

National Indian Health Board



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March 18, 2013

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention CMS-9958-P
P.O. Box 8010
Baltimore, MD 21244-8010

RE: Comments on CMS-9958-P; Eligibility for Exemptions; Miscellaneous Minimum Essential Coverage Provisions

I write on behalf of the National Indian Health Board (NIHB)¹, to comment on CMS-9958-P, Patient Protection and Affordable Care Act; Exchange Functions: Eligibility for Exemptions; Miscellaneous Minimum Essential Coverage Provisions (Proposed Rule). We appreciate the opportunity to provide comments.

On Thursday, February 21, 2013, the Department of Health and Human Services (HHS), in conjunction with the Department of the Treasury, held a Tribal consultation session on the Proposed Rule as well as on the Internal Revenue Code issued proposed rule REG-148500-12 (Shared Responsibility Payment for Not Maintaining Minimum Essential Coverage) proposed by the Internal Revenue Service (IRS). We are providing these comments as a supplement to the input provided by Tribal Leaders, Tribal Technical Advisory Group members, and other Tribal representatives at the Tribal consultation session.

BACKGROUND

The Proposed Rule defines the circumstances that would exempt individuals from a “shared responsibility payment” or tax penalty for not having health insurance coverage. The American Indian and Alaska Native (AI/AN) perspective is that Tribes have already pre-paid their health care through treaties that transferred millions of acres of land to the United States. The federal trust responsibility to provide health care for AI/ANs has been established in law and is carried out in practice by the Indian Health Service (IHS), an agency of the Federal government. Congress has authorized funding for Indian

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



health services to be provided directly through the Indian Health Service and other Indian Health Care Providers, and by billing other programs, including Medicaid, Medicare, and plans offered in the new Health Benefit Exchanges established under this and other regulations with authorization from the Patient Protection and Affordable Care Act (Affordable Care Act or ACA).

The specific statutory functions covered in this Proposed Rule include determining eligibility for and granting certificates of exemption from the shared responsibility payment for not maintaining minimum essential coverage as described in section 5000A of the Internal Revenue Code (IRC). The Proposed Rule includes a list of additional hardship exemption categories to be established pursuant to the Secretary's authority under ACA § 1311(d)(4)(H). In addition, the Proposed Rule implements the responsibility of the Secretary of HHS, in coordination with the Secretary of the Treasury, to designate certain health benefits coverage as minimum essential coverage. The Proposed Rule outlines – in addition to the exemption categories establish in the Proposed Rule itself – substantive and procedural requirements that additional types of coverage must fulfill to obtain certification as minimum essential coverage under the Code.

We are addressing two discrete issues in these comments. First, in Part I we address the issues arising from the narrow interpretation of the definitions of Indian for various Indian specific provisions of the ACA, including the exemption from the tax penalty. Second, in Part II we address the need for a further hardship exemption beyond that discussed in Part I for certain members of Indian families.

PART I – DEFINITION OF INDIAN

SUMMARY OF FINDINGS AND RECOMMENDATIONS

Summary of Findings

Under section 1501 of the Affordable Care Act (which established IRC § 5000A),² a “shared responsibility payment” is required from (nonexempt) individuals who do not maintain minimum essential coverage (MEC). AI/ANs, as defined under IRC § 45A(c)(6), are exempt from payment of the penalty under ACA § 1501\ IRC § 5000A(e)(3). But under the current narrow interpretations by HHS and the IRS of the statutory provisions that define who is an “Indian” for purposes of the ACA, some AI/ANs who are eligible for services from the Indian Health Service are *not* eligible for the Indian-specific exemption from the tax penalties for not maintaining MEC.³ As a result, some AI/ANs who rely on Indian Health Care Providers for their medical care in accordance with their federal rights and,

² Patient Protection and Affordable Care Act, Public Law 111–148, amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111–152 (collectively, the Affordable Care Act). Section 5000A was subsequently amended by the TRICARE Affirmation Act of 2010, Public Law 111–159 and Public Law 111–173.

³ See *Tribal Technical Advisory Group to the CMS, Analysis of and Recommendation on Proposed Rule, Exchange Functions in the Individual Market*, CMS-9972-P, October 31, 2011.

therefore, do not purchase health insurance, may be subject to a tax penalty under IRC § 5000A beginning in 2014. This annual tax penalty could be substantial and would likely increase over time.⁴

Summary of Recommendations

This comment letter provides two paths to eliminate the potential tax penalty that may be imposed on IHS beneficiaries who have a federal right to IHS services, but who may not qualify for the Indian exemption under the HHS and IRS current statutory interpretation of IRC 45A(c)(6).⁵ Because of the discretion afforded the Secretaries of HHS and Treasury and because the Proposed Rule anticipates that some people may be eligible for more than one type of exemption from the tax penalty, it is our understanding that CMS and IRS may use either or both of these approaches. One approach adds a hardship exemption category; the other approach designates an additional type of minimum essential coverage but does so solely for purposes of the tax penalty and not with regard to determining eligibility for premium tax credits and cost-sharing assistance through an Exchange.

- Recommendation 1: Pursuant to the HHS Secretary's authority under ACA § 1501 \ IRC 5000A(e)(5), designate "Indian, as defined in 42 CFR § 447.50" as a hardship category.⁶
- Recommendation 2: Pursuant to the HHS Secretary's authority under IRC § 5000A(f)(1)(E), designate "a medical care program of an I/T/U" as minimum essential coverage solely for purposes of IRC § 5000A coupled with a statement in regulations confirming that the designation does not impact the determination of a "coverage month" under IRC § 36B(c)(B)(i) pertaining to eligibility for premium tax credits and cost-sharing assistance.⁷

Both approaches would enable the Federal government to use the IHS registration data base as an efficient way to identify a significant percentage of the persons who would be eligible for the protections from the tax penalties.

⁴ The shared responsibility payment amounts are calculated as follows: Under § 5000A(c) of the IRC, as added by § 1501(b) of the ACA and amended by § 10106 of the Reconciliation Act, the tax penalty for not maintaining minimum essential coverage is equal to the greater of: (1) 2.5% of household income in excess of the threshold amount of income required for income tax return filing under section 6012(a)(1); or (2) \$695 per uninsured adult in the household (and ½ this amount for each child), capped at three times the applicable dollar amount (e.g., \$695). The penalty will be phased in from 2014–2016. For 2014, the penalty will be the greater of 1% of household income over the filing threshold or \$95; for 2015, it will be the greater 2% of household income over the filing threshold or \$325; and for 2016 it will be the full 2.5% or \$695 amount.

⁵ At 78 Fed Reg 7353 of the Proposed Rule, CMS states "We note that the definition of Indian used in the statute for this exemption is the same as is used for the cost-sharing and special enrollment provisions in subparts D and E, respectively."

⁶ The TTAG proposes this provision be added as § 155.605(g)(6). We are aware that in a recent set of proposed rules, CMS proposed changing "42 CFR 447.50" to a new section number. If that rule becomes final, then any reference to "42 CFR 447.50" in this comment letter and proposed exemption should be updated, as well.

⁷ If the two items in Recommendation 2 cannot be implemented in tandem, the NIHB opposes the adoption of only one of the components of Recommendation 2.

- Recommendation 3: Enter into discussions a) through the TTAG and b) through formal tribal consultation to fashion an approach under 45 CFR § 155.350⁸ to provide electronic data matching with the IHS data base as one means of verifying Indian status for purposes of the (requested) exemptions from the tax penalties.⁹

ANALYSIS AND RECOMMENDATIONS

As we believe CMS is clearly aware, a critical problem was created by the drafting and implementation of the Affordable Care Act in such a way so that not all AI/ANs who are eligible for health care services from an I/T/U as a result of their status as Indians are considered eligible for the other Indian-specific benefits and protections under the ACA. In prior communications with CMS and the IRS, the NIHB, Tribal Technical Advisory Group (TTAG) to CMS and numerous tribal organizations have recommended various remedies to this issue. The Administration has consistently responded that a correction must be made through legislation and has voiced support for that legislation.¹⁰ Recognizing that the political climate may make it difficult to enact an amendment to the ACA in time for orderly implementation of the ACA, Tribes have requested the issuance of uniform operational guidance on a temporary basis.¹¹

The primary recommendations made here are offered to address one ramification of this problem, namely that some AI/ANs will be subject to tax penalties even though they have access to I/T/Us for their health care needs, if they do not also purchase health insurance. AI/ANs have a longstanding federal right to access care through the I/T/Us, and many will not be aware of the fact that they could be subject to a tax penalty for failing to purchase health insurance coverage. We are concerned that a manifest injustice will result if these AI/ANs are subject to a tax penalty for continuing to rely on their federal right to access care through the I/T/U system. If either or both of the approaches we recommend are not acceptable, we believe it is incumbent on the agencies to identify other approaches to remedying this problem. It is vitally important that any remedy enacted does not create other unintended consequences, such as a result that would bar AI/ANs from accessing the premium tax credits and cost-sharing assistance otherwise available in the individual market through an Exchange.

As indicated by CMS in the preamble to the Proposed Rule, “The intent of this rule is to implement the relevant provisions while continuing to afford states substantial discretion in the design and operation of

⁸ 77 Fed Reg 18461.

⁹ Once established, the electronic verification of Indian status could also apply to verifying eligibility for the Indian-specific cost-sharing protections under Medicaid (45 CFR § 155.350).

¹⁰ The legislative remedy being advanced is to define Indian for purposes of provisions of the ACA as defined in section 447.50(b)(1) of title 42 of the Code of Federal Regulations, as in effect on July 1, 2010.

¹¹ See Northwest Portland Area Indian Health and Board and California Rural Indian Health Board, letter to Valerie Jarrett and Jodi Gillette on *Enabling Exchanges Implement a Streamlined Application Process: The Need for a Uniform Operational Definition of Indian to Efficiently and Accurately Identify Individuals Who Are Eligible for Special Benefits and Protections as American Indians and Alaska Natives*, September 21, 2012.

an Exchange, with greater standardization provided where directed by the statute or where there are compelling practical, efficiency, or consumer protection reasons.”

In the recommendations offered here, we have attempted to adhere to this general guide, and we believe the recommendations offered do in fact enable continued state flexibility while providing standardization that supports consistent determinations of eligibility for AI/ANs no matter in which state an AI/AN person resides. For example, we are proposing that pursuant to the authority established under 45 CFR § 155.350(c)(2)¹² an existing data base maintained by the Indian Health Service (IHS) be made accessible to State-based and Federally-facilitated Exchanges (either directly or through the federal data services hub) for the purpose of the electronic verification of Indian status for both a) the Medicaid cost-sharing protections and b) the Indian-specific exemption(s) from the tax penalty for not securing minimum essential coverage. Although we recognize that this database is not comprehensive and cannot form the exclusive means of verification, it provides an efficient means of electronic verification that can be supplemented by other means.

Protecting IHS eligible persons from the tax penalty for not purchasing health insurance coverage

Under ACA §1501/ IRC § 5000A(e)(3), AI/ANs are exempt from a tax penalty for not maintaining minimum essential coverage (MEC). As indicated in this Proposed Rule as well as in REG-148500-P issued by the IRS, AI/ANs meeting the definition under IRC § 45A(c)(6) may request the exemption either through an Exchange or directly in the tax filing process.¹³ As described above, a problem for AI/ANs arises in that the HHS and IRS interpretation¹⁴ of who is an “Indian” for purposes of ACA §1501/ IRC § 5000A(e)(3) is different from the eligibility standard for who is eligible as an Indian for services from an I/T/U. The result is that some AI/ANs who are eligible for, have accessed and who continue to access services from I/T/Us will, effective January 1, 2014, become subject to a tax penalty if they do not also purchase health insurance.

Individually and in the aggregate, the problem of differing eligibility determinations is significant. For example, an individual AI/AN family of four could be subject to an annual tax totaling \$2,085 (or more depending on the family’s income) once the tax penalty is fully phased-in in 2016. In the aggregate, it is estimated that, for example, roughly 37,500 of the 150,000 AI/ANs in California who are currently active users of the I/T/U system will not be eligible for the tax exemption under the HHS and IRS

¹² 77 Fed Reg 18461-2, March 27, 2012.

¹³ An individual eligible for an exemption as an Indian under ACA §1501/ IRC § 5000A(e)(3) would not have to file an income tax return to receive their exemption if their income was below the income tax filing threshold.

¹⁴ See 78 Fed Reg 7351 wherein CMS indicates it intends to define “Indian tribe” in the same manner as in 26 CFR 1.5000A-3g of the Treasury Department / IRS proposed rule (REG 148500-12). And see 78 Fed Reg 7353 wherein CMS noted: “We note that the definition of Indian used in the statute for this exemption is the same as is used for the cost-sharing and special enrollment provisions in subparts D and E, respectively.”

interpretation of IRC § 45A(c)(6).¹⁵ A similar result will occur in Alaska where thousands of descendants of the original Alaska Native Claims Settlement Act village and regional corporation shareholders may not be considered “members” and therefore not “Indian” for the purposes of the ACA.

Recommendation 1: Designate “Indian, as defined in 42 CFR § 447.50” as an additional hardship exemption category

In Attachment A, a table is provided that lists the exemption categories contained in the Affordable Care Act as well as the “hardship” exemption categories established by the Secretary in the Proposed Rule pursuant to ACA § 1501 \ IRC 5000A(e)(5). The table also indicates the method that may be used to claim an exemption.¹⁶

We are recommending that CMS include an additional hardship exemption category. The additional category of exemption would be added under § 155.605(g) as follows:

(6) For a month on a continuing basis, until such time that the applicant reports that he or she no longer meets the standards provided herein, if he or she meets the definition under 42 CFR § 447.50¹⁷

We believe adding “Indian, as defined under 42 CFR § 447.50” as an additional hardship category to be warranted for several reasons:

- For AI/ANs who are eligible to receive and do receive health care services from an I/T/U, paying for health insurance or an annual tax penalty for themselves and their family members will create a financial hardship.
 - The tax penalty would worsen the affordability of health care services for AI/ANs.
- Due to the drafting of the ACA and the subsequent interpretations of who is an Indian, an unintended consequence of the law was created whereby some IHS eligible persons are eligible for an exemption from the tax penalty and others are not.
 - For another unintended consequence of the ACA (the unaffordable “affordable” employer offered coverage), HHS established a hardship category.
- An “Indian, as defined under 42 CFR § 447.50” hardship category would provide relief during a transition period while amendments are made to the Affordable Care Act to fix the discrepancies in the eligibility for various Indian-specific benefits and protections under the ACA.

¹⁵ Testimony of James Crouch, Executive Director, California Rural Indian Health Board, at the joint HHS / Treasury Tribal Consultation, February 21, 2013.

¹⁶ We recommend that CMS publish such a table, with any modifications that are warranted, in the Federal Register or through a guidance document so as to provide further clarification of these provisions.

¹⁷ In the recently proposed CMS regulation CMS-2234 (78 Fed. Reg. 4594 (Jan. 22, 2012)), CMS proposes to modify and renumber this section as § 447.51. If implemented, the citation to § 447.50 would be modified accordingly.

- This is similar to the hardship exemption granted to people living in states where Medicaid Expansion is not being implemented, as a transitional measure to address an unforeseen problem in the implementation of the ACA.
- Furthermore, there may be difficulties for some Tribes to issue or re-issue documentation for members in a timely way to qualify them for the existing, but narrower Indian exemption, so this hardship exemption provides the (potential) additional pathway of using the IHS data base for verification.
- The distinctions between definitions of Indian that are used for Medicaid, CHIP, ACA, IHS and other federal programs are not going to be understood in AI/AN communities. People who have never been expected to purchase health insurance are not going to know what this is all about, and it is likely that there will be insufficient resources to reach everyone to explain the distinctions, choices and consequences. Furthermore, it is possible that plans offered on the Exchanges will not even have providers in or near Indian communities to serve people who do purchase insurance.

We believe adding such an additional hardship category is permissible because the Secretary is granted broad authority under ACA § 1501 \ IRC 5000A(e)(5) to designate hardship categories.¹⁸ And in fact, as illustrated in Appendix A, the Secretary is indicating in this Proposed Rule that she will exercise broad authority to designate hardship categories under this section of the ACA. For example, the Secretary is proposing under § 155.605(g)(1) to grant hardship exemptions if a person is experiencing “a significant, unexpected increase in essential expenses.”

Recommendation 2: Designate “a medical program of an I/T/U” as MEC for purposes of IRC § 5000A but not IRC § 36B

We are also recommending that the Secretary of HHS, in coordination with the Secretary of the Treasury, designate coverage under “a medical care program of the Indian Health Service (IHS), a Tribe or Tribal organization, or urban Indian organization” as minimum essential coverage (MEC) solely for purposes of and applicable to the exemption from tax penalties under IRC 5000A, and indicate that the designation would not be applicable for purposes of determining a coverage month under IRC § 36B(c)(B)(i). The terms “Indian tribe”, “Tribal Organization”, and “Urban Indian Organization” have the meaning given those terms in Sec. 4 of the IHCA, 25 USC §1603.

¹⁸ Section 1501 \ IRC 5000A(e)(5) HARDSHIPS reads: “Any applicable individual who for any month is determined by the Secretary of Health and Human Services under section 1311(d)(4)(H) to have suffered a hardship with respect to the capability to obtain coverage under a qualified health plan.” Section 1311(d)(4)(H) reads: “[HHS Secretary is to] grant a certification attesting that, for purposes of the individual responsibility penalty under section 5000A of the Internal Revenue Code of 1986, an individual is exempt from the individual requirement or from the penalty imposed by such section because— (i) there is no affordable qualified health plan available through the Exchange, or the individual’s employer, covering the individual; or (ii) the individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty.” Section 1411(b)(5)(A), in turn, grants the Secretary broad discretion to require “such information as the Secretary shall prescribe” for applicants seeking an exemption.

In the preamble to the Proposed Rule,¹⁹ CMS states:

Under section 36B of the Code, individuals eligible to enroll in minimum essential coverage other than coverage in the individual market are generally not eligible for the premium tax credit. Recognizing that some of the categories of coverage designated by the Secretary may be widely available, the Treasury Department will consider providing appropriate rules in guidance under Code section 36B to address when individuals are treated as eligible to enroll in various types of coverage designated by the Secretary.

For purposes of designating “a medical care program of an I/T/U” as minimum essential coverage, we believe that “providing appropriate rules in guidance under Code section 36B” is necessary and warranted in this instance. Without such a clarification in IRC § 36B that the designation of “a medical program of an I/T/U” does not apply for purposes of determining a coverage month under IRC § 36B(c)(B)(i), some IHS beneficiaries who are eligible for, but do not have ready access to I/T/U services could be barred from accessing the premium tax credits and Indian-specific cost-sharing protections that would otherwise be available through an Exchange. This result could have seriously detrimental impacts on AI/AN individuals and families that are in this situation. Congress recognized this issue in developing the ACA legislation by allowing AI/AN individuals a monthly enrollment option so that AI/AN people would have access to health care coverage when leaving an I/T/U health service delivery area. This Indian-specific monthly enrollment provision was provided as many AI/AN people leave deplorable economic conditions that exist on many Indian reservations to pursue education, training and job opportunities away from reservations and, in the process, lose access to I/T/U services.

If the two components of Recommendation 2 cannot be adopted in tandem, the NIHB does not support the adoption of only component of Recommendation 2.

Currently, a medical care program operated by an I/T/U is not considered “minimum essential coverage.” In general, eligibility for minimum essential coverage, other than in the individual market, prevents an individual from accessing the premium tax credits and cost-sharing assistance offered through an Exchange.

In comments to CMS by the National Indian Health Board (NIHB) in October of 2011, NIHB concurred with CMS in *not* identifying Indian health care programs as minimum essential coverage.²⁰ Also, in response to comments from NIHB to the IRS on the proposed premium tax credit regulation (REG-131491-10), the Internal Revenue Service confirmed that eligibility for I/T/U services is not considered minimum essential coverage, and eligibility for I/T/U services would not bar I/T/U-eligible persons from

¹⁹ 78 Fed Reg 7360.

²⁰ National Indian Health Board, October 31, 2011, Comments on CMS-9974-P, *Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers Consistent with the Patient Protection and Affordable Care Act*. “Confirm and retain that health services provided by Indian Health Care Providers do not constitute government-sponsored minimum essential coverage.”

accessing the Indian-specific cost-sharing protections (or the premium tax credits and other cost-sharing protections) through an Exchange, because I/T/U services are not designated as minimum essential coverage.²¹

At the time the earlier comments were submitted by NIHB, the rationale for agreeing with CMS in not identifying I/T/U programs as minimum essential coverage was twofold: 1) AI/ANs were understood to be (or would be made to be) protected from the tax penalty under § 1501\5000A(e)(3) and so additional protections were not needed; and 2) designation of I/T/U services as “minimum essential coverage” could prevent AI/ANs from accessing the premium tax credits and cost-sharing assistance otherwise available through an Exchange as persons eligible for minimum essential coverage, except in the individual market, are generally prevented from accessing the affordability programs through an Exchange.

Due to 1) the failure to achieve an interpretation from HHS and/or IRS of the references to “Indian” under the ACA in a manner consistent with the identification of Indians for IHS eligibility and Medicaid purposes (i.e., the failure to secure a uniform operational definition of Indian for health care purposes), 2) the failure to, as of yet, secure a legislative fix, and 3) because the effective date for the tax penalty is approaching, there is a need to consider a change in course on this issue. In addition, in the final rule on premium tax credits, the IRS indicated its ability and willingness to permit eligibility for one type of minimum essential coverage to not bar an individual from accessing health insurance premium tax credits through an Exchange.²² The IRS indicated that it was able, for “administrative convenience,” to permit eligibility for veteran’s programs to not bar an individual from accessing health insurance premium tax credits through an Exchange.²³ Although the specific remedy sought for AI/ANs is not identical to that provided persons eligible for veteran’s programs, the examples are analogous. The

²¹ In the preamble to the final rule, IRS noted: “Commentators requested that the final regulations provide that individuals eligible to receive health care from the Indian Health Service (IHS) are not eligible for government-sponsored minimum essential coverage. Section 5000A(f) defines minimum essential coverage. It does not designate the IHS as providing minimum essential coverage. Section 5000A(f)(1)(E) authorizes HHS to designate other coverage as minimum essential coverage. HHS has advised the IRS and the Treasury Department that it does not intend to designate access to the IHS as minimum essential coverage. Thus, individuals who are eligible to receive health care from the IHS will not be barred by IHS access alone from eligibility for the premium tax credit or from access to the special cost-sharing reduction for tribal members under section 1402(d) of the Affordable Care Act.” (77 Fed Reg 30380.)

²² 77 Fed Reg 30377 (May 23 2012).

²³ 77 Fed Reg 30379. “B. Definition of ‘Eligible’ The proposed regulations provide that an individual is eligible for government sponsored minimum essential coverage when an individual meets the requirements for coverage under the program. For administrative convenience, however, because the standards for eligibility in veterans’ programs do not allow Exchanges to identify everyone who may be eligible for veterans’ coverage at the time he or she is seeking an eligibility determination for advance payments of the premium tax credit, the proposed regulations provide that an individual is eligible for minimum essential coverage under the veteran’s health care program authorized under chapter 17 or 18 of Title 38, U.S.C. only if the individual is enrolled in a veteran’s health care program identified as minimum essential coverage in regulations issued under section 5000A. The final regulations conform the rules to amendments to section 5000A that delete the word “veteran’s” in describing health care programs under chapter 17 or 18 of Title 38. Thus, the special rule for veterans’ coverage may apply to individuals who are not veterans but are eligible for the Civilian Health and Medical Program of the Department of Veterans Affairs (VA) or the VA’s spina bifida program.”

primary difference in the remedy sought is that under the veteran's accommodation, an individual could be eligible for the veteran's program but could not enroll in the veteran's program in order to remain eligible for premium tax credits through an Exchange.²⁴ In the case of AI/ANs, the ability to enroll in an Exchange plan, secure premium tax credits and cost-sharing protections, and continue to access I/T/U services is consistent with – and central to – the design of the Affordable Care Act as it pertains to AI/ANs. As such, AI/ANs are seeking to retain the ability to be eligible to use, and to use I/T/U services without losing eligibility for premium tax credits – or cost-sharing protections – through an Exchange.

For example, under ACA § 1402(d), AI/ANs enrolled through an Exchange are provided full cost-sharing protections when receiving services at I/T/Us whether or not the AI/ANs are eligible for or secure premium tax credits through an Exchange. Again, enrollment of AI/ANs in health plans through the individual market in an Exchange, 2) accessing the premium tax credits and cost-sharing assistance otherwise available, and 3) continuing to use I/T/U providers are central to the structure provided by Congress for AI/ANs under the Affordable Care Act, and not in conflict with the intention of Congress or the ACA.

The approach taken by the IRS for persons eligible for veteran's services and the recommended approach here (where eligibility for a medical care program of an I/T/U is designated as minimum essential coverage for purposes of protection from the tax penalty but not for determining eligibility for financial assistance through an Exchange) are even more parallel than may initially appear. Because I/T/U programs are the payer-of-last resort, coverage under an Exchange plan would be the "primary" coverage for an AI/AN person enrolled through an Exchange. The I/T/U would bill the Exchange plan for services rendered that are within the essential health benefits package and, as such, are reimbursable under the Exchange plan. Only in cases where the I/T/U provided services outside of the Exchange plan's essential health benefits package would the medical care program of the I/T/U pay for health care services for the AI/AN. In essence, in instances where an AI/AN is enrolled in an Exchange plan and therefor covered for services that are within the essential health benefits package, the AI/AN would not be enrolled in – nor eligible for – minimum essential coverage under the medical care "program" of the I/T/U because federal law requires the medical care program of an I/T/U to seek reimbursement for such services from the primary payer, which in this case is the Exchange plan.²⁵

On February 21, 2013, tribal representatives presented a recommendation on minimum essential coverage at the CMS and IRS Tribal Consultation that was held at HHS headquarters. The recommendation was:

Using the authority granted to the HHS Secretary under the Internal Revenue Code (IRC § 5000A(f)(1)(E)), designate 'Eligibility for a medical care program of the Indian Health Service, Tribe or tribal organization, or urban Indian

²⁴ From reviewing the proposed rule, it is not clear whether the person eligible for the veteran's program but who does not enroll is still able to use the health care services and providers generally available to veterans, such as the VA.

²⁵ See section 206 of the Indian Health Care Improvement Act.

organization (I/T/U)' as minimum essential coverage solely for purposes of and applicable to the exemption from tax penalties under IRC 5000A and not for purposes of determining a coverage month under IRC § 36B(c)(B)(i).

As such, the designation of eligibility for a medical care program of an I/T/U as minimum essential coverage would not change the eligibility of AI/AN persons for premium tax credits or cost-sharing assistance (under IRC § 36B(c)(B)(i)) that may be available as a result of enrollment in a qualified health plan in the individual market through an Exchange.

Recommendation 3: Electronic verification of Indian-status

We also recommend that HHS and CMS enter into discussions 1) with the TTAG and 2) through formal Tribal consultations to fashion an approach under 45 CFR § 155.350,²⁶ which is referenced in § 155.615 of this Proposed Rule, to provide electronic verification for persons eligible, as defined under 42 CFR § 447.50, to receive I/T/U services and who would, as recommended by the TTAG and others, be eligible for one or more Indian-specific exemptions from the tax penalty.²⁷ As we have indicated in prior comments, we do not believe an electronic verification source on its own is sufficient to verify the status of *all* AI/ANs who are eligible for the Indian-specific hardship exemption, and that other forms of verification must be allowed as well. However, the electronic database we describe below would provide one efficient mechanism for verifying the AI/AN status of a significant percentage of eligible persons..

The National Data Warehouse, which is maintained by the Indian Health Service, is a functional and up-to-date repository of data generated from IHS and tribal sites on persons determined eligible for I/T/U services. From the National Data Warehouse, a subset of data could be extracted to enable real-time electronic verification of IHS eligibility for purposes of confirming an Indian-specific hardship exemption or MEC exemption from the tax penalty. It is understood that the IHS-maintained National Data Warehouse would not possess the ability to verify eligibility for persons not yet in contact with the I/T/U system or those who interacted with the system prior to 2000, but it would provide verification for nearly all AI/AN persons who have recently interacted with the I/T/U system.

Providing a means for the real-time, electronic verification of Indian status for a significant percentage of AI/ANs would increase the likelihood that 1) AI/ANs (and only AI/ANs) are determined eligible for the Indian-specific benefits and protections that they are eligible to receive and 2) the verification of Indian status is accomplished without the costs and delays associated with AI/ANs re-submitting paper documentation that they previously provided to the I/T/U.

²⁶ 77 Fed Reg 18461.

²⁷ At a minimum, once established the electronic verification of Indian status could also apply to verifying eligibility for the Indian-specific cost-sharing protections under Medicaid (45 CFR § 155.350).

We anticipate that few AI/ANs will enroll in Exchange plans unless there are Indian-specific accommodations in the FFE (such as aggregate payment for Tribal Sponsorship, network adequacy standards that include I/T/U providers, an Indian Addendum for contracts, etc.) We also anticipate that a significant number of AI/ANs who do not have health insurance provided by their employer or a government program will apply for the Indian exemption for the tax penalty. The manpower and cost to the Exchanges to review documents manually to verify Indian status will be enormous. The cost to Exchanges would be cut dramatically by accessing the IHS data base. Use of the IHS data base would also reduce the cost to Tribes, which are not prepared to respond to a massive increase in inquiries for documentation of membership.

As might be evident from this recommendation to use electronic matching as one means to verify IHS beneficiary status for an Indian-specific exemption(s) as requested above, we differ with the statement made on 78 CFR 7359. The statement reads: “Further, with the exception of income, we are unaware of electronic data sources with which it would be useful to conduct data matching for purposes of eligibility for exemptions.” As noted above, an electronic data base is currently maintained by the Indian Health Service that could enable real-time electronic data matching as one source to verify eligibility for the Indian-specific hardship exemption. This data source could also be valuable as one means of verifying eligibility for the Indian-specific cost-sharing protections under Medicaid. Depending upon the outcome of the legislative change being sought on this issue, this data source might also have use as a means of verifying Indian status for the Indian-specific cost-sharing protections and the Indian-specific special enrollment periods available through Exchange-facilitated coverage, as well as the existing exemption from the tax penalty for AI/ANs (defined under IRC § 45A(c)(6)) included in the ACA.

A report is currently being drafted by the Tribal Self-Governance Advisory Committee (TSGAC) on the adequacy and potential use of the IHS data base for verification purposes. The TSGAC will be submitting the report to IHS and CMS after final reviews are completed.

It is possible that an Indian Verification Data-Mart could be established, maintained, and made accessible with minimal additional effort on the part of IHS and Tribes. This data mart could accurately identify IHS patients who meet eligibility criteria for IHS services as AI/AN individuals. An example of how one State-based Exchange is utilizing this data is in Oregon. The Cover Oregon exchange will allow Tribal health programs to upload their RPMS²⁸ or other health practice management data for the purposes of determining AI/AN eligibility for Medicaid premium and cost sharing exemptions and eligibility for ACA benefits and protections. This is the same data that is uploaded on a routine basis to the IHS National Data Warehouse. Similarly, the Alaska Medicaid program uses data matching with tribal health programs to verify AI/AN eligibility. If this process can work at the state level it only stands to reason that it will work at the national level.

²⁸ Resource and Patient Management System maintained by the Indian Health Service.

If such an electronic verification mechanism is established for purposes of verifying eligibility for an Indian-specific hardship exemption, we concur with the use of the procedures identified in § 155.330(e)(1) and (e)(2) pertaining to updated information.²⁹

Claiming the Indian exemption through an Exchange and/or tax filing process

We concur with the option provided under § 155.605(f) for AI/ANs (defined under IRC § 45A(c)(6)) to secure from an Exchange a certificate of exemption from the tax penalty *so long as it is coupled with* the provision in the regulations recently proposed by the IRS which provides an AI/AN the option of claiming their exemption from the tax penalty by including information with their Federal income tax return (if required to file a tax return.)³⁰ The ability to file for the exemption during tax filing process is key, particularly in the early years of implementation. Many AI/ANs will not learn of their obligation to secure MEC or to file for an exemption until notified after the coverage year ends – during the tax filing process.

We recommend that CMS apply a similar approach for AI/ANs to claim the Indian-specific hardship exemption through an Exchange. In addition, in comments to be filed in response to REG-148500-12, the NIHB will be recommending to the IRS that a parallel option be established for claiming the Indian-specific hardship exemption with an individual's Federal income tax return. We recognize that individuals meeting the existing hardship exemptions in the Proposed Rule are not provided an opportunity to file for the hardship exemption through the tax filing process, and this policy may be carried over to an Indian-specific hardship exemption. The potential lack of an ability to file for a hardship exemption after the year's end through the tax filing process is a key reason the we are recommending that Recommendation 2: “a medical care program of an I/T/U” be established as MEC and, thereby, an AI/AN meeting the broader definition of Indian would be able to file for the exemption post year-end in the tax filing process.

Duration of exemption

We concur with the approach taken on the duration of the exemption from the tax penalty for AI/ANs under § 155.605(f)(2). The Proposed Rule provides that the exemption is provided on a “continuing basis, until such time that the applicant reports that he or she no longer meets the standards provided in § 155.605(f)(1).”

In the recommendation above whereby 1) “Indians, as defined under 42 CFR § 447.50” are added as a hardship exemption and 2) “a medical program of an I/T/U” is designated as MEC for purposes of IRC § 5000A (but not IRC § 36B), we request that a similar approach to duration be applied.

Cross-populating applications

²⁹ On page 78 Fed Reg 7359, CMS solicited comments as to whether an Exchange should handle changes which are identified through an electronic data matching process that is used for verification of eligibility for exemptions from the tax penalty in a similar manner as that specified in 45 CFR 155.330.

³⁰ See 78 Fed Reg 7322, February 1, 2013.

The NIHB concurs with the proposal in § 155.610(c) wherein “if an individual submits the application in 45 CFR 155.405 (pertaining to the single streamlined application for Exchange-facilitated coverage) and then requests an exemption, the Exchange must use the information collected on the application for coverage and not duplicate any verification processes that share the standards specific in this subpart.”³¹

In comments recently filed by the NIHB in response to CMS-10440-P (regarding the single streamlined application form), we recommended that information on Indian status be consistently obtained across the various application forms. In part, this was recommended so that, consistent with the proposed § 155.610(c), AI/ANs would be determined eligible for Indian-specific benefits and protections without having to duplicate verification processes.

As shown in Attachment B,³² the information requested on the single streamlined application (as indicated in CMS-10440) corresponds to both the definition of Indian as it is being applied under IRC § 45A(c)(6) and to who is eligible for IHS services. The information gathered on eligibility for I/T/U services could subsequently be used to establish eligibility for a hardship exemption, if such an exemption is established pursuant to these comments.

We encourage CMS to enable cross-population of data fields, as appropriate, to minimize administrative costs and to maximize timely determinations of eligibility. And, as indicated above, we encourage CMS to facilitate the real-time verification of Indian status through electronic data matches, whenever possible.

PART II – OTHER FAMILY MEMBER HARDSHIP EXEMPTION

Even when the issues addressed in Part I of these comments are resolved, through response to these comments or in permanent legislation, there will still be a need for an additional hardship amendment for certain individuals who are family members of Indians, but who are themselves not Indian (regardless of the definition used.) Pursuant to § 813(a) and (b) of the Indian Health Care Improvement Act (IHCIA)³³ certain members of the family of an AI/AN are entitled to health services of the IHS. These are principally children who include all individuals who are under age 19 years, and are “the natural or adopted child, step-child, foster child, legal ward, or orphan of an eligible Indian,” even if they are not themselves Indian. Such a child shall be eligible for all health services provided by the

³¹ 78 Fed Reg 7356.

³² See Attachment B for a screen shot of the section of the proposed single streamlined application form that pertains to AI/AN eligibility.

³³ Pub. L. 94-437, as amended, codified at 25 U.S.C. § 1680c(a) and (b).

[Indian Health] Service on the same basis and subject to the same rules that apply to eligible Indians until such individual attains 19 years of age.³⁴

A child of an Indian may not themselves be “Indian” under many different circumstances. The most obvious examples are non-Indian children adopted by an Indian family and children of a non-Indian spouse who become the step-children of an Indian parent. More commonly though, this situation may arise in tribes in which enrollment cannot occur prior to reaching adulthood, or in those that have blood quantum requirements that tie only to the specific tribe or that are based on matrilineal or patrilineal descent and the children have been born of parents both may be AI/ANs, but are not members of the same tribe.

We recommend a hardship exemption be allowed for individuals who are eligible for services of IHS pursuant to 25 U.S.C. § 1680c(a) or (b).³⁵ We make this recommendation out of respect for the importance of families treating each member equally. We are concerned about the unintended consequences that could result if an adopted or step-child who is non-Indian is the cause of an Indian family being charged tax penalties even though this child, like all the Indian children in the family, is able to use Indian health programs to obtain his or her health care. We are confident that the numbers of children in this situation are small and granting a hardship exemption will have little impact on the revenue of the Treasury. However, imposing a penalty on a family would certainly be significant to that family and might be devastating to the way in which each member of the family is treated.

While each of these provisions reference only services provided by the Indian Health Service, they are applicable to the tribal health programs that assume programs from the Indian Health Service under the Indian Self-Determination and Education Assistance Act (ISDEAA).³⁶ Although tribes that assume programs of Indian Health Service have considerable authority to reallocate and redesign the programs to meet their own tribal needs, there are limits. Under the self-determination provisions of Title I of the ISDEAA, a tribe may not redesign without Indian Health Service approval and may only reallocate funds if doing so “would not have an adverse effect on the performance of the contract.”³⁷ The requirement is even more clearly stated in Title V regarding self-governance where redesign and

³⁴ 25 U.S.C. § 1680c(a). And, in fact, entitlement to health services continues past 19 years if the child was “determined to be legally incompetent” before reaching 19 years old, in which case “such remain eligible for such services until 1 year after the date of a determination of competency.” *Id.*

³⁵ The new hardship exemption would appear as § 155.605.(g)(7). Subsection (b) of 25 U.S.C. § 1680c provides for services to a non-Indian spouse, but only under very limited circumstances that arise rarely in Indian country.

Any spouse of an eligible Indian who is not an Indian, or who is of Indian descent but is not otherwise eligible for the health services provided by the Service, shall be eligible for such health services if all such spouses or spouses who are married to members of each Indian tribe being served are made eligible, as a class, by an appropriate resolution of the governing body of the Indian tribe or tribal organization providing such services.

³⁶ Pub. L. 93-638, as amended, codified at 25 U.S.C. § 450 *et seq.*


³⁷ 25 U.S.C. § 450j-1(o).

reallocation are permitted provided they do “not have the effect of denying eligibility of services to population groups otherwise eligible to be served under applicable Federal law.”³⁸

Indian families that include individuals entitled to health services of an Indian Health Service or tribal health program under these provisions should be exempt from tax penalties or treated as if they have minimum essential coverage for all the family members in so far as it prevents the application of a tax penalty.

Thank you once again for providing an opportunity to comment on the Proposed Rule. Please contact Jennifer Cooper, jcooper@nihb.org if you would like to discuss the issues addressed in this comment.

Sincerely,



Cathy Abramson

Chairman, National Indian Health Board

Cc: Marilyn Tavenner, Acting Administrator, CMS
Gary Cohen, Director, Center for Consumer Information and Insurance Oversight
Kitty Marx, Director of Tribal Affairs, CMS
Dr. Yvette Roubideaux, Director, IHS
Stacy Bohlen, Executive Director, NIHB

³⁸ 25 U.S.C. § 458aaa-5(e). *See also*, 42 C.F.R. § 137.185.

**ATTACHMENT A: EXEMPTIONS FROM THE REQUIREMENT TO MAINTAIN MEC AND
EXEMPTIONS FROM TAX PENALTIES FOR NOT MAINTAINING MEC**

Category of Exemption ³⁹	Method to Claim Exemption		Code Section	Reg Section	Notes:
	Exchange Certification ⁴⁰	Tax Filing Process ⁴¹			
Exemptions Identified in ACA					ACA §1501\5000A(d) & (e)
Religious Conscience	✓	No	IRC § 5000A(d)(2)(A)	§ 1.5000A—3(a); § 155.605(c)	
Health Care Sharing Ministry	✓	✓	IRC § 5000A(d)(2)(B)	§ 1.5000A—3(b); § 155.605(d)	
Not Lawfully Present	No	✓	IRC § 5000A(d)(3)	§ 1.5000A—3(c)	IRS PR does not identify a process for claiming this exemption.
Incarcerated	✓	✓	IRC § 5000A(d)(4)	§ 1.5000A—3(d); § 155.605(e)	
Individual with No Affordable Coverage	No	✓	IRC § 5000A(e)(1)	§ 1.5000A—3(e)	Actual income for the year. Special rules for employees' "related individuals". (78 Fed Reg 7320.)
Individual Below Tax Filing Threshold	No	✓	IRC § 5000A(e)(2)	§ 1.5000A—3(f)	Actual income for the year
Indian (IRC 45A)	✓	✓	IRC § 5000A(e)(3)	§ 1.5000A—3(g); §155.605(f)	
Short Coverage Gap	No	✓	IRC § 5000A(e)(4)		
Hardship	✓	No	IRC §5000A(e)(5) and ACA §1311(d)(4)(H)	§ 1.5000A—3(h); § 155.605(g)	

³⁹ “The term ‘applicable individual’ is used in section 5000A to describe an individual who is subject to the minimum essential coverage provision under section 5000.*** Although the two categories are distinct in the statute, the consequence for individuals described in either category is the same: individuals in both categories are not subject to the shared responsibility payment for not maintaining minimum essential coverage.” (78 Fed Reg 7318-9.)

⁴⁰ 78 Fed Reg 7369 lists the exemption categories and the process (as proposed by CMS) for claiming the exemption.

⁴¹ 78 Fed Reg 7322 lists the exemption categories and the process (as proposed by the IRS) for claiming the exemption.

Category of Exemption ³⁹	Method to Claim Exemption		Code Section	Reg Section	Notes:
	Exchange Certification ⁴⁰	Tax Filing Process ⁴¹			
Hardship Exemptions Proposed by HHS Secretary (under IRC §5000A(e)(5) and ACA §1311(d)(4)(H))					CMS-9958-P (78 Fed Reg 7368)
Unexpected increased in expenditures	✓	No		§ 155.605(g)(1)	
Unable to afford coverage	✓	No		§ 155.605(g)(2)	Using projected annual household income.
Gross income below the filing threshold	✓	No		§ 155.605(g)(3)	
Not eligible for Medicaid bc State didn't expand Medicaid (§2001(a))	✓	No		§ 155.605(g)(4)	
Unaffordable "affordable" employer coverage	✓	No		§ 155.605(g)(5)	
<i>Indian, as defined in 42 CFR § 447.50</i>	✓	✓		§ 155.605(g)(6)	
<i>Eligible for services of IHS under 25 U.S.C. § 1680c(a) or (b)</i>	✓	✓		§ 155.605(g)(7)	

Attachment B: Questions on CMS Proposed Single Streamlined Application Pertaining to Status as an AI/AN (CMS-10440-P; 78 Fed Reg 6109)

STEP 4

Is anyone in your family American Indian or Alaska Native (AI/AN)?

No, nobody in my family is American Indian or Alaska Native. If no, skip to Step 5 on the next page.

Yes. If yes, continue.

American Indians and Alaska Natives who enroll in Medicaid, the Children's Health Insurance Program (CHIP), and the Marketplace can also get services from the Indian Health Services, tribal health programs, or urban Indian health programs.

If you or your family members are American Indian or Alaska Native, you may not have to pay cost sharing and may get special monthly enrollment periods. We are asking you to answer the following questions to make sure you and your family get the most help possible.

NOTE: If you need more space please attach another piece of paper.

	AI/AN PERSON 1		AI/AN PERSON 2		AI/AN PERSON 3	
Name (First Name, Middle Name, Last Name)	First	Middle	First	Middle	First	Middle
	Last		Last		Last	
Member of a federally recognized tribe? If yes, give the name of the tribe.	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No
Did this person ever get a service from the Indian Health Service, a tribal health program, or urban Indian health program or through a referral from one of these programs? If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs or through a referral from one of these programs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No