.O. Box 8010
Baltimore, MD 21244-8010

**Re: Comments Regarding 45 CFR Part 170: Planning and Establishment of State-Level Exchanges;
Request for Comments Regarding Exchange-Related Provisions in Title I of the Patient Protection
and Affordable Care Act**

These comments are filed on behalf of the National Indian Health Board (NIHB) in response to the Request for Comments from the Department of Health and Human Services (HHS) regarding Exchange-related provisions in Title I of the Patient Protection and Affordable Care Act (ACA) published in the Federal Register on August 3, 2010.

Established nearly 40 years ago, the NIHB is an inter-tribal organization, which advocates on behalf of Tribal governments, American Indians and Alaska Natives (AI/ANs) for the provision of quality health care to all AI/ANs. The NIHB is governed by a Board of Directors consisting of 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 the NIHB. Whether Tribes operate their own health care programs through contracts or compacts, or receive health care directly from the IHS, NIHB is their advocate. NIHB serves as a conduit for advancement of Indian health care through partnerships with other national and international organizations, foundations, corporations and others in its quest to advance the health care status of AI/ANs.

The purpose of these comments is to make HHS aware of issues, concerns and opportunities in Indian communities relative to implementing Exchange-related provisions of the ACA.

BACKGROUND

The system of Indian health programs is complex and governed by unique laws, regulations and policies. These programs serve some of the poorest and most isolated populations in the country. Severe underfunding of Indian Health Service (IHS), an agency of HHS, has exacerbated the shameful health status among AI/ANs.

Before commenting specifically on the Exchange related provisions, we want to make three essential points:

- Tribes know the way their communities work and how to access potentially eligible members
- Tribal consultation must be proactive and ongoing, not after the fact
- Resources are required, at the Tribal level, to conduct education, outreach, enrollment and systems modifications.

Furthermore, the complexity of implementing Exchange policies that actually improve access for AI/ANs goes beyond Tribes as health care providers and purchasers. Tribes are governments, small and large employers as well as beneficiary advocates. In all of these roles, Tribes want to be sure that Exchange policies acknowledge the essential role they play in effective ACA implementation.

INDIAN OUTCOME MEASURES OF ACA

At the request of the Centers for Medicare and Medicaid Services (CMS) officials, the Tribal Technical Advisory Group (TTAG), the panel of tribal leaders that advises CMS on Indian health policy matters, identified Indian health outcome measures for ACA implementation. These goals include—

- Significantly increase the rate of health coverage for American Indians and Alaska Natives, both on and off reservations.
- Financially strengthen Indian health providers so programs can expand service capacity and access to health care.
- Significantly reduce the glaring health disparities that oppress American Indians and Alaska Natives.

To achieve the TTAG's desired outcomes, the Secretary's obligation to carry out the Federal government's trust responsibility for Indian health was emphasized, and Indian-specific language was identified as being needed in regulations to achieve these goals.

The TTAG's outcome measures document, together with policy papers on several ACA provisions affecting Indian health, was provided to Director Jay Angoff of the Office of Consumer Information and Insurance Oversight (OCIIO) in a letter dated August 17, 2010. We hope that the TTAG's comments will be considered by OCIIO in this proceeding.

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COMMENTS ON EXCHANGE-RELATED PROVISIONS IN TITLE I OF ACA

A. State Exchange Planning and Establishment Grants

Question: What is the most effective way to engage Indian Tribes regarding the planning and implementation of the ACA, including the Exchange related provisions?

Importance of Tribal Consultation

We commend the OCIIO and the IHS for planning a meeting with Tribal leaders to discuss State Exchanges this November. We urge that the official announcement of this meeting will be set and widely announced as soon as possible so that Tribal leaders will have the opportunity to plan to attend. This meeting is a good beginning, but the need for *ongoing* and meaningful consultation with Tribes is critical in the development of the Exchanges and other provisions under OCIIO's authority.

Every action taken by the Federal Government must take into consideration the federal government's duty to Indian Tribes, the government-to-government relationship and the current state of Indian health. This relationship between the U.S. and federally-recognized Indian Tribes is rooted in the U.S. Constitution and has been reaffirmed by judicial decisions, executive orders and congressional law. As Tribes ceded millions of acres of land to the U.S. government, the United States agreed to provide a variety of services, including health care, to Indian people. The IHS was created to honor this responsibility and today, the current Indian health system consists of services provided by the IHS, programs operated by Indian Tribes and Tribal organizations (through self-determination and self-governance agreements with the IHS pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA))¹, and urban organizations that receive funding from IHS under Title V of the Indian Health Care Improvement Act (IHCIA)².

The Indian health system, as a community-based delivery system, supplies culturally-appropriate health care services essential to promoting a healthy lifestyle. Existing health disparities, high rates of poverty, and the remote, rural nature of Indian communities demand the support for the Indian health care delivery system. Furthermore, across the United States, Indian cultures, resources and health system structures differ greatly. Implementation of the ACA provisions will be a challenge to ensure that they work in all of these situations, but these challenges can be readily addressed through direct consultation with the Tribes.

The unique government-to-government relationship requires the Tribes to deal directly with the Federal government, that is, the Tribes can deal with Federal agencies directly. A commitment to honoring this relationship was reiterated through the Presidential Memorandum issued on November 5, 2009. In addition, HHS has implemented a department-wide Tribal consultation and coordination policy for over ten years. Many HHS agencies, such as IHS and Centers for Disease Control and Prevention (CDC), have developed their own consultation policy. The strength of this relationship affects what and how federal policies are implemented. CMS has a very effective Tribal Technical Advisory Group that works with CMS to make sure that policies and new program implementation overcome the many barriers to AI/AN enrollment in Medicare, Medicaid and CHIP.

¹ Pub. L. 93-638, as amended, codified at 25 U.S.C. § 450 et seq.

² Pub. L. 94-437, as amended most recently pursuant to Sec. 10221 of the ACA, which incorporated by reference S. 1790 as reported by the Committee on Indian Affairs of the Senate, and codified at 25 U.S.C. § 1601 et seq.

During the health care reform debate, Tribes and Tribal leaders recommended that the opportunity for Tribes to be engaged in policy decisions through consultation must be maintained. In the end, the ACA contained many provisions that explicitly require Tribal consultation.

- Sec. 4001: National Prevention, Health Promotion and Public Health Council
- Sec. 5101: National Health Care Workforce Commission

Yet, there are many provisions, such as the establishment of Exchanges, that will have a greater impact on Tribes, but these provisions do not explicitly call for Tribal consultation. The OCIIO will be overseeing the operation of Exchanges for all Americans, including AI/ANs, but there are many provisions specifically aimed at improving access to health care for AI/ANs that OCIIO is also responsible to implement.

- Sec. 1311(c)(6)(D) – Affordable Choices of Health Benefit Plans: Enrollment periods – special enrollment periods for Indians
- Sec. 1402(d)(1) – Enrolling in Qualified Health Plans: Reduced cost-sharing for individual Indians enrolled in Qualified Health Plans in the individual market with income less than 300% federal poverty line
- Sec. 1402(d)(2) – Enrolling in Qualified Health Plans: Items or services furnished through Indian Health providers
- Sec. 1411(b)(5)(A) – Procedures for Determining Eligibility for Exchange, Participation, Premium Tax Credits and Reduced Cost Sharing, and Individual Responsibility Exemptions: Exemption from individual responsibility requirements
- Sec. 1501(b) – Requirement to Maintain Minimum Essential Coverage: Exemption from penalty

A strong direct relationship between OCIIO and Tribes is critical to achieving positive health outcomes across Indian Country. Only by directly consulting with Tribes can OCIIO develop policies and regulations that achieve the promise of improving the Indian health system and the health status of AI/ANs. We would look forward to working with OCIIO and other Federal agencies on the range of ACA implementation issues that are before us.

State Consultation with Implementation of the State Exchanges

Although the initial design of the Exchanges begins with the Federal government, the implementation and administration of the Exchanges largely will fall to the States. Due to the central role of the States, we recommend that for States who choose to run the State Exchanges OCIIO requires State- Tribal consultations. Currently, Sec. 1311(d)(6) requires consultation with stakeholders regarding the design and implementation of the state Exchanges. Although not specifically listed as stakeholders under this provision, Indian Tribes play multiple roles in the health care system, including governmental entities, direct care providers, employers, payers of care purchased from public and private sources, and beneficiary advocates. In addition, as indicated above, Tribes have a strong interest in the successful implementation of the Exchanges.

Such a requirement for Tribal consultation for states is not new. Section 5006(e) of the American Recovery and Reinvestment Act of 2009 (Recovery Act), Public law 111-5, requires each State to utilize a process to seek advice on a regular, ongoing basis from designees of the Indian health programs and urban Indian organizations concerning Medicaid and CHIP matters that have a direct effect on Indians,

Indian health programs, or urban Indian organizations. The Exchanges will also have a significant and direct impact on AI/AN individuals. Moreover, State implementation of Exchanges may blur the changes to and expansion of Medicaid given the requirement for Medicaid enrollment simplification and coordination with State health insurance Exchanges required under Sec. 2201 of the ACA. There will be no meaningful way, nor would it serve any public policy purpose, to separate the consultation required regarding the Medicaid program from that needed for successful implementation of the Exchange plan related Indian-specific benefits and protections.

A State consultation requirement is in our view prudent policymaking as the public is well served by evaluating all impacts of a proposal, including Indian health impacts. Those States that consult with Tribes provide benefit to all concerned – Tribes, the State, and Federal agencies such as OCIIO and CMS. However, since some States are resistant to consult with Tribes, it is incumbent on the OCIIO to either require them to do so or to establish another mechanism for full tribal review on state level activities under ACA. See recommendation below regarding “Consultation by Exchanges.”

Summary of Recommendations: State Exchange Planning and Establishment Grants

- Include among the criteria for the certification of an Exchange under Section 1311(c) that the Exchange engage in consultation with the Tribal governments.

B. Implementation Timeframes and Considerations

Question: How should States engage Tribal governments to satisfy the requirements for consultation with “stakeholders” under Section 1311(d)(6)?

Consultation by Exchanges

Section 1311(d)(6) states that “an Exchange shall consult with stakeholders relevant to carrying out the activities” of an Exchange. The discussion above, and other analysis found in these comments regarding Indian benefits and protections provided for under the ACA, plainly demonstrate that Tribal governments, in States where they exist, are stakeholders for purposes of implementing Exchanges. We urge that the Department include among the criteria for the certification of an Exchange under Section 1311(c) that the Exchange engage in consultation with the Tribal governments within the geographic boundaries of the Exchange through a clearly articulated (and written) process that satisfies at a minimum the requirements for consultation found in Sec. 5006 of the Recovery Act. The range of issues identified in these comments, and the need to provide opportunities for those implementing Exchanges within and across State boundaries to coordinate with Tribal governments and to hear their concerns highlights the need and value of establishing a clear consultation process between States and Tribal governments.

C. State Exchange Operations

Question: What are some of the major considerations for States in planning for and establishing Exchanges?

Current AI/AN-Specific Medicaid Protections to Remain in Place

As States move forward and innovations proliferate, we ask that OCIIO and HHS require States to remain explicit about the special Indian protections under Medicaid. There is an intention, and now some real examples, that Exchanges will be able to make coverage options look seamless to consumers. While this is a laudable goal, we believe that it is essential for States to continue to respect these important provisions, which have been enacted in order to promote access to Medicaid coverage for AI/ANs and provide adequate reimbursement to Indian health programs. Examples of these Medicaid protections include exemption from cost-sharing, exemption from mandatory Managed Care enrollment, payments to Indian health programs, and income and estate recovery protections.

In addition, applicant should always be able to discern easily and without any confusion whether they will be obtaining Medicaid coverage or coverage under an Exchange plan. The pros and cons of each should be easily recognizable by making side-by-side comparisons of costs and benefits apparent so AI/ANs who may consider one or the other can readily assess what best meets their needs. We also reiterate our recommendation that tribal consultation on exchange plans occur and be integrated with consultation about any changes to Medicaid that might be occurring. See recommendations under section *Importance of Tribal Consultation*.

Medicaid Expansion and Exchanges

Under the ACA, Medicaid coverage will be expanded to include additional children and adults with incomes up to 133% of the Federal Poverty Level (FPL). States (or the HHS Secretary) will also be required to have in place insurance exchanges by January 1, 2014. Insurance exchanges will create a single marketplace through which individuals and businesses can purchase health insurance from competing health plans, as well as to secure Medicaid coverage. State discussions have centered on coordinating screening for eligibility for Medicaid, CHIP, and assistance to purchase health coverage through insurance exchanges.

It is estimated that that over 277,800 non-elderly AI/AN will be newly eligible for Medicaid.³ Today, AI/ANs are under-enrolled in the Medicaid program despite significantly higher rates of poverty and suffer some of the highest rates of health disparities. To address this, Congress passed special provisions and protections dealing with Indian people in the Medicaid program.⁴ There are also Tribal

³ "Issue Brief, Health Reform: Help for American Indians and Alaska Natives", Families USA, May 30, 2010.

⁴ Section 5006(a) of the Recovery Act amends sections 1916 and 1916A of the Social Security Act, to preclude States from imposing Medicaid premiums or any other Medicaid cost sharing on Indian applicants and participants served by Indian health providers and to assure that Indian health providers, and providers of contract health services (CHS) under a referral from an Indian health provider, will receive full payment.

consultation requirements for states to seek advice on Medicaid and CHIP matters having a direct effect on IHS programs on a regular and on-going basis.⁵

Key issues related to setting up Exchanges include how to establish a system that will allow individuals and families to apply for whichever forms of assistance they are eligible: premium tax credits (for coverage through state exchanges), Medicaid, or CHIP. How will applicants be screened for eligibility for all three programs and referred to the appropriate program for enrollment. Key issues for IHS and Tribal health programs include: how can IHS and Tribal governments integrate and interface with Exchange systems to ensure that AI/AN beneficiaries are enrolled in the appropriate programs; how will IT funding and/or technical assistance be made available to assist Medicaid/CHIP agencies; and how to align the special rules and cost-sharing and income exemptions so that AI/AN get enrolled into programs without any adverse effects.

States will continue to have significant leeway in how they operate their Medicaid and CHIP programs. Overall, implementation of the ACA will create a large number of new Medicaid eligibles and will make enrollment and renewal much easier. It will be critical that there be additional funding for the outreach, education and enrollment activities that need to take place. Furthermore, Indian health programs in each State will have to work closely with their Medicaid programs, and vice versa, to make sure the range of policy changes and implementation activities actually improve access, as all of these issues will have a direct effect on IHS and Tribal health programs.

In light of these issues, we ask that OCIIO and HHS require States to be explicit about the special Indian protections that remain under Medicaid.

Question: How will OCIIO facilitate the ability of Tribes to pay premiums on behalf of Exchange eligible individuals?

Tribes Paying Premiums on Behalf of Members

Special Exchange rules for AI/ANs will make participation in health insurance coverage much more accessible. The exemption from cost sharing and special monthly enrollment periods will help AI/AN both on and off-reservations achieve portability of coverage. However, the most significant obstacle to accessing this benefit is the premium. While all AI/ANs are exempt from penalties for failing to acquire health coverage,⁶ and many AI/ANs whose household income is below 300 percent of poverty will be entitled to premium free coverage under a health exchange plan,⁷ others above 300 percent of poverty may still benefit from the coverage opportunities available through the Exchanges.

Many benefits accrue to Tribes and Indian health programs when tribal members are covered by some form of third-party coverage. These benefits are significant enough in some cases to cause Tribes and Indian health programs to consider paying premiums on behalf of beneficiaries either with Tribal funds

⁵ Section 5006(e) of the Recovery Act codifies in statute, at section 1902(a)(73) and section 2107(e)(1)(C) of the Social Security Act, the requirement for the Secretary of Health and Human Services (HHS) to maintain a Tribal Technical Advisory Group (TTAG) within CMS and the requirement that States seek advice on a regular and ongoing basis where one or more Indian Health Program or urban Indian health organization furnishes health care services.

⁶ ACA Sec. 1501(b) and 111(b)(5)(A). See, discussion under section "Importance of Tribal Consultation".

⁷ ACA Sec. 1402(d)(1)(A). See, discussion under section "Waiver of Cost-Sharing for AI/AN".

or under the authority of Sec. 402 of the IHCA, as amended.⁸ These benefits include increased Tribal health program revenues from third party payers, decreased Contract Health Service expenditures as Tribal members have alternative resources, reduced reliance on the contract health emergency fund, to reimburse for extraordinary costs, and the opportunity to provide to their members more access to health care than the funds appropriated to IHS can support (especially given the facility limitations in many Service units. Unfortunately, there is no clear mechanism specified under the ACA that will enable a Tribe to directly pay a high risk pool or Exchange plan premium on behalf of an eligible member or to supplement premium tax credits to which the individual AI/AN may be eligible. We strongly recommend that specific mechanisms be established.

Some Tribes already pay health insurance premiums on behalf of members. These premium payment programs include Medicare Part B and Part D as well as State based program like Basic Health in Washington State and commercial individual plans. Typically, such premium support either requires retroactively reimbursing the member for the premiums or arranging to send and account for numerous small checks. Neither is a satisfactory method and both create additional, unnecessary costs that are better invested in health care. Explicitly permitting Tribes to “group pay” Exchange plans on behalf of eligible members is an essential policy to improve AI/ANs enrollment in health insurance.

We would like to work with you to provide examples of implementation approaches that do and do not work in these situations.

If OCIO can include in the Exchange regulations permissive options for direct payment of premiums by Tribes and Indian health programs, AI/AN have the potential of achieving significantly higher health insurance coverage rates.

Because premium payment is such a significant barrier to Indian enrollment in Exchange plans or high risk pools, the regulations should establish an administratively simple mechanism which allows Tribes and Indian health programs to group-pay premiums on behalf of individual beneficiaries. Such group payment mechanisms are now used for enrolling individual beneficiaries in Medicare Part D plans. Since Exchanges will likely be operated by the States, the HHS regulations must expressly require the availability of such group pay options in order to assure the state systems will include them.

Question: How to maximize the resource of Navigators for Tribes and individual American Indians and Alaskan Natives?

Tribal Governments Have Interest in Operating Navigators

The concept of Navigators is promising; however, we are concerned about how Tribes, Tribal enterprises, Indian health programs and individual AI/ANs will have access to the programs and information they need. The size and sophistication of Indian health programs is diverse. While large Tribes may have the volume to provide all of the duties of a Navigator, others do not. Often even applying for grants or contracts creates situations where these important resources are available in only a limited number of Tribal communities. We ask that OCIO work with Tribes to better understand how

⁸ See, Sec. 152 of S. 1790. We should note that we are not ignoring the possibility that some AI/ANs will opt to pay premiums personally if there is no other source of funding. However, many, if not most, AI/ANs believe, correctly, in fact, that the United States has a duty to provide health care to them at no cost. As Senator Inouye commented in 1999, American Indians and Alaska Natives have the first pre-paid health plan in this country – paid for with the cession of millions of acres of land and abundant resources.

guidance to States about Navigators can ensure that these important functions are available to all Indian communities. We have found that the best way to guarantee this access is to be sure Tribes themselves are able to directly provide the services they have the capacity to deliver. See recommendations under “AI/AN Outreach and Navigator Resources”.

Question: To what extent are Tribes interested in participating and administering Exchanges?

Potential Tribal Interest in Operating Interstate, Regional or Subsidiary Exchanges

Tribal governments are evaluating the most appropriate role for Tribal governments in the implementation of the ACA. Section 1311(f) of the ACA provides “flexibility” in the establishment of Exchanges. “Regional or other interstate Exchanges” as well as “subsidiary Exchanges” may be established under the law. Prior to the establishment of a regional, interstate or subsidiary Exchange, agreement must be reached between the Secretary of HHS and the State or States involved.

We would like to communicate to HHS the potential interest of one or more Tribal governments, or groups of Tribal governments, to operate interstate, regional or subsidiary Exchanges. It is understood that such an Exchange might be required to be geographically distinct from other Exchanges, in which case it would be required to serve all persons in the geographic region. The interest on the part of Tribal governments is generated by the need to ensure full enforcement of the requirements and consumer protections provided for in the ACA for AI/AN persons, in particular, but for all individuals who reside in areas with significant numbers of AI/AN residents. Also, in several locations across the country, Tribal boundaries stretch across State boundaries into two or more states. A regional or interstate Exchange might very well serve the border residents of these multi-state communities.

Another option that may be pursued by one or more Tribal governments is found in the authority established under Section 1311(f)(3), “Authority to Contract.” Under this section, a State may elect to authorize an Exchange that is established by the State to enter into an agreement with an entity to carry out one or more responsibilities of an Exchange. This option may permit Tribal governments to conduct some or most of the functions of an Exchange while building on the broader infrastructure of an Exchange that may be established separately.

Summary of Recommendations: State Exchange Operations

- OCIO and CMS communicate the requirement to States to retain Indian-specific Medicaid protections that existed prior to ACA and that are to continue.
- Establish a clear mechanism by which Tribal governments may make premium contributions to an Exchange on behalf of Tribal members.
- Outreach by OCIO to Tribal governments, particularly smaller Tribes, is necessary to ensure that Navigator services are accessible to all AI/ANs.
- Consider operation of interstate, regional or subsidiary Exchanges by Tribal governments and/or contract with Tribal governments to carry out select functions of an Exchange pursuant to Section 1311(f)(3).

D. Qualified Health Plans

Question: What issues need to be considered in establishing appropriate standards for ensuring a sufficient choice of providers and providing information on the availability of providers?

The following recommendations address the need to assure that the providers in the Federally-created Indian health system have full and effective rights of participation as providers in the networks of qualified health plans who offer products through the Exchanges.

AI/AN Access to Providers

AI/ANs must be able to fully utilize the insurance coverage they may acquire through qualified health plans (QHPs) whose products are marketed through Exchanges. In order to do so, they must be able to obtain care from the health system established by the Federal government to serve the AI/AN population – health programs operated by the IHS, Indian Tribes and Tribal organizations, and urban Indian organizations (collectively called "I/T/U") – the three components of the Indian health system. The IHS and Tribally-operated programs supply essential personal health services to 1.9 million AI/ANs⁹ on/near reservations in 35 states, and an additional 46,000 AI/ANs who do not have access to reservation-based programs receive medical and public health services from 34 urban Indian organizations supported by Federal funds.¹⁰

Culturally Appropriate Care

The Secretary's regulations must require that I/T/U programs must be allowed to participate in provider networks of qualified health plans. This is necessary to ensure that AI/AN enrolled in a QHP have a sufficient choice of providers – especially providers with whom they are familiar and who can provide care in a culturally appropriate manner.

Essential Community Provider Designation

The Secretary's regulations should expressly designate I/T/U programs as "essential community providers" (pursuant to ACA Sec. 1311(c)(1)(C)) which must be admitted to QHP provider networks. I/T/Us serve predominately low-income, medically under-served individuals and their circumstances put them squarely within the law's objective for designating essential community providers. I/T/Us are often the only source of health care in remote, sparsely populated communities, and due to the high rates of poverty in Indian communities, their service population includes a significant percentage of low-income individuals. The well-documented, shocking health disparities suffered by Native Americans makes this population "medically under-served" by any definition.

FQHCs and providers eligible to obtain discounted drugs under the 340B program are among the examples of entities which the law suggests be designated as essential community providers that must be included in plan networks. Tribally-operated outpatient clinics and urban Indian organization clinics are eligible for FQHC status¹¹, and many have acquired that designation. IHS and tribally-operated

⁹ Indian Health Service, *Fiscal Year 2011 Budget Justifications*, at CJ-57.

¹⁰ *Id.*, at CJ-123.

¹¹ Secs. 1861(aa)(4) and 1905(I)(2)(B) of the Social Security Act [42 USC §§1395x(aa)(4) and 1396d(I)(2)(B)].

programs are expressly eligible to collect payments from both Medicare and Medicaid.¹² I/T/U providers are also eligible to obtain pharmaceutical products from Federal discount drug programs: Some Indian health providers acquire prescription medications under the 340B program, and many others access discount drugs through the Federal Supply Schedule prime vendor program administered by the Department of Veterans Affairs.

Avoid Windfalls to Qualified Health Plans

Unless the requirement for I/T/U programs to be reimbursed by health plans is effectively enforced, health plans may realize a windfall by collecting premiums for Indian enrollees – many paid with Federal subsidies – but without making payment for the health services their Indian enrollees receive from these I/T/U providers.

Congress recently recognized the imperative for leveling the playing field for I/T/U providers when it required States to include in their Medicaid managed care contracts a requirement to admit I/T/Us to provider networks. This Medicaid amendment was needed to overcome barriers faced by I/T/U programs in gaining access to managed care organization provider networks. Indians enrolled in Medicaid would continue to seek care from I/T/U providers, but denial of access to MCO networks meant they would not be paid for the services provided. While the change in law discussed next helps to address the latter concern, it does not address the importance of allowing I/T/Us to be part of the network so that care coordination is improved. Accordingly, we reiterate our recommendation that this be a criterion for approval of a qualified health plan. Under the Medicaid managed care amendments enacted in the Recovery Act, Medicaid managed care entities must agree to pay an I/T/U provider – regardless of whether it is in a provider network – at the same rate the entity would pay a network provider that is not an I/T/U.¹³ In addition, as we discuss below, other changes of law found in the IHCIA amendments improved the right of recovery by I/T/Us, whether they are enrolled or not. Requiring health plans to proactively enlist I/T/U providers remains an important criterion that should be required.

Proactive Enforcement of Section 206 of the IHCIA Will Avoid Unnecessary Litigation Costs

We urge action on the recommendations made above because being part of a network can facilitate better integration of care when an AI/AN requires care covered by the qualified health plan in which he or she is enrolled that is outside the scope of what the Indian health program they routinely use is able to provide. However, the recent amendments to the IHCIA establishes as federal policy that being part of a part of plan's network is not a necessary condition for payment. Sec. 206(a) of the IHCIA, as amended,¹⁴ provides I/T/Us:

the right to recover from an insurance company, health maintenance organization, employee benefit plan, third-party tortfeasor, or any other responsible or liable third party (including a political subdivision or local governmental entity of a State) the reasonable charges billed by the

¹² Secs. 1880 (Medicare) and 1911 (Medicaid) of the Social Security Act [42 USC §§1395qq and 1396j].

¹³ Sec. 1932(h) of the Social Security Act [42 USC §1396u-2(h)], enacted by Sec. 5006(d) of the American Recovery and Reinvestment Act.

¹⁴ See, Sec. 125 of S. 1790.

Secretary, an Indian Tribe, or Tribal organization in providing health services through the Service, an Indian Tribe, or Tribal organization, or, if higher, the highest amount the third party would pay for care and services furnished by providers other than governmental entities, to any individual to the same extent that such individual, or any nongovernmental provider of such services, would be eligible to receive damages, reimbursement or indemnification for such charges or expenses if –

- (1) such services had been provided by a non-governmental provider; and
- (2) such individual had been required to pay such charges or expenses and did pay such charges or expenses.

Subsection (c) goes further:

(c) Non-applicability of Other Laws.—No law of any State, or of any political subdivision of a State and no provision of any contract, insurance or health maintenance policy, employee benefit plan, self-insurance plan, managed care plan, or other health care plan or program entered into or renewed after the date of enactment of the Indian Health Care Amendments of 1988, shall prevent or hinder the right of recovery of the United States, an Indian Tribe, or Tribal organization under subsection (a).¹⁵

Since the Secretary is responsible for enforcing IHCA Sec. 206, she should assure that qualified health plans that market their products through Exchanges are directed to comply with it. It would be inefficient and ineffective to put the IHS, Tribal programs and urban Indian organizations in the position of having to undertake litigation or pursue other enforcement actions against qualified health plans in order to obtain the compensation due them under Sec. 206.

This IHCA Sec. 206 payment obligation is similar to the ACA requirement for payments to FQHCs. Under ACA, any item or service covered by a qualified health plan provided by an FQHC requires the plan to pay the FQHC at an amount that is not less than the FQHC Medicaid rate.¹⁶ It is clear that Congress intended that FQHCs and I/T/Us – both of which serve low-income, medically under-served populations – receive appropriate payment for services provided to qualified health plan enrollees.

Special Indian Health Requirements for QHP Provider Agreements

The unique status of I/T/U programs and the Federal laws and regulations to which they are subject make it necessary for the Secretary's regulations to impose modifications to standard network provider agreements with I/T/Us. In fact, the Secretary, in carrying out the United States' trust responsibility for

¹⁵ Subsection (i) of Sec. 206 makes the provisions of Sec. 206 applicable also to urban Indian organizations in the same manner they apply to Indian tribes and tribal orgs.

¹⁶ ACA Sec. 10104(b)(2), amending Act Sec. 1302.

Indian health,¹⁷ has an *affirmative obligation* to take action to facilitate full participation by the Indian health system in all federally-supported health programs.¹⁸ At a minimum, the regulations must require special provision on the following topics:

- Recognize that an I/T/U may limit who is eligible for services at I/T/Us (without imposing limits on those I/T/Us that may serve individuals who are not eligible for IHS services);
- Recognition of specific federal laws and regulations applicable to I/T/Us;
- Recognition of the non-taxable status of I/T/Us;
- Recognition of the applicability of the Federal Tort Claims Act to IHS and Tribal programs, and to those urban Indian organizations who have achieved FTCA coverage through PHSA Sec. 224(g)-(n), to eliminate any QHP requirement to carry professional liability insurance or to otherwise indemnify a QHP;
- Recognition that employees of the IHS and Tribal programs are not required to hold a license issued by the State in which the program operates as long as they are licensed in any State.¹⁹
- Recognition that I/T/U health programs are not required to obtain a license from the State as a condition of reimbursement by any Federal health care program so long as the I/T/U meets “generally applicable State or other requirements for participation as a provider of health care services under the program.”²⁰ “A Federal health care program” means “any plan or that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly in whole or in part, by the United States Government,” including health insurance programs under chapter 89 of title 5; and any State health care program, which includes Medicaid, and CHP, as well as any program receiving funds under certain other provisions of federal law. Thus, a QHP cannot require licensing in the State as a condition for network provider status nor as a condition for payment for services.
- Special disputes resolution process and recognition of governing law
- Any medical quality assurance requirements must be subject to new IHCA Sec. 805
- Compliance with IHCA Sec. 206 regarding payment obligations and amounts
- Compliance with ACA Sec. 1402(d)(2) prohibiting assessment of cost-sharing on any AI/AN enrolled in a QHP
- I/T/Us must be permitted to establish their own days/hours of operation so that any different QHP requirements do not impose barriers to participation

¹⁷ See Secs. 2 and 3 of the Indian Health Care Improvement Act [25 USC §§1601 and 1602], including revisions to these provisions may by S. 1790 enacted into law by Sec. 10221 of the ACA.

¹⁸ New IHCA Sec. 408 provides that an I/T/U program must be accepted as a provider eligible to receive payment under any federal health care program on the same basis as any other qualified provider if it meets generally applicable state or other requirements for participation, but the I/T/U provider is not required to obtain a license or other documentation under state or local law.

¹⁹ IHCA Sec. 221, enacted into law by Sec. 10221 of the ACA.

²⁰ IHCA Sec. 408(b)(3), as amended, defines “a Federal health care program” by reference to 42 U.S.C. § 1320a-7b(f), which includes “any plan or that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly in whole or in part, by the United States Government.” Sec. 408(b)(3) does not exclude health insurance programs under chapter 89 of title 5. It also includes any State health care program (as defined at 7 U.S.C. § 1320a-7(h), which includes Medicaid and CHP programs, as well as any program receiving funds under certain other provisions of federal law.

- Nothing in a QHP network provider agreement shall constitute a waiver of federal or tribal sovereign immunity.

This recommendation for Indian-specific network contract modifications is modeled on the policy that has worked so effectively in the Medicare Part D program. CMS regulations require Part D plans to offer network contracts to I/T/U pharmacies and to include in those contracts special CMS-approved provisions (such as those identified above) to facilitate participation by those pharmacies.²¹ Indian Tribal representatives look forward to assisting the Secretary in developing appropriate provisions for I/T/U agreements with QHPs.

Providing Information on the Availability of Indian Health Providers

The Secretary's regulations should require the Exchanges and QHPs offering products in each Exchange to make the following information available to prospective AI/AN enrollees:

- A statement that an enrollee has the right to utilize his/her insurance coverage at I/T/Us in the geographic areas in which a QHP operates
- A description of the geographic area in which each QHP offers coverage
- A list of the I/T/U providers in the geographic area served by the QHP that are in the QHP provider's network
- An assurance that I/T/U providers will receive payment as network providers for services provided to enrolled AI/ANs whether the I/T/U provider is enrolled in the network or not.

Question: What factors are needed to facilitate participation of a sufficient mix of QHPs in the Exchanges to meet the needs of consumers?

Offering of Indian-sponsored health plans through an Exchange

One aim of the ACA is to reduce the market concentration that exists in most health care markets across the country by increasing the number of qualified health plans offered in these local markets.²² Beginning in FY 2014, States will be required to have in place Insurance Exchanges where health insurance products will be made available to small businesses and eligible individuals. Increasing the availability of health insurance plans in local markets and on Indian reservations will provide the opportunity for high quality services that will improve access to health care services and promote quality of care. This will be the case for the American population at large and should also be the case for AI/ANs living within and outside of Indian reservations. This goal can be promoted if Indian-sponsored health plans are encouraged and if regulations are tailored to permit them to be offered in Insurance Exchanges.

One or more Tribal governments may seek to establish one or more qualified health plans for purposes of offering coverage in the individual and small group markets in an Exchange, and possibly in large group markets.

²¹ 42 CFR 423.120(a)(6).

²² American Medical Association, "Competition in Health Insurance: A Comprehensive Study of U.S. Markets: 2008 Update."

We believe that the inclusion of one or more AI/AN-sponsored plans holds great promise for several reasons. First, the plan could tailor benefits in a way that would have the greatest impact on the health disparities facing Indian communities. Second, an AI/AN plan could develop provider networks that are most culturally and linguistically responsive to a Tribal population. Finally, an Indian-sponsored plan could develop administrative structures that would streamline enrollment, provider payment, and implementation of Indian specific policies.

- As Governments, do Tribes face any barriers related to governance and ownership of an Exchange eligible plan?
- Can an Indian-sponsored plan limit enrollment to individuals who are eligible to receive services through IHS?
- What issues or barriers would there be to using a Tribal employer's self-insured plan as the basis for an Indian-sponsored Exchange plan?

To increase the health plan options available to AI/AN in certain markets and on Indian reservations across the country, one or more Tribal governments may seek to establish one or more qualified health plans for purposes of offering coverage in the individual and small group markets in an Exchange, and possibly in large group markets. We understand that the ACA requires plans to meet State licensure requirements in the States in which they operate (or, if provided under Section 1333, are regulated through interstate health care choice compacts), as well as any additional requirements established by an Exchange (if the plan is offered through an Exchange.) Most health insurance plans today do not have provider networks sufficient to meet the health care needs of AI/AN on Indian reservations. These health plans have not developed this capacity for a variety of reasons related to market forces, risk factors associated with health status of AI/AN, remoteness and isolation factors of Indian reservations, and other reasons too complex to explain here. Given the status of Tribal governments, the lack of provider networks on Indian reservations, and the unique circumstances associated with providing health care to AI/ANs, consideration must be given to allowing Tribal health plans and IHS or Tribal health coverage to exist in insurance exchanges. Otherwise, there may not be sufficient benefit to AI/ANs to cause them to enroll.

Issues that will need to be addressed with technical assistance provided to States and Tribes in order for Tribal health plans to exist in the Exchanges include:

- How can Tribal self-funded plans exist in exchanges? If they do, what are the consequences?
- Can IHS or tribal health programs meet qualified health plan requirements to be included in insurance exchanges?
- How can IHS and tribal health coverage meet the essential health benefit requirements?
- Can IHS be included even it must continue to restrict access to comply with its strict eligibility rules?

Question: Which regulatory language does OCIO need to include in order to permit Indian health plans to be offered on the Exchange?

Permissive Regulations May Be Necessary to Facilitate Tribal Operated Health Plans

We would like an opportunity to discuss the possibility of regulatory language that permits Indian-sponsored plans to be offered through the exchange. We are unaware of any health plans currently

offering coverage, although numerous Tribes self-insure employees and members. These plans may require specific regulations that address the unique status of Tribes as governments, distinctive benefit structures for AI/ANs and compatibility with Indian health care programs. It would be uncertain whether such a plan would be developed prior to 2014, however without permissive regulations, Indian plans could be squeezed out by State imposed commercial requirements.

Question: Are resources available to facilitate establishing addition health plans in order to foster competition in local markets?

Access to the Consumer Operated and Oriented Plan Program

Section 1322 of the ACA makes available assistance for the establishment of new, nonprofit health plans under the Consumer Operated and Oriented Plan program. The assistance under this program is designed to cover start-up costs as well as to meet solvency requirements. There is a prohibition under Section 1322(c)(2)(B) on participation in the program if an “organization is sponsored by a State or local government, any political subdivision thereof, or any instrumentality of such government of political subdivision.” No prohibition is indicated for Tribal governments or any instrumentality of such governments. For the purpose of expanding the choices of high quality health plans available to AI/AN, there is the possibility of interest on the part of one or more Tribal governments to apply for assistance through the Consumer Operated and Oriented Plan program.

Summary of Recommendations: Qualified Health Plans

- Communicate to Exchanges the requirement that I/T/U providers are to be allowed to participate in networks of qualified health plans.
- Secretary’s regulations should designate I/T/U providers as “essential community providers” pursuant to Section 1311(c)(1)(C).
- Require health plans offered through an Exchange to comply with Section 206 of the IHCA pertaining to payment for services to enrollees by I/T/U providers
- Require health plans offered through an Exchange to include I/T/U-specific provisions in provider agreements with I/T/Us.
- Require Exchanges and health plans offered in an Exchange to notify AI/AN of the option to continue to seek services from I/T/U providers and provide information on the I/T/U providers available in the plan’s service area.
- Assist Tribal governments in assessing whether and, if so, how best to offer Tribal-sponsored health plans in an Exchange, and provide permissive regulations that would allow such plans to be offered through an Exchange.
- Confirm that Tribal governments are not prohibited from applying to the Consumer Operated and Oriented Plan program.

E. Quality

Question: What factors are most important for consideration in establishing standards for a plan rating system?

Exchange Rating System for Health Plans

Under Section 1311(c)(3) of the ACA, a rating system is to be developed by the Secretary for the purpose of evaluating health plans based on relative quality and price. A key factor in determining the quality and overall value of a health plan is the ability to secure timely, high quality health care services. For AI/AN living in remote areas as well as AI/AN living in urban centers, access to I/T/U providers is a primary mechanism to access culturally appropriate, high quality health care services.

The ACA further expanded the opportunity to obtain additional resources necessary to improve or increase the availability of services provided by an I/T/U to AI/ANs. This was accomplished through the amendments to Sec. 206 of the IHCA, which was discussed earlier, and requires health plans to reimburse I/T/U providers for services provided to a health plan's enrollees. Enrolling in a qualified health plan through an Exchange does not affect eligibility of an AI/AN to use his or her Indian health program. Sec. 206 does assure that if the AI/AN does make that choice, the Indian health provider will be paid for the services by the health plan in which the AI/AN is enrolled.

In establishing a rating system, we recommend that the Secretary include a measure or measures that indicate whether (1) enrollees who are AI/AN have experienced unimpeded access to I/T/U providers and (2) I/T/U providers have received timely and full reimbursement for services provided to enrollees of the health plan.

Question: To what extent are health care services access across State lines?

Insurance Portability Across State Borders

AI/AN with household income up to 400% of the poverty level will have the benefit of receiving subsidies for the purchase of health insurance through State-wide or regional Exchange. The opportunity to purchase affordable health insurance coverage through an Exchange should provide an opportunity to expand utilization of private health insurance in the Indian health care system. AI/AN that may qualify for the subsidy as well as others will be interested in obtaining health insurance coverage through State-wide or regional Exchanges that is guaranteed to be portable across state lines and inclusive of IHS, Tribal and urban Indian providers in their respective networks.

Assuring health insurance portability across state borders is an important concern of the Tribal nations as in many cases in the Indian health care system, services are organized by Service Unit and IHS Regions that cross-state borders. For example, hospitals and health care centers in the Navajo Area serve eligible American Indians that reside in the states of Arizona, New Mexico, Utah and Colorado. The Phoenix Indian Medical Center also serves Tribal members in the Phoenix Area IHS that includes the states of Arizona, Nevada and Utah. Youth substance abuse treatment centers, located in each IHS Area, serve clients from their respective Areas, but may also serve others if an opening is available. A substantial number of AI/AN youth attend Bureau of Indian Affairs and tribally operated secondary boarding schools and Tribal colleges and universities across the United States. In order for American Indians to fully benefit from the health insurance coverage offered through an Exchange, health

insurance portability must encompass access to critical health care services that may be located in adjoining States.

Summary of Recommendations: Quality

- Include as a criteria for a plan's rating system whether AI/AN have ready access to I/T/U providers and whether I/T/U providers have received timely and full payment for services provided to plan enrollees.
- Ensure health plans offered through an Exchange have sufficient provider networks, including instances where provider networks need to extend across State boundaries.

F. An Exchange for Non-Electing States

No comments.

G. Enrollment and Eligibility

Question: What is the definition of "Indian" to be used in determining who meets certain eligibility requirements for Exchange participation?

In short, we recommend that the definition of "Indian" adopted by CMS (at 42 C.F.R. § 447.50 and effective on July 1, 2010) in its implementation of the cost-sharing protections made available under the Recovery Act should be adopted uniformly in implementation of the ACA for both Exchange plans and the Medicaid expansion as this definition is consistent with the substantially similar language used in the various definitions of Indian contained in the ACA.

The ACA contains numerous favorable procedural rules, cost-sharing protections, and mandatory enrollment exemptions that apply specifically to AI/ANs, referred to generally as "Indians" in the ACA. However, the ACA uses substantially similar but not exactly the same language to define "Indian" in every instance, and in many cases do not include any definition at all. This creates enormous potential for confusion and inefficiency in the implementation of the ACA and makes it likely that AI/ANs will not receive the benefits and special protections intended for them in the law.

Effective July 1, 2010, CMS adopted a definition of "Indian" in its implementation of the cost-sharing protections made available under the Sec. 5006 of the American Recovery and Reinvestment Act ("Recovery Act") (codified at 42 U.S.C. § 1396o(j)). This regulation, 42 C.F.R. § 447.50, which is applicable to Part 447, Subpart A, Payments; General Provisions, 42 C.F.R. § 447.1-447.520, broadly defines the term "Indian" consistent with the IHS's regulations on eligibility for IHS services. This definition should be adopted uniformly in implementing the ACA for both Exchange plans and the Medicaid expansion. Doing so will avoid bureaucratic confusion, fulfill the federal government's special trust responsibilities toward AI/ANs, promote the ACA's objectives of achieving nearly universal health coverage, and address the alarmingly inadequate access to health services by AI/ANs due to underfunding of the IHS.

Definition of Indian

Where the term “Indian” or “member of an Indian tribe” is defined in the ACA, one of three definitions is used:

1. Section 4(d) of the Indian Self-Determination and Education Assistance Act, as amended, (“ISDEAA”);
2. Section 45A(c)(6) of the Internal Revenue Code (IRC); and
3. IHCA Sec. 4, 4(c), or 4(d).²³

See Appendix A for a list of ACA sections citing to definitions. Although three different definitions are relied upon, their wording is substantially similar. IHCA Sec. 4(13) (formerly Sec. 4(c)) and ISDEAA Sec. 4(d) each define the term “Indian” as a “person who is a member of an Indian tribe.”²⁴ The definition of Indian tribe is almost identical among the three laws:

²³ Subsections (c) and (d) of the IHCA 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 Sec. 10221.

²⁴ The IHCA also defines two additional terms related to who is Indian. Section 4(3) defines California Indian to mean any Indian who is eligible for health services provided by the Service pursuant to section 809 who are:

- (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 Indian community in which such descendant lives.
- (3) Any Indian who holds trust interests in public domain, national forest, or 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.

Section 4(28) defines “urban Indian” to mean any individual who resides in an urban center (“any community which has a sufficient urban population with unmet health needs to warrant assistance under title V [of the IHCA], as determined by the Secretary”) and who meets one or more of the criteria in Sec 4(13)(1) through (4). These are: “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

IHCIA Sec. 4(14)	ISDEAA Sec. 4(d)	IRC Sec. 45A(c)(6)
		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 (85 Stat. 688), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.		

In the table above, the words and phrases shown in combined columns are included in the law referenced in those combined columns. For instance, the phrase "The term" is only contained in the IRC whereas "'Indian tribe' means any Indian Tribe, band, nation" appears in all three laws. The commonality among these definitions is critical for determining how they should be interpreted.

The definition of "Indian" throughout Titles XIX (Medicaid) and XXI (CHIP) of the Social Security Act has the meaning given to the term in Section 4 of the IHCIA.²⁵ In regulations, effective July 1, 2010, HHS and CMS interpreted Section 5006 of the Recovery Act, which amended Sec. 1916 of the SSA (codified at 42 U.S.C. § 1396o) and defined "Indian" to mean:

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:

- (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

²⁵ Sec. 1139(c) of the SSA (codified at 42 U.S.C. § 1320b-9(c)), as amended by ACA Sec. 2901(d).

(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.²⁶

HHS's construction of the term "Indian" is entitled to deference both as a matter of law and practicality and should be applied throughout the ACA. As a matter of law, the United States Supreme Court has "long recognized that considerable weight should be accorded to an executive department's construction of a statutory scheme it is entrusted to administer."²⁷ HHS is the umbrella agency 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 and CHIP as well as Exchange plans newly enacted under the ACA. Its interpretation of the term "Indian" is due deference and should be controlling.

As a matter of practicality, if different definitions are used to implement different provisions of the ACA, there is no conceivable way to effectively administer the various avenues for the extension of health coverage program is achieve the purposes of the ACA. This is clearest when one considered the requirement that applications for Exchange plans and for Medicaid must be integrated into a single online-accessible application by 2014.

Nor, can any narrower definition than that adopted by HHS to implement Medicaid cost-sharing be reasonably adopted to apply to protections for Indians under the Exchange plans or the Tax Code without creating chaos. For example, all "Indians" (as that term is defined under the IHCA Sec. 4 (i.e. the same definition underlying the ARRA Sec. 5006 regulation) are entitled to special monthly enrollment. Items and services provided to an "Indian" enrolled in a qualified health plan and furnished "directly by the [IHS], an Indian Tribe, Tribal Organization, or urban Indian organization" are not subject to any cost-sharing. ACA Sec. 1402(d)(2). The definition of "Indian" in (d)(2), refers to the definition in the ISDEAA. However, urban Indians must be intended to benefit because of the reference to services provided by urban Indian organizations. And, since (d)(1) and (d)(2) rely on the same definition of "Indian," the protection under (d)(1) for Indians under 300 percent of poverty must be intended to apply to all of the Indians entitled to protection under (d)(2), which corresponds to the definition adopted by HHS pursuant to the definition in the IHCA.

Similarly, according to Sec. 1411(b)(5)(A), individuals entitled to an exemption certificate under Sec. 1311(d)(4)(H) include Indians. The definition in Sec. 1311(c)(6)(D) of the term "Indian" is the one that applies to special enrollment periods, which is the definition in the IHCA; however, the definition that is referred to in the provision regarding exemption from tax penalties under Sec. 1501(e)(3) is for those individuals who are members of tribes as defined in the IRC.

Just as fundamentally, ACA Sec. 1413(a) requires States to integrate the application for Medicaid and the Exchange Plans into a single form. If an individual is to be able to apply to both programs at the same time, and since both Medicaid and the Exchange Plans have special rules for Indians, then the implementation of the term "Indian" must be the same for both programs. As noted, for purposes of

²⁶ 42 CFR 447.50(b)(1)

²⁷ *Chevron U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 844 (1984).

Titles XIX (Medicaid) and XIX (CHIP), purposes, the definition of Indian is that found in the IHCA (now construed by HHS at 42 C.F.R. § 447.50). Thus, in order for Indians to make use of the single application, the definition of the term "Indian" for both Medicaid expansion and the Exchange Plans must be identical: that found in the IHCA.

The various references to the meaning of "Indian", which are functionally identical, can be reconciled by using a single implementation definition. The correct one, given the intent of the ACA and of individual provisions within it, the objectives to be achieved, and the deference due to HHS under longstanding legal principles, is that adopted by HHS at 42 C.F.R. § 447.50 in which it has already construed the meaning of "Indian" under Section 4 of the IHCA.

- "Indian" must be defined consistently for all provisions of the ACA, including those related to enrollment in exchange plans, exemption from tax penalties, and Medicaid expansion and the consistent definition that must be used is that already adopted by HHS at 42 C.F.R. § 447.50, which construes the meaning of the term "Indian" under the IHCA.

Question: What are the verification and data sharing functions that States are capable of performing to facilitate the determination of Exchange eligibility and enrollment for individual Indians?

The initial task of identifying who qualifies for the various Indian provisions will be difficult because no centralized database exists. Furthermore, there is great sensitivity within Indian communities about providing the names of Indian people to outside entities. This stems from past federal policies where children who were identified as Indian were taken from their parents and communities and placed in Indian boarding schools. We strongly recommend that tribal leaders be consulted on this issue.

Self-Certification

Imposing documentation requirements as a condition of enrollment in an Exchange plan or prior to being able to enjoy the protections afforded AI/ANs under the ACA will almost certainly limit access to these important benefits and protections. Over time, the Exchange eligibility system is bound to become more complex as various situations become apparent. It is likely that determining Indian status, like citizenship documentation is a one-time task. But, determining Indian status, like providing citizenship documentation, should be a one-time task. Just as with any other information required for an application, we assume that if an applicant misstates information, there will be separate enforcement actions and penalties that can be relied upon. We ask that OCIIO and HHS work closely with Tribal leaders on this important issue.

Data Matching

We understand that data matches to identify AI/AN eligible for ACA provisions would provide a fast and efficient way to assist Indian people access programs through the Exchanges. There is no central database that could be used, but there are several that could be considered and combined to identify many eligible AI/ANs. There are many data sources include the HHS, IHS, CMS, IRS and Department of the Interior. However, reports provided under such matches should provide only the information

essential to establish that the individual is an Indian in order to protect the privacy of the individual from unwarranted intrusions. Again, this is an area for significant consultation with tribal leaders.

Other Evidence

We appreciate that either in cases where there is a need to verify a self-certification or there is a gap in the information available through data matching, there must be other vehicles by which an individual AI/AN can establish qualification for benefits and protections under the ACA. We believe that any agency or entity that has the responsibility of determining eligibility “as an Indian” for any benefit or protection under the ACA, including the special monthly enrollment option under Sec. 1311(c)(6)(D), cost-sharing protections under Sec. 1402(d), exemption from penalties under Sec. 1311(d)(4)(H), Sec. 1411(b)(5)(A), Sec. 1501(b), and exemption from gross income of qualified health care benefits provided by a Tribe under Sec. 9021, and any others, should be required to accept any reasonable documentation, which may include, but not be limited to:

- Any documentation from a Tribe evidencing membership or enrollment that satisfies the requirements of 42 U.S.C. § 1396b(x)(3)(b);
- A certificate of Indian blood issued by the Bureau of Indian Affairs or a Tribal entity listed in the BIA Notice of “Indian Entities Recognized and Eligible to Receive Services from the United States Bureau of Indian Affairs,” 75 FR 190 (October 1, 2010), or its successor;
- Any documentation provided by an official of the IHS, a Tribal health program, or an urban Indian organization, or other evidence, that the person has ever received services at an Indian health program as a result of being an Indian or that the person is eligible for such services;
- Any documentation of an ownership interest in or receipt of income entitled to exemption from gross income from judgment fund distributions; tribal tribe income per capita; income directly derived from a trust allotment; or income derived from certain fishing rights under 26 U.S.C. § 7873;
- Any documentation of ownership of property held in trust.

Notice to Applicants and the Public

Regardless of the method of documentation that is accepted, it is critical that all applicants or potential applicants be given notice that there may be certain benefits or protections that apply if the applicant is an Indian. We believe that for such a notice to be meaningful it should either contain in it, or refer the applicant to, a more detailed set of inquiries that will allow each person who may qualify to review the specific criteria. This could be in the form of a worksheet available in hard copy and online. Whatever the form, it should spell out the criteria in terms recognizable to the person, rather than in “legalese.”

For instance, Appendix B provides an example of a set of questions which could be provided, in hard copy or online, to enable an applicant to identify the benefits and protections that apply if the applicant is an Indian.

Question: What Indian-specific financial protections are afforded to AI/ANs in Exchange plans?

Waiver of Cost-Sharing for AI/AN

Section 1402(d) of the ACA provides special rules applicable to Indians regarding protection from cost sharing. There are two special protections provided under this subsection: 1) waiver of premiums and cost-sharing for AI/AN at or below 300 percent of the poverty level and 2) no cost-sharing for AI/AN without regard to their income who receive services from an I/T/U provider.

1. Indians at or below 300% of Poverty. For an Indian whose household income is not more than 300 percent of the poverty level for a family of the size involved, then for the purposes of Section 1402, (A) the individual shall be treated as an eligible insured; and (B) the issuer of the plan shall eliminate any cost-sharing under the plan.²⁸ Together, we believe these provisions provide a complete waiver of an AI/AN enrollee's cost-sharing as well as a waiver of an AI/AN enrollee's premium contribution amounts.

Cost-Sharing and Premium Protection. As a matter of law and policy, Sec. 1402(d)(1) should be interpreted as eliminating both cost-sharing and premiums for Indians under 300% of FPL enrolled in a qualified health plan. This conclusion is supported by paragraph (B) which expressly exempts such an Indian from cost-sharing, and by paragraph (A) which treats such an Indian as an "eligible insured". The designation as an "eligible insured" would not be needed if the individual were required to pay a premium in order to qualify for the protections offered by subsection (d)(1).²⁹ In addition, other subsections of Sec. 1402 addressing cost-sharing protections for individuals other than Indians do not include such a phrase, although they are also based on thresholds associated with the poverty level.

Although, we believe that the argument above is sufficient, we also believe there are compelling public policy justifications for such an interpretation. The Congress has declared –

that it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligation 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; . . .³⁰

The underfunding of the IHS for health services directly provided by it or provided by Tribes or Tribal organizations or urban Indian organizations has been thoroughly and repeatedly documented.³¹

The funds that have been made available to the Indian health system to fulfill the special trust responsibility have come through a mix of direct appropriations and authority for these federal programs to bill Medicaid and Medicare – authority which is exceptional and did not exist prior to 1976 and the enactment of the IHCA. Providing premium protection for Indians under 300 percent of

²⁸ Sec. 1402(d)(1).

²⁹ It is an accepted canon of statutory construction that “a court should give effect, if possible, to every clause and word of a statute.” *Moskal v. U.S.*, 498 U.S. 103, 109-110 (1990).

³⁰Section 3 of the IHCA, as amended, and incorporated into the ACA pursuant to Sec. 10221.

³¹ National Indian Health Board, Comments Submitted to CMS on Interim Final Rule for the Preexisting Condition Insurance Plan program, dated September 28, 2010

poverty would create a third funding mechanism by which satisfying the Federal responsibility could be furthered, and it would not come at the expense of the issuer of the qualified health plan, to whom the Secretary must pay the “increase in actuarial value of the plan required by reason of subsection (d).”³²

Other Cost-Sharing for AI/AN at or below 300 Percent of Poverty Level. In addition to the premium protection afforded under paragraph (1), Sec. 1402(d)(1) also provides across the board protection against any other cost-sharing. It will be critical that Exchanges offering plans be required to notify the qualified health plans about the status of each individual who enjoys this protection and that the plans in turn are required to provide information to non-Indian health providers that the individual is exempt from any cost-sharing obligation. Whatever mechanisms are set in place to protect others who are entitled to some level of cost-sharing reductions, these mechanisms need to be extended to ensure co-payment requirements are imposed for AI/ANs whose family income is at or below 300 percent of poverty.

2. Items and Services Furnished through Indian Health Providers. Under Section 1402(d)(2), regardless of the income of the covered AI/AN, any item or service provided to him or her directly by the IHS, an Indian Tribe, a Tribal Organization, or an urban Indian organization or through referral under contract health services must be provided without any cost-sharing being imposed on the individual.³³ In addition, the plan may not reduce the payment due the provider as a result of the protection from cost-sharing provided under this subparagraph.³⁴ Again, the issuer of plans must be required to effectively implement this provision by providing adequately for identification of all individuals eligible for this protection and the plans must notify all providers and assure that they are fully reimbursed.

Question: What procedures are recommended to best facilitate determining eligibility for enrollment, cost-sharing protections, and individual responsibility exemptions?

Procedures for Determining Eligibility for Exchange Participation, Cost Sharing Protections, and Individual Responsibility Exemptions³⁵

We have discussed in detail our views about protections that should be incorporated into enrollment processes to insure that all AI/ANs obtain information about and the specific benefits and protections to which they are eligible under the ACA. We offer these additional comments regarding implementation of Sec. 1411.

Citizenship Status. According to Sec. 1411(b)(2), all applicants for Exchange coverage must provide information regarding citizenship. We read this provision to allow an applicant to attest to his or her citizenship so long as the application includes the individual’s name, address, date of birth, and social security number. We believe this should be adequate. If for any reason, however, additional documentation is required, we believe that the documentation that is acceptable under Sec. 211(b) of Pub. L. 111-3 (CHIPRA) (codified at 42 U.S.C. § 1396b(x)(3)(B)(v)), should be deemed to be adequate. This would require accepting any document issued by a federally-recognized Indian Tribe evidencing membership or enrollment in, or affiliation with, such Tribe. CMS has decided that no additional information is required from a Tribe located on an international border and includes in its membership

³²Sec. 1402(d)(3).

³³ACA Sec. 1402(d)(2)(A).

³⁴ACA Sec. 1402(d)(2)(B).

³⁵ACA Sec. 1411.

non-U.S. citizens. The direction that has been provided by CMS to the States regarding the form of documentation that must be accepted should be adopted for the purpose of satisfying this requirement.

Accepting this form of documentation, assuming any is needed beyond the attestation, is essential in order that the integration of a single online application for Exchange plans as well as Medicaid can be seamless.

Indian Status. Sec. 1411 does not identify being Indian as one of the categories of information to be obtained. While this information is not required, if significant effort is not made to assure that AI/ANs know the benefits and protections that are available and the forms are not simple enough, many AI/ANs will not receive the benefits and protections to which they are entitled. All communications, forms, online applications and other materials must have simple, easy to find and read information and easy to complete materials so the applicant can provide notice that he or she is Indian.

Family Size and Income Information. Section 1411 addresses how to obtain information on family size and income if the individual is claiming either premium or other cost sharing protection. As discussed above and in our general comments about enrollment, we urge that the Exchange Navigators, other providers of outreach and enrollment activities, issuers or plans, and plans themselves, should be required to provide easily visible, highlighted material throughout the process that assures that AI/ANs will have the opportunity to learn about the benefits and protections available to them and specifically how to obtain them.

Summary of Recommendations: Enrollment and Eligibility

- The definition of “Indian” adopted by CMS on July 1, 2010 in its implementation of the cost-sharing protections made available under the Recovery Act should be adopted uniformly in implementation of the ACA.
- AI/AN should be able to self-certify that they qualify as an Indian. If documentation requirements are imposed, HHS, IHS, CMS, IRS, and DOI should cooperate to make electronic data matching, if with the necessary safeguards on the data, available among themselves and with Exchange plans so that the process of providing “proof” of being AI/AN can be streamlined. There must be a vehicle by which an individual AI/AN can establish qualification for benefits and protections under the ACA.
- Confirm that Section 1402 of the ACA provides a complete waiver of an Exchange enrollee’s cost-sharing and premium obligations for AI/AN whose household income is at or below 300 percent of the poverty level.

H. Outreach

Question: What kinds of consumer enrollment, outreach, and educational activities are States and other entities likely to conduct relating to Exchanges, insurance market reforms, premium tax credits and cost-sharing reductions, available plan choices, etc., and what resources and technical assistance is likely to be most beneficial to individual AI/AN and Tribes?

I/T/U Programs Have Existing Lines of Communication with AI/AN

Indian health providers (including urban Indian organizations) and Tribes (whether they are carrying out health programs or not) are logical and culturally appropriate entities to conduct consumer enrollment activities, including encouraging AI/ANs to participate in and to assist them in navigating through the Exchanges. The I/T/U programs have existing lines of communication and relationships with AI/ANs who in many instances live in remote rural areas. Tribes, Tribal health programs, the IHS, and urban Indian programs will be much more effective than States in conducting consumer enrollment and outreach among AI/ANs. I/T/U programs should have the same access to funding for administrative outreach and education costs as States and Navigators do.

In addition, all providers of outreach and Navigator services should be required to include information that will inform AI/ANs about the benefits available to all eligible applicants as well as the special benefits and protections that may be available to them.

Question: What resources are needed for Navigator programs?

Navigator Support

In order to effectively provide Navigator services, certain basic supports will be required. We believe these include the following:

- Initial and ongoing training to assure that information to be shared is correct and complete and to prepare the navigator programs and their staff to work with diverse Indian populations.
- Promotional materials, such as brochures, posters, radio ads, television spots, public service announcements for radio and television as well as print media copy, that provide general information and that are tailored to identify local Tribal contacts and sources of information.
- Internet portals for application and inquiry that will provide AI/AN with confidence that information will be confidential and reflect an understanding of the their community, culture, income, education, and family situations.
- Access to resources to translate promotional materials, including information contained on Web sites, into the languages spoken or read in the community where the materials will be distributed or the portals accessed.
- Ready access to online information that tracks the status of enrollment efforts in the aggregate and on an individual applicant basis. Specifically, the online program should be able to monitor completed enrollments (by denied and approved), pending applications, and incomplete applications. The software program should be designed to make follow up efforts more efficient, and it should be made available to all Navigators at no cost.

AI/AN Outreach and Navigator Resources

In addition to all Navigators having access to the resources described, there are additional resources that Navigators who provide targeted outreach for AI/ANs will need.

- Preference should be given to selecting I/T/Us as Navigators, where possible. If there is no I/T/U Navigator in a community or region where Tribes or Indian health programs are present, then the Navigator should be provided with resources to contract with the I/T/U to obtain the Tribal and cultural information that will be required to effectively communicate within the AI/AN community.
- Funding for additional promotional materials that will reflect the particular Tribal and cultural community
- Funding for travel to Tribal or other community gatherings to engage in outreach and enrollment activities.

Question: What kinds of outreach strategies are likely to be most successful in enrolling individuals who are eligible for tax credits and cost-sharing reductions to purchase coverage through an Exchange, and in retaining these individuals? How can these outreach efforts be coordinated with outreach and enrollment efforts for other public programs?

Focused Outreach to AI/AN

If targeted outreach efforts to AI/AN are to be successful, they must be tailored to meet the individual, varied, and unique needs of each of the Tribal communities across the country. In addition, outreach efforts must be culturally appropriate and sensitive to Tribal and community issues. These are challenging criteria for anyone to satisfy, but certainly nearly impossible for outreach provided by anyone other than I/T/Us.

In order to be successful, all outreach efforts, whether targeted or general, must inform potential AI/AN applicants about the unique benefits and protections to which they may be entitled and provide simple, easy to understand materials so that potential applicants can determine whether they are likely to qualify, especially for cost-sharing protections and waiver of any penalties.

The I/T/U programs have successfully been conducting CHIP, Medicaid and Medicare outreach for many years. As a result, many Tribes and I/T/U programs have existing outreach infrastructure that could be supplemented and expanded to conduct outreach and enrollment in Exchange plans. Tribes and I/T/U health programs have successfully coordinated with other public programs in CHIP, Medicaid and Medicare enrollment; the same positive, dynamic coordination that currently exists can be continued as Tribes and I/T/U health programs expand into Exchange Navigator and Exchange outreach and enrollment activities.

Question: How will OCIO work with Tribes and direct States to incorporate specific strategies to conduct effective outreach in tribal communities?

Effective Outreach Strategies

We hope that OCIO will use recent Medicaid and CHIP outreach efforts in Tribal communities as a model for this important activity. The barriers that cause under enrollment of AI/ANs in Medicaid have been well documented. Learning from these studies, OCIO has the ability to create mechanisms that can overcome the barriers to enrollment. These barriers to AI/AN enrollment include these factors:

- AI/AN understanding that the trust responsibility of the United States to them should provided them with free health care without having to apply for programs like Medicaid or CHIP, and now Exchange Plans.
- Language and cultural differences.
- Remoteness.
- Poverty and lack of access to computers and other online tools in many, many AI/AN communities.
- The misperception by many State and local officials that IHS resources are sufficient to meet AI/AN health needs and that special outreach and enrollment for AI/ANs is an unreasonable and unnecessary burden on their increasingly limited budgets.

Policy directives from the Secretary to State Exchanges will provide important guidance that may help establish effective and consistent outreach for AI/ANs no matter where they live. Without that direction, AI/ANs may not get the access to the important new health coverage that will be available through Exchange plans.

Question: What guidance will OCIO or HHS issue to States regarding the availability of explicit and useful information specific to American Indian and Alaska Natives and Indian health programs?

Web Content and Design Needed to Provide Adequate Indian-Specific Information

As a model, www.healthcare.gov includes a button to screen for options unique to AI/ANs. This type of visible self-identification as an AI/AN is an important feature that permits viewing more detailed information about options uniquely available to Indian people. We understand that this site remains very basic and that State Exchanges will have to include much more detailed information. Right now, the HHS site only leads to the links posted on the IHS area website. We believe that States will need more guidance about the types of links that are needed to make sure adequate information is available for AI/ANs. Exchanges will need to populate their websites with more detailed information about special Indian provisions in a culturally appropriate way.

We understand that States will have significant flexibility and responsibility. However, we believe that the Federal trust responsibility to AI/ANs requires more Federal involvement where the interests of AI/ANs are at issue. Specifically, a clear Federal presence in State implementation will be needed to protect the interests of AI/ANs. We recommend the following.

- The Secretary provide clear and specific direction to States about the specific benefits and protections available to AI/ANs and the requirement that such information be readily accessible to AI/ANs who may inquire.
- Standardized materials specific to the AI/AN-related provisions of the ACA (including applications or worksheet that will help individuals determine whether they are Indian for for the purposes of the benefits under the ACA) be developed in a process that includes extensive Tribal input (technical and through formal consultation) and provided to States with direction about how those materials may be personalized to the unique elements of the program and the Tribes in that State.
- Consultation by States with Tribes be required and assisted, if necessary, to assure that the consultation is meaningful.(See recommendations under “Importance of Tribal Consultation.”)

Summary of Recommendations: Outreach

- Tribes, IHS and urban Indian health programs should have the same funding for administrative outreach and education costs as States do.
- Access to a range of HHS and State-supplied resources will be critical to the successful operation of Navigators.
- Preference should be given to selecting I/T/Us to operate Navigators serving AI/AN populations where possible.
- Build on existing outreach infrastructure of Tribal governments and I/T/U providers to conduct outreach to AI/AN populations.
- Directives from OCIIO to States on effective outreach strategies to AI/AN are needed to provide important guidance to enable States to implement effective outreach to AI/AN.
- Exchanges will need to populate their Web site with more detailed information about Indian-specific provisions and will need additional guidance from OCIIO to accomplish this.
- A clear Federal presence in State implementation of the ACA is needed to ensure the Federal trust responsibilities are carried out.

I. Rating Areas

No comments.

J. Consumer Experience

Question: What kinds of information are likely to be most useful to consumers as they determine whether to enroll in an Exchange and which plan to select (within or outside of an Exchange)?

Enrollee Satisfaction System/Survey

Section 1311(c)(4) of the ACA established as a responsibility of the Secretary the duty to develop an enrollee satisfaction survey system that can evaluate the level of enrollee satisfaction with qualified health plans offered through an Exchange. We request that Tribes are consulted regarding this provision with regards to the designing the survey instrument and how data is organized. In addition, we recommend that in Exchange service areas with AI/ANs, the survey system be designed to obtain participation by AI/ANs as stakeholders. Because of the potential difficulty of accessing a sufficient number of AI/AN to participate in such a survey (due to AI/AN living in remote locations, lower rates of telephone access, etc.), proactive steps may be required by Exchanges when conducting the surveys in order to secure the necessary level of AI/AN participation. These proactive steps might include coordination with Tribal governments to conduct in-person surveys or to encourage tribal members to participate.

Summary of Recommendations: Consumer Experience

- Ensure Tribal consultation in the development of the survey instrument, the distribution of the survey, and the use of the data collected.

- Ensure sufficient sampling of AI/AN in enrollee satisfaction surveys in order to generate valid findings.
- Establish usable comparative measures, such as a measure on comparative plan disenrollment rates and reasons for disenrollment from a plan.

K. Employer Participation

Question: Are AI/AN who are offered employer-sponsored coverage able to access the Indian-specific cost-sharing protections in the Exchange and would doing so financially disadvantage the AI/AN's employer?

Access to Exchange Cost-Sharing Protections for AI/AN Employees Who Are Offered Employer-Sponsored Coverage

As reviewed above, the ACA provides AI/AN significant protections from cost-sharing beyond that provided to the general population. These protections, though, are only available to AI/AN who are enrolled in the individual market through an Exchange. The concern is that, if not implemented with consideration of the interaction of the various provisions, a substantial number of AI/AN may not be able to access these protections through an Exchange, and would be saddled with substantial out-of-pocket costs. This result would seem to be in conflict with the Congressional intent of the law and run counter to the policies sought by Tribal governments and their members in working to enact the law.

As a mechanism for the Federal government to carry out its Trust responsibilities to AI/AN, and as a supplement to the direct provision of health care services through the IHS, the ACA included a number of health insurance-related provisions that are specific to Tribal governments and AI/AN. For example, one mechanism to fulfill the Federal government's responsibility to provide access to comprehensive health care services to AI/AN is contained in Sec. 1402(d)(1)(B). This provision of the ACA provides for the complete elimination of cost-sharing requirements for AI/ANs whose household income is not more than 300 percent of the poverty level and who "is an individual enrolled in any qualified health plan in the individual market through an Exchange."

The cost-sharing protections afforded AI/AN in the Exchange are substantial and access to these is critical to improving access to comprehensive health care services by AI/AN. For example, in contrast to having no cost-sharing required under Exchange coverage, for an individual employee enrolled in an employer-sponsored health plan that meets the "minimum essential coverage" definition in the ACA it is estimated that the employee will be obligated to pay, on average (in 2010 dollars), nearly \$2,000 in (non-premium) out-of-pocket costs.³⁶ And, an individual with employer-sponsored coverage may have to spend as much as \$5,950 in (non-premium) out-of-pocket costs to secure covered services. Family coverage for an employee would result in even higher out-of-pocket costs, with the average (non-

³⁶ Presentation of Doneg McDonough, Consultant to the National Indian Health Board, at the NIHB 2010 Annual Consumer Conference, September 23, 2010.

premium) out-of-pocket costs for a family being approximately \$5,378 per year, with a maximum liability for (non-premium) out-of-pocket costs for covered services of more than \$11,900.

Because the protections from these potential out-of-pocket costs are only available under the ACA for AI/AN who are enrolled in the individual market in an Exchange, we recommend the following be clarified and implemented in order to maximize enrollment of AI/AN in comprehensive health insurance coverage through an Exchange and maximize access to needed health care services for AI/AN. For AI/AN whose household income is not more than 300 percent of the poverty line, enrollment through the individual market in an Exchange would be permitted if the employer-sponsored plan available to the individual requires cost-sharing. For purposes of determining the shared responsibility payment for employers under Section 4980H of the Internal Revenue Code, as modified by Section 1513 of the ACA, the employee's coverage would be considered "unaffordable" and the employee would be counted under Section 4980H(c).

The availability of the cost-sharing protections for AI/AN through an Exchange will not disadvantage employers (whether Tribal governments or non-Tribal governments) that employ AI/AN. Although there is a significant reduction in obligations for the individuals described above who move from employer-sponsored coverage to coverage in the individual market in the Exchange, the financial obligation of their employers would not change significantly. For employers who have no shared responsibility obligations under the ACA, no obligations would be created by having employees who are AI/AN have access to coverage through an Exchange. For employers who have employer shared responsibility obligations and satisfy the obligations by offering the "minimum essential coverage", the employer's premium contribution is estimated to be nearly identical whether under employer-sponsored coverage (\$2,887) or by making a contribution to the Exchange as called for under the ACA (\$3,000).³⁷ And for employers who provide more generous coverage or who provide family coverage, they would experience a reduction in their financial obligations as a result of the AI/AN employee securing coverage through an Exchange.

Summary of Recommendations: Employer Responsibility

- Permit AI/AN whose household income is not more than 300 percent of the poverty level to enroll in an Exchange plan in the individual market if the employer-sponsored health plan offered to the AI/AN requires cost-sharing.

L. Risk Adjustment, Reinsurance, and Risk Corridors

Question: To what extent are payment adjustments to be made to health plans serving AI/AN enrollees as a result of risk adjustment and/or other required adjustments?

³⁷ Ibid.

Health Plan Payment Adjustments for AI/AN Enrollees

We believe that proactive enforcement by the Secretary of the risk adjustment provisions of Section 1343 and the Indian-specific adjustments called for in Section 1402(d) are critically important to ensure that the necessary resources are readily available to serve AI/AN persons.

The ACA, including the IHClA as authorized by Section 10221 of the ACA, includes several AI/AN-specific provisions that serve to increase access to quality health care services for AI/AN. Although reducing the costs to enrollees, these provisions increase the financial obligations of the health plans if not otherwise offset.

Under Section 1402(d)(1), a waiver is provided of cost-sharing requirements by health plans for AI/AN enrollees whose household income is not more than 300 percent of the poverty line and who are enrolled through the individual market in an Exchange. This provision is expected to have a greatly favorable impact on access to health care services for AI/AN. A second provision, found in Section 1402(d)(2), ensures that no cost-sharing is imposed on an AI/AN enrollee who is provided services by an I/T/U provider, *and* the health plan is not to reduce the payment to the I/T/U provider for the cost-sharing amount otherwise due from the enrollee.

To not disadvantage a health plan or a health care provider that serves AI/AN, and conversely to not create a disincentive for plans to enrollee AI/AN persons nor to create a disincentive for providers to serve AI/AN patients, Section 1402(d)(3) states that “The Secretary shall pay to the issuer of a qualified health plan the amount necessary to reflect the increase in actuarial value of the plan required by means of this section [*i.e.*, provisions (d)(1) and (d)(2) above].”

In addition to these provisions, Section 1343 of the ACA establishes a general risk adjustment mechanism that calls for risk adjustment charges and payments between plans “if the actuarial risk of the enrollees of such plans or coverage for a year is less than [or greater than] the average actuarial risk of all enrollees in all plans or coverage in such State for such year...”

Timely and Accurate Risk Adjustment Payments are Critical

We view the enforcement by the Secretary of the general risk adjustment provisions of Section 1343 and the Indian-specific payment adjustments called for in Section 1402(d) as critically important to ensuring the necessary resources are available to AI/AN persons—and the providers and health plans serving those persons—in order to readily secure high quality health care services.

From the perspective of some health plans, AI/AN residents in many Indian communities may represent a greater-than-average actuarial risk. To attract a sufficient number of health plans to these areas, and to support the efforts of health plans that wish to provide high quality services to enrollees in these communities, risk adjustment payments that are accurate and timely will be required to be made to these plans. For plans that ultimately prove to provide high quality services to potentially higher-than-average-risk populations and, as such, attract additional persons that are higher-than-average risk, an accurate and timely risk adjustment payment system will be key to the viability of these plans.

Risk Adjustment Across Multiple Exchanges Operating Within A State

And as indicated in the law, risk adjustment charges and payments are to be implemented across all plans operating in the individual and small group market within a State, and not restricted to charges and payments between plans that are operating in a sub-State (interstate, regional, or subsidiary) Exchange. If risk adjustment payments were limited to within a sub-State exchange, this may have the effect of raising health insurance premiums in high-risk regions and/or reducing the number of health plans willing to operate high quality plans within such regions. Enforcement of this provision by the Secretary will be central to the functioning of the risk adjustment mechanism.

Summary of Recommendations: Risk Adjustment, Reinsurance, and Risk Corridors

- Proactively enforce, through the Secretary, the risk adjustment provisions of Section 1343 and the Indian-specific adjustments called for in Section 1402(d) in order to ensure the necessary resources are readily available to serve AI/AN persons.
- Enforce the requirement to conduct risk adjustment payments across all plans operating in a State.

M. Economic Analysis, Paperwork Reduction Act, and Regulatory Flexibility Act

No comments.

N. Comments Regarding Exchange Operations

Comments and other considerations were included above where appropriate.

Appendix A

ACA PROVISIONS DEFINING INDIAN OR MEMBER OF INDIAN TRIBE

Title I Quality, Affordable Health Care for All Americans; Subtitle D Available Coverage Choices for All Americans; Part I Establishment of Qualified Health Plans

Sec. 1311(d)(4)(D) (“special monthly enrollment periods for Indians (as defined in section 4 of the [IHClA].”)

Title I, Subtitle E Affordable Coverage Choices for All Americans, Part I Premium Tax Credits and Cost-Sharing Reductions; Subpart A—Premium Tax Credits and Cost-Sharing Reductions

Sec. 1402(d)(1) Indians under 300% of Poverty (“If an individual enrolled in any qualified health plan in the individual market through an Exchange is an Indian (as defined in section 4(d) of the [ISDEAA] . . .”.)

Sec. 1402(d)(2) Item or services furnished through Indian Health Providers (“If an Indian (as so defined) is furnished an item or service directly by the [IHS], an Indian Tribe, Tribal Organization, or urban Indian Organization . . . no cost sharing” and no reduction in payment to provider).

Title I, Subtitle E Affordable Coverage Choices for All Americans, Part I Premium Tax Credits and Cost-Sharing Reductions; Subpart B—Eligibility Determinations

Sec. 1411(b)(5)(A) Exemption from Individual Responsibility; obtaining an exemption certificate under Sec. 1311(d)(4)(H) includes “an Indian”. The only definition of Indian in Sec. 1311 is found in Sec. 1311(d)(4)(D), which uses section 4 of the IHClA

Sec. 1501(b) amended Internal Revenue Code of 1986 (IRC) by adding new section 5000a. Subsection (e)(3) provides for no tax penalty for “Any applicable individual for any during which the individual is a member of an Indian Tribe (as defined in section 45A(c)(6).

Title II—Role of Public Programs, Subtitle K—Special Protections for AI/ANs.

Sec. 2901(a) refers back to Sec. 1402(d).

Sec. 2901(c) Facilitating Enrollment of Indians under Express Lane Option amends Sec. 1902 of the SSA (42 U.S.C. § 1396a(e)(13)(F(ii))

Sec. 2901(d) Amends SSA Sec. 1139(c) (42 U.S.C. § 1320b-9(c)) to made it read: “For the purposes of this section, title XIX, and title XXI, the terms ‘Indian’, ‘Indian Tribe’, ‘Indian Health Program’, ‘Tribal Organization’, and ‘Urban Indian Organization’ have the meanings given those terms in section 4 of the [IHClA].”

Title IV—Prevention of Chronic Disease and Improving Public Health; Subtitle B—Increasing Access to Clinical Preventive Services

Sec. 4102(a) amended the Public Health Service Act by adding a new Part T— Oral Healthcare Prevention Activities. In the new Sec. 399LL the campaign is targeted to include “Indians, Alaska Natives and Native Hawaiians (as defined in section 4(c) of the [IHCIA]. . .” *Also see*, Sec. 399LL-2(b), which provides for grants “to Indians, Indian tribes, tribal organizations and urban Indian organizations (as such terms are defined in section 4 of the [IHCIA].”

Title VI—Transparency and Program Integrity; Subtitle D—Patient-Centered Outcomes Research

Sec. 6301(e), which establishes a trust fund to support patient centered outcomes research, provides an exemption for fees on insurance plans under new IRC Sec. 4377(b)(3)(D). The exemption applies to “any program established by Federal law for providing medical care (other than through insurance policies) to members of Indian tribes (as defined in section 4(d) of the [IHCIA].”

Title IX—Revenue Provision; Subtitle B—Other Provisions

Sec. 9021 Exclusion of Health Benefits Provided by Indian Tribal Governments. Adds a new IRC Sec. 139D Indian Health Care Benefits under which “qualified Indian health care benefits” are excluded from gross income. The exemption is extended to “a member of an Indian tribe or tribe, includ[ing] a spouse or dependent of such member”. “Indian tribe” has the meaning in IRC Sec. 45A(c)(6).

Appendix B

Sample Set of Questions to Facilitate Applicant Eligibility For, and Benefits Of, Indian-Specific Protections and Benefits

Below are sample questions to help indentify individual Indian Applicants who are eligibility for and received benefits of Indian specific protections and benefits under the ACA.

- Are you a member of a Federally recognized Tribe?
- Have you ever been considered by the Department of the Interior (or Bureau of Indian Affairs) to be an Indian for any purpose?
- Have you ever been considered by the Department of Health and Human Services (or the Indian Health Service) to be an Indian for purposes of eligibility for Indian health care services?
 - Have you ever received health services at an IHS or tribal health program because you are an Indian, including as a California Indian, Eskimo, Aleut, or Alaska Native?
 - Are you the child, grandchild, or other descendent of a member of a person who belongs to an Indian community served by an IHS or tribal health program?
 - Are you a California Indian?
- Have you been determined to be an Indian under regulations adopted by HHS?
- Have you ever been allowed an exemption from gross income due to being an Indian, (such as income from judgment fund distributions; tribal Tribe income per capita; income directly derived from a trust allotment; or income derived from certain fishing rights under 26 U.S.C. § 7873)?