

National Indian Health Board



Submitted via: <http://www.regulations.gov>

July 12, 2017

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9928-NC
P.O. Box 8016
Baltimore, MD. 21244-8016

**RE: Request for information regarding the Patient Protection and Affordable Care Act:
Reducing Regulatory Burdens and Improving Health Care Choices to Empower Patients
(CMS-9928-NC)**

Dear Administrator Verma:

On behalf of the National Indian Health Board (NIHB), I write to submit comments on the request for information, published in the Federal Register on June 12, 2017, titled *Reducing Regulatory Burdens Imposed by the Patient Protection and Affordable Care Act & Improving Healthcare Choices to Empower Patients* (CMS-9928-NC).

Established in 1972, the 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 (AI/ANs). The 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 the 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, the NIHB is their advocate.

Background

Since the earliest days of the United States, all branches of the federal government have acknowledged the nation's obligations to the Tribes and the special trust relationship between the United States and American Indians and Alaska Natives. The United States assumed this responsibility through a series of treaties with Tribes, exchanging compensation and benefits for Tribal land and peace. The Snyder Act of 1921 (25 U.S.C. 13) legislatively affirmed this trust

responsibility. As part of upholding its responsibility, the federal government created the Indian Health Service (IHS) and tasked the agency with providing health services to AI/ANs.

American Indians and Alaska Natives are among the nation's most vulnerable populations, and yet the IHS remains woefully underfunded. IHS is currently funded at around 60% of need,¹ and average per capita spending for IHS patients is only \$3,688 compared with \$9,523 nationally.² Most of our citizens live in areas of chronic unemployment, which leaves many of them without any form of coverage other than Medicare and Medicaid, and until recently, Marketplace coverage. Without supplemental Medicaid and insurance resources, the Indian health system would not survive.

In 2010, with the creation of the federally facilitated marketplace in the Patient Protection and Affordable Care Act (ACA), Congress included important and critical cost-sharing protections for AI/ANs in fulfillment of the federal trust responsibility to provide health care to Indians. These cost-sharing protections incentivize AI/ANs to sign up for health insurance, making it affordable. Marketplace coverage has proven to be a critically important resource for IHS and Tribal health systems. The funding it has provided has helped extend scarce IHS discretionary appropriations, including Purchased/Referred Care (PRC) funding. PRC funding is used to cover the cost of care by providers outside the IHS system when an IHS or Tribal facility cannot provide the service itself. Marketplace coverage helps extend PRC funding, which otherwise routinely runs out before the end of the year. In addition, marketplace coverage has increased revenues at I/T/Us that are being reinvested back into both the Indian and the larger national health care system.

Affirming the traditional regulatory authority of the States in regulating the business of health insurance

We support reforms that will increase State flexibility in working with Tribes to make Medicaid and Marketplace insurance more effective at addressing the country's most vulnerable populations, including Indian country. The United States has a trust and treaty based responsibility to provide access to health care for American Indians and Alaska Natives, and that responsibility includes ensuring access to federal health programs like Medicaid and the federally facilitated marketplace. Improvements to the regulatory authority of states, therefore, should move forward in a manner that respects Tribal sovereignty and upholds Federal treaty and trust responsibilities.

Tribes understand the need for States to regulate the business of health insurance in the manner that makes the best sense for the populations they serve, but Tribal health programs must have room to do the same for their citizens. Like States facing federal mandates, Tribes are often confronted with State requirements that may make perfect sense for their citizens, but fail to account for the unique attributes of the Indian health system. Like States, Tribal governments are in the best position to address the unique needs of their citizens and the Indian health system that serves them. We hope to be able to work with you to achieve a result where Tribal programs can work with States to adapt regulatory authority to their own needs without interfering with or delaying State goals and priorities and without shifting the federal trust responsibility to provide healthcare from the federal government to the states.

¹ See Indian Health Service, Frequently Asked Questions, <https://www.ihs.gov/forpatients/faq/>.

² Indian Health Service, IHS 2016 Profile, <https://www.ihs.gov/newsroom/factsheets/ihsprofile/>.

Indian Tribal governments are indigenous governments that possess a unique government-to-government relationship with the United States. Indian Tribes are part of the constitutional structure of government. Tribal authority was not created by the Constitution—Tribal sovereignty predated the formation of the United States and continued after it (Article 1, Section 8, Clause 3 of the U.S. Constitution). “*Indian relations are ... the exclusive province of Federal law.*” (County of Oneida v. Oneida Indian Nation, 470 U.S. 226, 234 (1989), making the unique status of Indian Tribes and the government-to-government relationship with the Federal Government clear.

The U.S. Supreme Court has repeatedly recognized Tribal sovereignty in court decisions for more than 150 years. In 1831, the Supreme Court agreed, in Cherokee Nation v. Georgia, that Indian nations had the full legal right to manage their own affairs, govern themselves internally, and engage in legal and political relationships with the federal government and its subdivisions. In 1942 Supreme Court Justice Felix Cohen wrote, “*Indian sovereignty is the principle that those powers which are lawfully vested in an Indian tribe, are not delegated powers granted by express acts of Congress, but rather inherent powers of a limited sovereignty which can never be extinguished.*” Tribal governments’ special political status is not that of a racial or ethnic group, nor are they associations or affiliations. Accordingly, the federal government has a duty to consult with Indian Tribes on federal policies with implications for the Indian health care delivery system. This consultation requirement, rooted in Tribal sovereignty, treaty rights, the government-to-government relationship, and the Trust responsibility, is reflected in federal policy and is confirmed in the HHS Tribal Consultation Policy.

Any proposed rule changing the regulatory authority of states to regulate the business of health insurance has the potential to significantly impact AI/AN access to health insurance and I/T/U program reimbursement. It is critical that CMS work directly with the NIHB and other Tribal entities to ensure that any proposed rule reflects suggestions from Indian Country about minimizing any disruption for individual AI/ANs or Tribes as a whole.

Accordingly, the NIHB reminds CMS of the need for meaningful Tribal consultation concerning any proposed rule or change in policy which CMS recognizes “has Tribal implications” and is subject to the CMS Tribal Consultation Policy.³ In addition, the states must consult with Tribes prior to any change or proposal to change their regulatory authority that has Tribal implications. We believe that this is necessary in order to ensure that AI/ANs may continue to access the federally facilitated marketplace in a meaningful way and to ensure continued critical third party revenue for Tribal health programs.

Protect existing Indian benefits and protections because they support AI/AN enrollment and Indian health provider participation. Stabilize markets by encouraging enrollment

Providing for Indian health care is a federal responsibility based on the United States’ treaty and trust obligations and the unique, government-to-government relationship between Indian tribes and the federal government expressly affirmed by the Congress. In approaching health care reform, it is critical that Congress act to protect and preserve Indian health care. Furthermore, there are a

³ 80 Fed. Reg. at 31,168.

number of provisions within the ACA separate from the Indian Health Care Improvement Act (IHCIA) that have significant implications for the Indian health system and that the NIHB requests to be preserved in order to provide quality health care services in Indian Country. Those include, but may not be limited to:

Support the Indian Health Care Improvement Act

The Indian Health Care Improvement Act (IHCIA), 25 U.S.C. Chapter 18, is the foundational legislation governing the Indian health care system. In 2000, IHCIA's authorization expired, and in 2010 IHCIA was permanently enacted by cross-reference in Section 10221 of the ACA. Although the ACA was the legislative vehicle through which the IHCIA was passed, the IHCIA predates and is independent from the ACA. CMS should ensure all regulations uphold the many protections and provisions within the IHCIA.

Safeguard Indian-specific Provisions of the Affordable Care Act

In addition to permanently reauthorizing the IHCIA, the ACA contained several crucial Indian-specific provisions unrelated to the rest of the ACA, and these provisions must be safeguarded as reform moves forward. These provisions include Section 2901, which makes Indian health programs the payer of last resort; Section 2902, which allows the Indian Health Service (IHS) permanent authority to bill Medicare Part B; and Section 9021, which excludes Indian health benefits from taxation.

Preserve Cost-Sharing Protections for AI/ANs

The important and critical cost sharing protections for AI/ANs that have incomes at or below 300% of the federal poverty level or through referral by the IHS Purchased/ Referred Care (PRC) program are of utmost importance in increasing enrollment of AI/ANs into health insurance. These cost-sharing protections make health insurance affordable for AI/AN people. Eliminating them would also have a destabilizing effect on the Indian health system. CMS must ensure all regulations uphold and reinforce these special protections and provisions.

Special Enrollment Periods (Section 1311)

Section 1311(c)(6) of the Affordable Care Act (ACA) establishes enrollment periods, including special enrollment periods (SEP) for qualified individuals, for enrollment in the Qualified Health Plans (QHPs) through an Exchange. Special enrollment periods exist to ensure that individuals who lose health coverage during the year or who experience other qualifying life events such marriage or the birth or adoption of a child) can enroll in a QHP outside of the open enrollment period for 60 days (30 days for employment-based health plans). Special enrollment periods are an important consumer protection to ensure access to health insurance. Under the ACA, AI/ANs (as defined in section 4 of IHCIA) are able to enroll in health coverage through the Marketplace any time of the year. AI/ANs qualify for monthly special enrollment periods (M-SEPs); therefore AI/ANs are able to enroll in health coverage through the Marketplace as often as once per month. At the request of Tribes and Tribal organizations, CMS extended the monthly special enrollment periods (M-SEP) to the family members of AI/ANs who meet the definition of Indian under the ACA, if the family

members enroll in the Marketplace coverage along with the AI/AN individual. We ask that CMS protect and maintain this provision.

Exemptions (Section 1501)

Section 1501 of the ACA exempts members of Indian Tribes from the shared responsibility penalty for failure to comply with the requirement to maintain minimum essential coverage. The consideration of IHS as minimum essential coverage is crucial for Tribal members to have access to quality health care and not be subject to penalties.

Payer of Last Resort (Section 2901)

Section 2901 of the ACA establishes that I/T/U providers are the payers of last resort for services provided to Indians by I/T/U for services provided through such programs. The statutory clarification reduces and/or eliminates disputes with other payers, such as Medicaid or private insurers.

Tax Exclusions for Health Benefits (Section 9021)

Section 9021 of the ACA excludes the values of health benefits provided or purchased by the Indian Health Service, tribes, or tribal organizations from gross income. Section 9021 added Section 139D to the tax code to make the value of health benefits provided by a Tribe to its members not includable as taxable income. This tax break is important both because it respects the trust responsibility and Tribal sovereignty, and also because it keeps more money in people's pockets.

Elimination of Sunset for Reimbursement for all Medicare Part B Services Furnished by Certain Indian Hospitals and Clinics (Section 2902)

IHS had been collecting reimbursements for selected services from Medicare Part B, but the language allowing this had a sunset clause. Section 2902 removed the sunset clause and saved the IHS funds that are sorely needed. Repealing this section would cut off a critical revenue stream and lessen IHS's ability to provide health services. We recommend that CMS make permanent reimbursement for all Medicare Part B services furnished by Indian health hospitals and clinics.

Quality Measures Related to Chronic Disease

The Indian health care system currently reports on a number of quality measures, one example being those required under the Government Performance and Results Act (GPRA). Quality measures for providers overall should align with these measures to eliminate duplication and limit the administrative burden on I/T/U providers. Additionally, baseline measures for these providers need to take into account that populations served by the I/T/U system are not currently included in statewide baseline data and health outcomes and status are statistically different for this population.

Tighter Restrictions on Premium Payment Grace Periods

Requirements related to premium payment for past months of non-payment when an individual re-enrolls in a plan must exempt the Tribal Sponsorship program to ensure Tribes are not restricted in helping individuals access coverage through this program. Insurer processes regarding invoicing and covered lives rosters should be evaluated alongside these changes to ensure the timing of payments and continuation of coverage are reasonable. In addition, for individuals, payment of past month's premiums should include a limit to avoid the amount in arrears becoming a permanent barrier to re-enrollment.

Advance Premium Tax Credit (APTC) and Cost Saving Reduction (CSR) Eligibility and Distribution

If eligibility for advanced premium tax credits (APTCs) is shifted to 0-300% of the FPL, the net cost of premiums that Tribal Sponsorship program is providing would be impacted. This shift could potentially result in cost savings for the program, as many sponsored individuals have incomes below 100% of the FPL. Eligibility for APTC should reconsider current exclusions under the ACA. For instance, in current law, if insurance is offered by the employer, affordability is based on only the employee premium cost -- not the cost for insurance for the employee's spouse and/or children. The employee-only cost is often less than the 9.5% threshold, however, the costs for the family is significantly higher, often resulting in a decision to decline coverage. In order to facilitate coverage, families should be eligible for APTC in these instances.

Assuming that AI/AN continue to be exempted from all cost sharing as provided in section 1402(d), we recommend that consideration would need to be given to distribution of cost saving reductions (CSR) to a consumer health account.

Consumer Health Accounts

The administration of consumer health accounts needs to consider the current Tribal Sponsorship program operations and ensure that the program can continue to support access to coverage for the AI/AN population. Tribal Sponsorship programs currently have assurance that the federal portion of the premium payment has been made on behalf of the individual and that the Tribal contribution completes the total payment. This ensures the individual receives health insurance coverage. The consumer health account should also provide direct payments to insurers, continuing the assurance to Tribal Sponsorship programs that insurance coverage is paid in full. Enrollment and purchasing insurance should be a prerequisite to access the consumer health account. Insurers must contract with I/T/Us using the CMS Model Indian Addendum to ensure that service provision is not interrupted, as well as utilizing the encounter rate as the payment rate to I/T/U providers.

Essential Health Benefits

The Essential Health Benefits required to be included in Qualified Health Plans (QHPs) should retain Preventive Health and Behavioral Health Services, which are high priorities for Tribes. The Indian health system is a very comprehensive system of care, and I/T/Us provide these services as well as public health in addition to clinical services. There is strong research support that investments in Preventive Health and Behavioral Health result in better health outcomes.

100% Federal Medical Assistance Percentage (FMAP)

The responsibility for Indian health care must remain with the federal government, rather than passing this obligation on to the states. In 1976, Congress amended Section 1905(b) of the Social Security Act to provide for a 100% Federal Medical Assistance Percentage (FMAP) for Medicaid. This ensures that the federal government pays 100% of the Medicaid costs for AI/ANs rather than draining state Medicaid funds. In early 2016, CMS issued a policy which interprets the 100% FMAP policy to include any services provided from a referral issued by an Indian Health Care Provider. We recommend that CMS ensure 100% FMAP is honored in any and all Medicaid reform efforts and regulations, etc.

Indian Health Care Provider payments exempt from Medicaid caps

Medicaid is an important tool through which the federal government works to fulfill its trust and treaty responsibility to provide for Indian health care. Exempting services received through an Indian Health facility from statewide caps is critically important, but not enough to protect IHS and Tribal programs from state limitations on eligibility or services that may result from capping Medicaid funds. The United States funds Medicaid reimbursements to States at 100 percent FMAP, and capping Medicaid services for AI/AN's regardless of need is fundamentally inconsistent with fulfillment of the trust responsibility and Congress' intent in authorizing the Indian health system to access Medicaid resources.

We recommend that CMS consider a mechanism to exempt reimbursements for services provided in and through an Indian health care facility from any state limitations on eligibility or services that may result from Medicaid caps. Such reimbursements would be covered by 100% FMAP and therefore will not affect state budgets.

Medicaid Eligibility Requirements

If states seek to impose eligibility requirements that are not consistent with the federal trust responsibility then CMS should ensure those requirements do not apply to the AI/AN population in the state. Not only are they inconsistent with the federal trust responsibility they simply don't work in Indian country because AI/AN's are eligible and have access to Indian health services, and will simply elect not to enroll in Medicaid and fall back on the already underfunded IHS.

Support State Flexibility While Preserving Tribal Rights

State flexibility is an important part of the Medicaid program. However, important existing Tribal protections in the Medicaid program must be preserved. These include:

An AI/AN who is eligible to receive or has received an item or service from an Indian health care provider or through referral under Contract Health Services (CHS) is exempt from Medicaid premiums or cost sharing (such as deductibles and copayments) if the items or services are furnished by an I/T/U or through referral under CHS. SSA § 1916(j)(1)(A); 42 U.S.C. § 1396o(j)(1)(A).

Payment to I/T/U providers cannot be reduced by the absence of copays or premiums from an AI/AN patient. SSA § 1916(j)(1)(B); 42 U.S.C. § 1396o(j)(1)(B).

A state is prohibited from classifying trust land and items of cultural, religious or traditional significance as “resources” for purposes of determining Medicaid eligibility for AI/ANs. SSA 1902(ff)(1)-(4); 42 U.S.C. § 1396a(ff)(1)-(4).

Certain income and resources (including interests in or income from trust land or other resources) are also exempt from Medicaid estate recovery. SSA § 1917(b)(3)(B); 42 U.S.C. § 1396p(b)(3)(B).

If an AI/AN elects to enroll in an MCO, they are allowed to designate an Indian health care provider as their primary care provider if in-network. SSA § 1932(h)(1); 42 U.S.C. § 1396u-2(h)(1).

An Indian health care provider must be promptly paid at a rate negotiated between the MCO and provider, or at a rate not less than the amount an MCO would pay to a non-Indian health care provider. SSA § 1932(h)(2)(A)-(C); 42 U.S.C. § 1396u-2(h)(2)(A)-(C).

If the MCO pays the Indian health care provider less than what the Indian health care provider would be paid under the State plan (the encounter rate), then the State must make up the difference in a wraparound payment to the Indian health care provider. SSA § 1932(h)(2)(C)(ii); 42 U.S.C. § 1396u-2(h)(2)(C)(ii).

Definition of Indian Inconsistency

Although the Affordable Care Act contains several beneficial provisions for AI/ANs, including permanent reauthorization of the Indian Health Care Improvement Act, the ACA contains definitions of the word “Indian” that are not consistent with the definition used for delivery of other federally supported health services to AI/ANs under Medicaid, the Children’s Health Insurance Program (CHIP), and the Indian Health Service (IHS). These definitions are narrower than those used by IHS and CMS, thereby leading to conflicting interpretations of eligibility for benefits and requirements for coverage under the ACA’s cost sharing (ACA §1402(d) and 2901(a)/ 42 USC § 18071(d), special enrollment (ACA §1311(c)(6)(d)/ 42 USC§ 18031(c)(6)), and tax penalty provisions (ACA §1501e(3) /Internal Revenue Code at 26 USC § 5000A(e)(3)). This issue has led to leaving out a sizeable population of AI/ANs that the ACA was intended to benefit and protect. We were happy to see the language contained in the FY 2015 Explanatory Statement that requested that CMS and the Internal Revenue Service write a report detailing these varying definitions. We believe that CMS and IRS also have the authority to adjust this through regulatory means.

Under the ACA, only members of federally recognized Tribes and shareholders in Alaska Native regional or village corporations who purchase coverage through a state or federal Marketplaces are eligible to receive special protections and some exemptions from cost sharing. This definition of “Indian” is narrower than the definition used by IHS, Medicaid and CHIP⁴, leaving out a significant

⁴ The definition of “Indian: used by IHS, Medicaid, and CHIP is found in 42 CFR § 447.51. Indian means any individual defined at 25 USC 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR §136.12. This means the individual:

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

population of AI/ANs that the ACA was intended to benefit and protect. Limiting the AI/AN individuals that are eligible for these benefits because of a technical error in the ACA has created a class of “sometimes Indians” who qualify for IHS services and Medicaid cost-sharing waivers, but not for Exchange cost-sharing waivers. Congress certainly intended to include all IHS-eligible AI/ANs in the category for cost-sharing protections.

AI/ANs affected by the ACA’s inconsistent definitions include California Indians who are entitled to IHS and Medicaid services as Indians, but who are not treated as Indian under the ACA. Additionally, many young Alaska Natives are not treated as Indian under the ACA because they are not shareholders in ANCSA corporations that stopped enrolling new members in the 1970s, or they are too young to have enrolled in an ANCSA corporation and have yet to become shareholders. By using the same definition of “Indian” for all federally-funded health programs that rely on the same streamlined application (i.e., Medicaid, CHIP, and state and federal exchanges) and for avoiding ACA tax penalties, all AI/ANs will be treated equally consistent with the federal government’s trust responsibility, as well as improve their access to all available health programs. The U.S. Department of Health and Human Services (HHS) has determined it does not have the administrative authority to align the inconsistent definitions under the ACA and that a legislative fix is necessary. The Center for Consumer Insurance Information and Oversight (CCIO) determined that the two exchange-related definitions (for exchange cost-sharing and enrollment protections) “operationally means the same thing,”⁵ but citing the legislative text of the ACA have declined to issue a clarifying regulation.

Tribes have been requesting that this issue be fixed legislatively in order to allow the law’s benefits be given to those who Congress intended. AI/AN national and regional organizations support the implementation of all Indian-specific ACA provisions using the Medicaid definition of “Indian” for all federally-funded health programs. Resolutions to this effect were adopted by the National Indian Health Board, National Congress of American Indians, and the Tribal Technical Advisory Group to CMS (TTAG).

One of the legislative proposals sought by IHS in the FY 2017 IHS Congressional Budget Justification was a consistent definition of “Indian” in the ACA⁶. The Budget proposed to standardize ACA definitions to ensure all AI/ANs would be treated equally with respect to the Act’s coverage provisions, including access to qualified health plans with no cost sharing.

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- (i) Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendent, in the first or second degree, of any such member;
 - (ii) Is an Eskimo or Aleut or other Alaska Native;
 - (iii) Is considered by the Secretary of the Interior to be an Indian for any purpose; or
 - (iv) Is considered to be an Indian under regulations promulgated by the Secretary;
- (3) Is considered by the Secretary of the Interior to be an Indian for any purpose; or
- (4) 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.

⁵ Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers. Federal Register / Vol. 77, No. 59 / Tuesday, March 27, 2012 / Rules and Regulations, page 18346.

⁶ FY 2017 Indian Health Service Congressional Budget Justification, pages 231-233.

In October 2015, Senator Lisa Murkowski introduced S.2441- “A bill to correct inconsistencies in the definitions relating to Native Americans in the Patient Protection and Affordable Care Act”. The bill was read twice and referred to the Committee on Finance, where it was never heard or acted upon. A related bill, H.R.5475 – “Health Equity and Accountability Act of 2016”, was introduced in the House in June 2016 by Congresswoman Robin Kelly. H.R.5475 has failed to progress after being referred to various subcommittees in June and September of 2016. Since at least 2012⁷, HHS has stated that it “is providing technical assistance to Congress regarding alignment of these definitions.” These efforts have failed. In order to fulfill its trust responsibility to AI/ANs, HHS must now either reconsider its own interpretation of its “regulatory flexibility” or double down on its efforts to ensure a legislative fix.

Zero and Limited Cost-Sharing Plan Variations

NIHB requests that CMS simplify the Family Plan and Provisions for Indians. We recommend that CMS/DHHS stop penalizing families that are composed of Natives and non-Natives by requiring them to enroll in two or more qualified health plans which raises their out-of-pocket expenditures and begin allowing a whole family to enroll in one family plan, which includes one person who is eligible for Indian-specific cost sharing reductions, and all receive the same cost sharing reduction as the person with Indian status.

A regulatory decision was made in the first year (2013) of the Affordable Care Act implementation that everyone on a family plan would get the least generous cost sharing reduction that anyone qualified to receive. At the time, the CMS TTAG challenged this approach, but because of a computer limitation, CMS said it would revisit in a couple of years. The NIHB is supporting TTAG again making this recommendation to revise the policy:

If a family plan includes one person who is eligible for Indian-specific cost sharing reductions, then others who are in the tax-filing unit who are eligible for the Indian Health Service will get the same cost sharing reduction as the person with Indian status.

American Indian and Alaska Native Enrollment Assisters

Enrollment assisters play a key role in Indian Country to empower patients and promote consumer choice. Enrollment assisters include Certified Application Counselors (CACs), Navigators and Patient Benefits Coordinators (PBCs) who are on-site at Indian Health Service clinics, Tribal health facilities, and Urban Indian Organizations (I/T/U) to assist American Indian and Alaska Natives (AI/AN) with enrolling in healthcare coverages through the Marketplace or other government programs such as Medicaid, Medicare, and the Children’s Health Insurance Program (CHIP). Federal regulations at 45 CFR § 155.205(d) and (e) provide that each Exchange must conduct consumer assistance, outreach, and education activities, including the Navigator program, to educate consumers about the Exchange and insurance affordability programs and to encourage participation Establishing a non-Navigator consumer assistance program pursuant to § 155.205(d) and (e) will help ensure that the Exchange is providing outreach, education, and assistance to as

⁷ Department Of Health And Human Services Centers for Medicare & Medicaid Services Center for Consumer Information and Insurance Oversight. “Exchange Final Rule: Indian Provisions” presentation at the Health Insurance Exchange System-Wide Meeting, May 21-23, 2012.

broad a range of consumers as possible so that all consumers can receive help when accessing health insurance coverage through an Exchange. The Navigator Grant Programs are required by section 1311(i) of the Affordable Care Act. On January 22, 2013 CMS issued a proposed rule at 78 F.R. 4593 introducing a separate class of certified application counselors, such as community health centers, health care providers and entities, and community-based organizations, to assist consumers with enrolling in coverage through the Marketplace. The Enrollment Assisters are on the front line in Indian Country connecting American Indians and Alaska Natives to health care coverage resources and services.

Outreach and Education occurred in many other fields before the Patient Protection and Affordable Care Act (ACA), including health benefits outreach. Enrollment assisters do a significant amount of work in Tribal communities to connect consumers to care and create networks specific to Tribal needs for understanding and accessing health resources. The Outreach and Education/Assister entities are crucial for Indian Country and should continue regardless of the changes to Tribal health care reform as they are integral to ensuring Tribal communities are informed, instituting changes, and securing third party billing. Enrollment assisters are knowledgeable about the needs of Tribal patients as well as the federal, state and Tribal community requirements for health insurance. They understand the needs of Tribal patients and what types of resources they can access. Enrollment Assisters are vital in explaining the complex health care insurance terminology and assisting individuals who do not have the technology to complete the entire enrollment process, including submission of key documents. Additionally, enrollment assisters are able to help patients if they get denied.

Conclusion

The unique relationship between 3rd party insurance coverage like Medicaid and Marketplace coverage; and the Indian health system means that the Administration has the tools it needs to allow States to design Medicaid programs that best fit non-Indian populations while simultaneously respecting Tribal sovereignty and maintaining Medicaid and the Marketplace as a critical source of funds for the Indian health system. NIHB is ready to partner with CMS to work on healthcare reform to create better healthcare outcomes for our people, and we look forward to meeting with you soon. We thank you for this opportunity to provide our comments and recommendations and look forward to further engagement with CMS. Please contact Devin Delrow at ddelrow@nihb.org or at (202) 507-4072 if there are any additional questions or comments on the issues addressed in these comments.

Sincerely,



Vinton Hawley
Chairman, National Indian Health Board

Cc: Kitty Marx, Director, CMCS Division of Tribal Affairs, Centers for Medicare and Medicaid Services