National Indian Health Board

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October 31, 2011

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G
Attention: CMS-2349-P
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

RE: NIHB Comments on CMS-9974-P: Patient Protection and Affordable Care Act; Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers

The National Indian Health Board[1] (NIHB) is submitting the attached analysis and recommendations (Comments) to the Centers for Medicare and Medicaid Services (CMS), Department of Health and Human Services (HHS) in response to the request for comments published August 17, 2011 in the *Federal Register* titled "Patient Protection and Affordable Care Act; Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers" (CMS-9974-P or Proposed Rule). We appreciate the opportunity to comment on this Proposed Rule.

Summary of Analysis and Recommendations

The Affordable Health Insurance Exchanges (Exchanges) represent an opportunity to expand access to health insurance for American Indians and Alaska Natives (AI/AN), one of the key goals of the Affordable Care Act.[2] Generally speaking, we believe that the critical

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[1] Established nearly 40 years ago, NIHB is an inter-Tribal organization that advocates on behalf of Tribal governments for the provision of quality health care to all American Indians and Alaska Natives. NIHB is governed by a Board of Directors consisting of a representative from each of the twelve Indian Health Service ("IHS") Areas. Each Area Health Board elects a representative to sit on the NIHB Board of Directors. In areas where there is no Area Health Board, Tribal governments choose a representative who communicates policy information and concerns of the Tribes in that area with NIHB. Whether Tribes operate their entire health care program through contracts or compacts with IHS under 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.

[2] Refers collectively to the Patient Protection and Affordable Care Act (Pub. L. 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), and referred to herein as the Affordable Care Act or ACA. The ACA was subsequently amended by the Medicare and Medicaid Extenders

aspects of this Proposed Rule are to ensure that its Indian-specific provisions are read broadly so as to maximize the scope of their benefits and to ensure that the enrollment processes and materials, verification requirements, and attestation requirements are user friendly and easily understood. This last point is particularly true with regard to the administration of the premium tax credits, the rules for which, as written, we are concerned may create disincentives for low and moderate income people from participating in the Exchanges.

Summary of Primary Recommendations

- Clarify the scope of the definition of "Indian" for the purposes of administering Indian-specific cost-sharing exemptions in the Exchanges (Proposed Rule §§ 155.300(a), 155.350).
- Ensure that the verification process as related to Indian status accepts a wide array of documentation and include clear, easily understood application questions to guide AI/ANs in their application process (Proposed Rule § 155.350(c)).
- Clarify the eligibility requirements for enrollment through an Exchange and for cost-sharing assistance, ensuring that no additional requirements are imposed beyond those contained in the Affordable Care Act. (Proposed Rule § 155.305)
- Confirm and retain that health services provided by an I/T[3] do not constitute government-sponsored minimum essential coverage, and exempt AI/ANs from the rule that the option of employer-sponsored minimum essential coverage will preclude eligibility for the premium tax credits (Proposed Rule §§ 155.305(f); 155.320(b), (e), 155.340).
- Simplify the regulations governing the calculation of an individual's premium tax credit by allowing an individual's previous year MAGI govern the calculation rather than an estimate of future income (Proposed Rule §§ 155.305(f), 155.310(d); 155.320(c)).
- Clarify that attestation will suffice for the purposes of the various verification requirements related to enrollment in a QHP, and allow applicants to include explanations of inconsistencies in their attestations (Proposed Rule §§ 155.315).
- Clarify the meaning and usage of terms used in the verification process, such as "household size" and "family size" (Proposed Rule § 155.320).

Act of 2010 (Pub. L. 111-309), the Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011 (Pub. L. 112-9), and the Department of Defense and Full-Year Continuing Appropriations Act, 2011 (Pub. L. 112-10).

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

- Reference the expanded AI/AN-specific MAGI exemptions and clarify the usage and scope of the term MAGI for the purposes of eligibility data collection (Proposed Rule § 155.320).
- Broaden the timeframe allowed for reporting changes in individual eligibility factors for an Exchange (Proposed Rule § 155.330).
- Consider the attached presentation on the definition of Indian as CMS proceeds to integrate implementation of the ACA.
- Engage in continued consultation with Tribes on these and other matters pertaining to the implementation of the Affordable Care Act in order to fully, efficiently and effectively carry out the Federal Trust Responsibility.

Conclusion

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

Sincerely,

Cathy Abramson
Chairman, National Indian Health Board

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

Attachment: "NIHB Comments on Exchange Functions in the Individual Market: Eligibility Determination; Exchange Standards for Employers" (CMS-9974-P)

National Indian Health Board

Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers Consistent with the Patient Protection and Affordable Care Act[1] (CMS-9974-P; Proposed Rule)

Analysis of and Recommendation on Proposed Rule by the National Indian Health Board[2] (Comments)

October 31, 2011

The National Indian Health Board (NIHB) appreciates the opportunity to provide comments on the Department of Health and Human Services' Proposed Rule, "Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers," published August 17, 2011 in the *Federal Register*.

In these Comments, NIHB provides analysis and recommendations on provisions specific to American Indians and Alaska Natives (AI/ANs) as well as to provisions generally applicable to all Americans. Furthermore, these Comments discuss the applicability to and impact on the Indian Health Service, Tribes and Tribal organizations, and urban Indian organization health care providers (which are referred to as Indian Health Care Providers or I/T/U).[3] The Affordable Care Act as well as a host of other Federal laws and regulations

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

2 Established nearly 40 years ago, NIHB is an inter-Tribal organization that advocates on behalf of Tribal governments for the provision of quality health care to all American Indians and Alaska Natives. NIHB is governed by a Board of Directors consisting of a representative from each of the twelve Indian Health Service (IHS) Areas. Each Area Health Board elects a representative to sit on the NIHB Board of Directors. In areas where there is no Area Health Board, Tribal governments choose a representative who communicates policy information and concerns of the Tribes in that area with NIHB. Whether Tribes operate their entire health care program through contracts or compacts with IHS under 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.

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

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govern Indian Health Care Providers and impact the structure and policies of such providers. These Federal laws and regulations (including, but not limited to, the Snyder Act, the Indian Health Care Improvement Act (IHCIA),[4] the ISDEAA, the Federal Tort Claims Act (FTCA) and the Anti-Deficiency Act[5]) also impact the range of functions, policies, and operations of an Affordable Health Insurance Exchange (Exchange) through which eligibility determinations will be made.

This Proposed Rule, although released by CMS/HHS, is interconnected with provisions of the ACA administered by the Department of the Treasury (Treasury), Internal Revenue Service (IRS), such as the premium assistance functions performed by IRS. As such, NIHB is submitting these Comments to both HHS and Treasury. Likewise, the analysis and comments prepared by NIHB in response to the IRS-issued proposed rule for "Health Insurance Premium Tax Credit" (IRS REG-131491-10) are incorporated herein by reference.[6] We are requesting that CMS consider the attached comments to IRS that are included as an attachment here also as comments in response to this Proposed Rule.

NIHB's comments follow the order of sections as presented in the Proposed Rule and reference the issue identifier, as per agency request.

Summary of Analysis and Recommendations

Preamble

NIHB notes that the drafters interpret the ACA to:

> establish a system of streamlined and coordinated eligibility and enrollment through which an individual may apply for enrollment in a QHP [Qualified Health Plan] and insurance affordability programs and receive a determination of eligibility for such programs. . . . that the eligibility and enrollment function should be consumer-oriented, minimizing administrative hurdles and unnecessary paperwork for applicants."[7]

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the meaning given that term in Sec. 4 of the IHCIA, 25 USC §1603. The term "urban Indian organization" has the meaning given that term in Sec. 4 of the "IHCIA", 25 USC §1603.

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

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

6 Hereafter referred to as "Premium Tax Credit proposed rule" or IRS REG-131491-10.

7 76 Fed. Reg. 51203.

To achieve this intent, under ACA § 1411, the Secretary is directed to establish a program for determining whether an individual meets the eligibility standards for Exchange participation, advance payments of the premium tax credit, cost-sharing reduction, and exemptions from the individual responsibility provisions.

NIHB shares this understanding of the ACA and vision of the Congress and applauds HHS's willingness to take leadership to find ways to simplify access to health care. We are honored to have the opportunity to submit comments to the proposed rules regarding Exchange eligibility that will help make that intent a reality.

There are many places where HHS has chosen to align policies and procedures and to simplify them. For example, with regard to the section on income verification, the discussion offered by HHS states:

> We note that this proposal represents a modification of the statutory verification process, based on the authority granted to the Secretary in section 1411(c)(4)(B) to modify the methods for obtaining data, including allowing an applicant to request that the Secretary of the Treasury provide return information directly to the Exchange through the Secretary of HHS. We believe that this approach will be far more efficient for applicants, the Exchange, and the Federal government than the basic procedure described in the statute . . .[8]

NIHB views this as a perfect example of HHS exercising the discretion Congress granted it to simplify processes. NIHB urges the Secretary to use the same discretionary authority when it comes to issues of significance regarding American Indians and Alaska Natives (AI/ANs). Specifically, HHS has not chosen to the align definitions of Indian, or to provide guidance to Exchanges regarding who qualifies as an Indian, even when there is ample evidence and legal authority to support this approach. Throughout the Comments, we will comment briefly with regard to individual sections of this Proposed Rule that implicate the definition of "Indian." However, we attach, and incorporate by reference into these comments, "Analysis and Comment on Definition of 'Indian' in Proposed Rules to Implement Provisions of Patient Protection and Affordable Care Act[9] in which we discuss the issues associated with the definition of "Indian" in depth.

Sec.155.300 Definitions and General Standards for Eligibility Determinations

<u>(a) Definitions</u>

<u>Applicable Medicaid modified adjusted gross Income (MAGI)-based income standard</u>.

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[8] 76 Fed. Reg. 51214.

[9] Hereafter "Definition of Indian Analysis."

In order to define the term "applicable Medicaid modified adjusted gross income (MAGI)-based income standard" for the purposes of Medicaid eligibility determinations, CMS proposes in 45 C.F.R. § 155.300 to adopt the definition of "applicable Medicaid modified adjusted gross income standard" as defined in proposed 42 C.F.R. § 435.911(b).

While we do not comment on this specific definition, we note that 42 C.F.R. § 435.911(b) (which is located in CMS's proposed Medicaid expansion regulation, CMS-2349-P) defines the eligible MAGI standard, with certain exceptions, as "133% of the Federal poverty level." However, the *actual* formula by which CMS determines whether an individual falls above or below the 133% level, rather than just the definition of the term "MAGI" itself, is established in proposed 42 C.F.R. § 435.603 (also in CMS-2349-P). 42 C.F.R. § 435.603(e) establishes a number of MAGI income exemptions for the purposes of Medicaid that differ from MAGI income exemptions for the purposes of the tax code. This includes a number of exemptions specific to AI/ANs that will be critical to the expansion of AI/AN access to Medicaid envisioned by the Affordable Care Act. NIHB therefore suggests that CMS include a provision in either proposed § 155.300 (definitions) or proposed § 155.305 (eligibility standards, which makes several references to the Medicaid and CHIP MAGI standards) explicitly referring to the income exemptions in proposed § 435.603, including those specific to AI/ANs. This will ensure that Exchange employees are kept aware of the evolving, and expanding, MAGI-based eligibility standards, particularly as they apply to AI/ANs.

Federal Poverty Level. For purposes of determining eligibility for advance payments of the premium tax credit and cost-sharing reductions, CMS proposes to define the term "federal poverty level" (FPL) as the most recently published FPL as of the date of the annual open enrollment period for the Exchanges. This could pose a problem for AI/ANs, who have access to monthly open enrollment periods pursuant to ACA § 1311(c)(6), if the FPL determination for AI/AN were based on subsequent updates of the FPL during the year. NIHB believes this problem could be easily avoided if, as called for in the Proposed Rule for the general population, the FPL determined as applicable for the general population "as of the first day of the **annual** open enrollment period" (emphasis added) is also used for AI/AN without regard for the month of the year the special monthly enrollment period may be exercised by an AI/AN.

Indian. NIHB drafted a general supplement response on the definition of "Indian" for the purposes of Exchange implementation. An extensive, focused response was required because the definition is of paramount importance and, thus far, CMS has misinterpreted the law and erroneously defined the term. As noted above, we have attached, and incorporate by reference, Definition of Indian Analysis. It is of particular relevance regarding the following statements and proposed rules in the Proposed Rule.

For example, on page 51,205 of the Proposed Rule, CMS writes:

> For purposes of determining eligibility for cost-sharing provisions, we propose to codify the definition of "Indian" to mean any individual defined in section 4(d) of the Indian Self-Determination and Education Assistance Act (ISDEAA) (Pub. L. 93– 638, 88 Stat. 2203), in accordance with section 1402(d)(1) of the Affordable Care Act. *This definition means an individual who is a member of a Federally-recognized tribe.* Applicants meeting this definition are eligible for cost-sharing reductions or special cost-sharing rules on the basis of Indian status, which are described in § 155.350 of this subpart.(emphasis added)

On pages 51,222 and 51,223 of the Proposed Rule, CMS outlines the process of determining Indian status for the purposes of cost-sharing protections. While this portion of the preamble only cites to the definition found in ISDEAA § 4(d), and does not elaborate on what that definition actually means, CMS previously (and erroneously) noted that § 4(d) is limited to enrolled tribal members. As a result, Exchange workers will misapply this crucial portion of the regulations. Finally, in proposed 45 C.F.R. § 155.300, CMS defines "Indian" as "any individual as defined in section 4(d) of the Indian Self-Determination and Education Assistance Act (Pub. L. 93–638, 88 Stat. 2203)." Exchange employees will similarly misapply this definition based on the incorrect interpretation that CMS attributed to the statute on page 51,205.

We will not restate all of the arguments made in the attached supplemental Definition of Indian Analysis, but do reiterate that there is no legal basis for limiting the definition of "Indian" to members of only Federally-recognized Tribes. Rather, there are compelling legal and policy justifications and authority for defining "Indian" as it is in 42 C.F.R. § 447.550.

<u>Qualifying coverage in an eligible employer-sponsored plan.</u> We have no comments on the substantive definitions in this section. However, we believe that there should be an exception to the requirement that Exchanges verify AI/AN access to employer-sponsored health care during the insurance affordability program verification, as well as the penalty of not being able to access tax credits for an Exchange plan if they don't accept the employer-sponsored plan. We comment on the premium tax credits in our response to IRS REG-131491-10, and on the insurance affordability programs below on page 8.

<u>(c) Attestation</u>

(2) The Proposed Rule states that the primary taxpayer must authorize advance payments of the premium tax credit. The preamble indicates that this is to ensure that the taxpayer appreciates and accepts the tax consequences that follow from receipt of advance payments. We caution that the explanation of advance tax credit payments must be in sufficiently plain English that it can be understood by an individual with low literacy, low levels of education, lack of experience with tax credits, and lack of access to tax preparers and advisors. If the tax credit prohibits use of the EZ form for filing taxes at the end of the

year, the IRS (or others) must disclose this consequence and provide assistance to low income people who cannot otherwise afford to get help filing their taxes. We strongly urge HHS and IRS to consult with Tribes and tribal organizations as to the language of the tax credit explanatory materials that will be used with AI/AN populations to assure that the intent and ramifications are understandable. Furthermore, the IRS and/or HHS need to provide language translation for AI/ANs and other populations whose primary language is not English. Without these critical steps, miscommunication and misunderstanding about the advanced tax credit will create a very significant obstacle to AI/ANs receiving federal subsidies for the insurance premiums to which they are entitled. Finally, as we discuss later in this comment, NIHB believes this process could and should be simplified by using the previous year's income for determining eligibility for tax credits, rather than having to reconcile the advance tax credits with end of the year income.

Sec.155.305 Eligibility standards.

(a) Eligibility for enrollment in a QHP through the Exchange**.**

As presented in § 155.305, there are three requirements that must be met for an individual to be eligible to secure health insurance coverage in the individual market through an Exchange. The individual —

- must reside in the State that established the Exchange,[10]
- not be incarcerated at the time of enrollment (other than while pending disposition of charges), and
- be a citizen or national of the United States or be lawfully present in the United States and be reasonably expected to be such for the entire period for which enrollment is sought.[11]

NIHB recommends that the preamble to the final rule emphasize this point and that IRS and CMS include this in educational materials that they may produce together or separately. The ACA is difficult for experts to parse through and laypeople are truly overwhelmed. Simple statements like that above can be helpful in assuring that everyone understands there is an opportunity for them to benefit. In addition, a statement that eligibility for enrollment in a QHP through an Exchange is not dependent upon eligibility for premium tax credits would provide further clarification.

(1) Citizenship. Citizenship is a basic standard of eligibility for Exchange QHPs. The intent expressed in the Proposed Rule is to align the citizenship requirements for the Exchange with those of Medicaid. The citizenship documentation for AI/AN to qualify for

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

[11] ACA § 1312(f)(1) and (3).

Medicaid was worked out through a lengthy tribal consultation process. We recommend using the same verification process for citizenship in the Exchanges as currently required for Medicaid.[12]

(2) Incarceration. AI/ANs are incarcerated at a higher rate than many other populations in the United States, often as a result of crimes related to alcoholism and/or fetal alcohol effects. In addition to poverty, alcoholism and homelessness, many AI/ANs who are incarcerated have low levels of literacy and education, as well as poor employment prospects upon their release. They often get better health care while they are incarcerated than when they are on the streets, particularly since the Federal government spends more on health care for prisoners than for the Indian Health Service on a per capita basis. Because these AI/ANs should be encouraged to take advantage of the AI/AN-specific benefits of coverage through an Exchange, efforts should be made to assist in this transition. This is particularly relevant given that many such individuals who are leaving periods of incarceration will also be eligible for Medicaid, which will share a common application portal and eligibility determinations with the Exchanges.

(3) Residency. Many AI/AN youth attend Federally-funded Indian boarding schools and youth treatment programs in a different State from the one in which their family resides. CMS should designate these children as meeting the proposed Exchange plan residency standards both in the State in which their family resides and in the State in which they are residing for boarding school or treatment programs. We therefore offer the following suggested edits to proposed 45 C.F.R. § 155.305(a)(3)(ii):

> (ii) In the case of an individual under the age of 21, who is not institutionalized, is not receiving assistance pursuant to Title IV–E of the Social Security Act, is not emancipated, and is not receiving an optional State supplementary payment, resides in the State within the service area of the Exchange in which he or she is requesting coverage, including with a parent or caretaker or without a fixed address. Any such individual who attends a school operated pursuant to Chapter 22 of Title 25 of the United States Code, or an Indian Health Service youth treatment program operated pursuant to 25 U.S.C. § 1665 *et seq.* shall be considered to satisfy this criteria in either the state in which such individual's parent or guardian is located or else the state in which such individual attends a school or a youth treatment program.

We believe that these provisions are crucial to ensuring that AI/AN youth have adequate access to Exchanges even if they spend a significant amount of time outside of their official

[12] *See* 42 U.S.C. § 1396a(ee)(1), under which the State submits the name and social security number of the individual to the Commissioner of Social Security and considers the individual's citizenship requirement fulfilled so long as the Commissioner does not find any discrepancies in the records. The individual is also afforded an appeals process.

State of residence.[13] We note that the proposals in 45 C.F.R. § 155.305(a)(3)(iv), allowing out-of-state dependants to enroll in the Exchange either in their State of residence or the State in which the taxpayer claiming them as dependents is a resident, could provide some flexibility on this point. However, that section is written in such a way that it is difficult to tell whether it only applies to individuals who live out-of-state full time, which might not encompass the children described above. We therefore believe that direct discussion on this point is needed specific to AI/ANs.

NIHB also notes that many AI/ANs are transitory, moving back and forth between their reservations and urban areas that may be in other states. Some reservations, most notably the Navajo Nation, Shoshone-Pauite Tribes of Duck Valley, Ute Mountain Ute, Colorado River, and Standing Rock illustrate this geographic reality as they span more than one State. AI/ANs who meet IHS eligibility requirements can seek care at any I/T/U facility in any state that has Indian health programs. The law and regulations direct the OPM to contract with health insurance issuers to offer at least two private multi-State plans in each Exchange. Whether plans are multi-state or limited to a single state, consideration should be given to requiring them to assure that they will pay for care provided across state borders for AI/ANs who reside on a reservation that is found in two or more states.

(c) Eligibility for Medicaid.

Eliminating asset tests will simplify the eligibility for Medicaid. However, reliance on the MAGI income standards may pose some problems for AI/ANs, who are often low income people and who may rely on traditional indigenous subsistence practices. As a result, they may not have filed tax returns and there may not be adequate information to determine their Medicaid eligibility in the IRS data system. Consideration should be allowed and accommodation provided for individuals that may not be able to or capable of filing required tax returns, if any.

(d) Eligibility for CHIP.

Eligibility processes for CHIP must identify AI/ANs so that the special CHIP provisions in § 5006 of the American Reinvestment and Recovery Act ("ARRA")[14] will be applied to those who qualify.

(e) Eligibility for Basic Health Program.

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[13] For a more complete understanding of the challenges that lead to AI/AN children requiring care in states other than where their parents live, see "Residency for Medicaid Eligibility (§ 435.403) in the "NIHB Comments on CMS-2349-P: Medicaid Program; Eligibility Changes under the Affordable Care Act of 2010."

[14] Pub. L. 111-5.

In the "Request for Information Regarding State Flexibility to Establish a Basic Health Program Under the Affordable Care Act" (CMS-9980-NC) issued by CMS and published in the Federal Register September 14, 2011, it is indicated that a person otherwise eligible for coverage through an Exchange would lose such eligibility if a State were to make the person eligible for a Basic Health Program in the State. There are a number of important AI/AN-specific and non-AI/AN specific protections and benefits for those who enroll in a health plan in the individual market through an Exchange. Any loss of these protections and benefits could be extremely problematic for AI/ANs if it were to occur. We would hope to see AI/ANs maintain eligibility for Exchange coverage, even if a State were to establish a Basic Health Program. And, we are requesting that HHS engage in tribal consultation on the issue of the Basic Health Program prior to issuing proposed rules on the program.

(f) Eligibility for advance payments of the premium tax credit.

(1) In general. Several of the proposed standards for eligibility for advance payment of tax credits could be problematic for AI/AN. Specifically, greater clarification is needed with regard to (B), eligibility for minimum essential coverage from government programs and employer-sponsored plans.

Government-sponsored minimum essential coverage. In order to qualify for the advance payment of premium tax credits, proposed 45 C.F.R. § 155.305(f)(ii)(B) includes a requirement that one or more of the individuals for whom a deduction will be claimed cannot be eligible for minimum essential coverage, in accordance with 26 CFR 1.36B–2(a)(2). 26 C.F.R. § 1.36B-2(a)(2) limits eligibility for the premium tax credit to individuals who are "not eligible for minimum essential coverage (within the meaning of paragraph (c) of this section) other than coverage described in section 5000A(f)(1)(C) (relating to coverage in the individual market)." According to proposed 26 C.F.R. § 1.36B–2(c)(2), one such type of minimum essential coverage is "government-sponsored," with an individual being "eligible for government-sponsored minimum essential coverage if the individual meets the criteria for coverage under a government-sponsored program described in section 5000A(f)(1)(A)." IRC section 5000A(f)(1)(A) lists the following programs as comprising "government-sponsored minimum essential coverage": (i) the Medicare program under part A of title XVIII of the Social Security Act, (ii) the Medicaid program under title XIX of the Social Security Act, (iii) the CHIP program under title XXI of the Social Security Act, (iv) the TRICARE program, (v) the veteran's health care program under chapter 17 of title 38, United States Code, or (vi) a health plan under section 2504(e) of title 22, United States Code (relating to Peace Corps volunteers).

The Tax Code therefore does not consider eligibility for the Indian Health Service to constitute eligibility for government-sponsored minimum essential coverage. NIHB appreciates this recognition of the fact that IHS services are often inadequate to fully

provide for the needs of AI/ANs. Nevertheless, NIHB recommends explicitly stating this in the regulations to avoid any confusion on the part of Exchanges.

Employer-sponsored minimum essential coverage. A second type of minimum essential coverage that 45 C.F.R. § 155.305(f)(ii)(B) incorporates by reference to 26 C.F.R. § 1.36B–2(c)(2) is "employer-sponsored," which, pursuant to 26 C.F.R. § 1.36B-2(c)(3), constitutes minimum essential coverage only if a variety of affordability and minimum value requirements are met.

However, as we also comment in our response to the premium tax credit regulations, NIHB does not believe that AI/AN eligibility for the premium tax credit should be tied in any way to the availability of employer-based coverage.[15]

NIHB recommends that proposed §1.36B-2(c)(3) "Employer-sponsored minimum essential coverage," be amended to explicitly exempt AI/ANs. The Premium Tax Credit proposed rule states that if an individual, or a person eligible to enroll because of their relationship to an employee, could have enrolled in an employer-sponsored plan and they did not do so, then they will not be eligible for premium tax credits through the Exchange. In general, AI/ANs who have access to Indian Health Care Providers do not enroll in employer-sponsored health plans if doing so will subject them to contributing to the cost of the premiums. AI/ANs prepaid their health care through the ceding of lands through treaties. They are entitled to receive services at no cost from the Indian Health Service. [16, 17]

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

If AI/ANs are eligible for IHS and I/T/U services are geographically accessible, they may reasonably be expected to decline the offer of employer-sponsored health care. As a result, we believe that if an individual is eligible for the IHS or is identified on a data match that shows the individual is an active user of an I/T facility, then no attestation or verification should be required regarding eligibility for employer-sponsored plans, as the AI/AN individual should be considered exempt from the requirement that they enroll in employer-sponsored plans. For AI/AN exempted from this provision, the Exchange should

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15 NIHB Comments on the "Premium Tax Credit proposed rule", October 31, 2011, page 11.

16 The Congress has found that "Federal health services to maintain and improve the health of Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people." 25 U.S.C. § 1601(1).

17 For the same reason, Congress prohibits IHS from imposing charges on patients for the services IHS provides. 25 U.S.C. §§ 458aaa-14(c) and 1880r(b).

not be required to transmit information to HHS regarding the employer not providing minimum essential coverage, or providing coverage that is unaffordable, or not meeting the minimum value.

This makes sense for both policy and equitable purposes. For example, both ARRA and the ACA are clearly designed towards increasing AI/AN access to federal health care programs such as Medicaid and plans through the Exchanges. ARRA § 5006 waives Medicaid cost-sharing for AI/ANs, and various provisions in the ACA allow for special monthly AI/AN enrollment in Exchanges, special cost-sharing protections in Exchanges, and exemptions from the individual mandate for AI/ANs. It is inconsistent with the thrust of this pro-AI/AN enrollment policy to force AI/ANs to choose between accepting employer-sponsored coverage and therefore qualifying for the premium tax credits, or else waiving the federal health benefits to which they are entitled in order to qualify for the tax credits associated with the programs that the government is urging them to join.

<u>(3) Enrollment required</u>. This section states that the exchange may provide advance payments of the premium tax credit "only on behalf of a primary taxpayer if one or more applicants for whom the primary taxpayer attests that he or she expects to claim as a personal exemption deduction for the benefit year, including the primary taxpayer and his or her spouse, is enrolled in a QHP through the Exchange." This wording is confusing because it appears that the taxpayer could not get a deduction for a child or another dependent enrolled in a QHP unless the primary taxpayer and his or her spouse were also enrolled in a QHP. We recommend that this be clarified in the final rule.

<u>(4) Compliance with filing requirement.</u> The requirement to file a tax return for years in which an advance tax credit was received could be a problem, depending upon the ease of filing a tax return. It is not clear whether people would be able to file the simplest (EZ) form, or if reconciling the advanced tax credit with year-end income would require a long form. The rules that have been proposed by the IRS for tax credits indicate this complexity as they include 42 different examples to explain how to apply the rules. The rules are written for tax attorneys, not for people on the verge of poverty who cannot afford to pay tax preparers.

We would like to highlight that the Affordable Care Act tax credits are intended to help, among others, poor people who are just above the federal poverty level. These are generally people with low education, low literacy rates, and part-time, seasonal, or sporadic employment. These are people without bank accounts; indeed, in some AI/AN communities, there simply are no banks. These are people whose lives are so unpredictable that they cannot know what their income will be twelve months ahead of time.

NIHB anticipates that the requirement that individuals pay back a portion of the advance tax credits that are applied to premiums if their income ends up being marginally higher than they expected at the outset will create significant jeopardy to individuals who

are least able to plan or prepare for such eventualities. People on the verge of poverty will almost certainly use any additional income to deal with unexpected or pressing needs. If their income turns out to be higher than they projected, and they are therefore required to reimburse overpayments from the advance tax credit, they are unlikely to be able to do so. When faced with a complicated tax return and no savings to pay the IRS, many people are likely to avoid filing a return.

In light of these problems, it is likely that many people will not file their tax forms at the end of the first year. Without this income documentation, they will be disqualified from future advance tax credits and will be unable to afford insurance. The regulations try to avoid this problem by making people sign an authorization for the advance tax credit that acknowledges their potential, future liability. But many people won't understand this and it won't solve the problem. It may even trap people in poverty by creating disincentives for people who are employed part-time or seasonally to seek full time employment.

Another approach suggested in the Proposed Rule is to have a "strong initial eligibility process that maximizes accuracy" and "a strong process by which individuals can report changes that occur during the year." However, for the population near the poverty level, the problem is not methodology; the problem is an unpredictable employment environment. For people with part-time and seasonal employment, the most effective way to maximize accuracy is to use a process that considers cash payment of wages and fluctuating pay. A strong process to report changes would put the burden on employers to assist new employees, and those getting raises or bonuses or overtime, to re-calculate their tax credits. However, this would probably be expensive for employers and not well received.

(6) Collection of social security numbers. When developing the citizenship documentation rules for Medicaid, CMS learned that some AI/AN do not have birth certificates, particularly if they were born at home in rural areas. People without birth certificates are not likely to have Social Security Numbers. Some AI/ANs who live subsistence lifestyles do not pay into Social Security and are not eligible to collect Social Security.

We note that the language of the Proposed Rule requires the provision of a Social Security number "*if an application filer attests* that the primary taxpayer has a Social Security number and filed a tax return for the year for which tax data would be utilized for verification of household income and family size." (Emphasis added.) This makes it seem as if the application filer can attest that he or she does *not* have a Social Security number. We believe that such flexibility is warranted in the case of AI/ANs, but that tribal consultation is needed to figure out the best way to handle these situations.

(g) Eligibility for cost-sharing reductions.

As HHS acknowledges in the preamble, § 1402(d) establishes a number of favorable cost-sharing protections that are specific to Indians (as defined). Specifically, a QHP issuer may not impose any cost-sharing on an Indian who has household income at or below 300 percent of the FPL and is enrolled in a QHP at any level of coverage, and may not impose any cost-sharing on an Indian for services furnished directly by the Indian Health Service, an Indian tribe, tribal organization, or urban Indian organization, or through referral under contract health services. This provision applies regardless of an Indian's income or plan level.

In proposed 45 C.F.R. § 155.305(g), CMS establishes the generally applicable cost-sharing reduction rules for the purposes of the Exchanges. Although the preamble repeatedly notes that cost-sharing for Indians is addressed specifically in § 155.350, § 155.305(g), where Exchange employees are likely to look first for guidance, barely mentions Indians. An Exchange employee who only looks at § 155.305(g), and/or who is not familiar with the special status of AI/ANs, could easily erroneously assume that § 155.305(g) applies to everyone including AI/AN.

In order to clarify, we suggest that CMS add a new paragraph (3) to 45 C.F.R. § 155.305(g), reading as follows (or an equivalent):

> (3) Additional cost-sharing guidance for Indians can be found under 45 C.F.R. § 155.350.

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

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

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

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

- is enrolled in any qualified health plan in the individual market through an Exchange,

- is determined to be an "Indian",
- has household income that is not more than 300 percent of the poverty line, and
- is lawfully present in the United States.

Pursuant to these sections of the ACA, cost-sharing assistance is not dependent upon eligibility for premium tax credits (or vice versa.) And as discussed earlier in these Comments, eligibility for enrollment in a health plan in the individual market through an Exchange *is not* dependent on eligibility for either premium tax credits or cost-sharing reductions. Eligibility for premium tax credits and cost-sharing assistance *is*, though, dependent upon enrollment in a health plan in the individual market through an Exchange.

Yet, in § 155.305(g)(1)(ii) of the Proposed Rule, it indicates that to be eligible for cost-sharing reductions an applicant must "meets the requirements for advance payments of the premium tax credit, as specified in paragraph (f) of this section." NIHB recommends that CMS not establish an additional requirement for accessing cost-sharing reductions beyond that required in the ACA.

NIHB further recommends that the preamble to the final rule emphasize the limited set of requirements for accessing cost-sharing reductions as well as do so in educational materials that may be produced. The ACA is difficult for experts to parse through and laypeople are truly overwhelmed. Simple statements like that above can be helpful in assuring that everyone understands where there is an opportunity for them to benefit.

Sec. 155.310 Eligibility determination process.

<u>(b) Choice to request determination of eligibility for insurance affordability programs.</u>

As noted above, ACA § 1402(d)(2)(A) precludes qualified health plans from requiring any cost-sharing by an Indian for services furnished directly by the Indian Health Service, an Indian tribe, tribal organization, or urban Indian organization, or through referral under contract health services. Unlike certain other AI/AN cost-sharing protections, this provision applies regardless of an Indian's income or plan level, and thus exists completely independently of an eligibility determination under § 155.310. But, Exchange employees and AI/ANs themselves may not be familiar with this distinction and could erroneously assume that all cost-sharing waivers are tied to the Exchange eligibility determination.

We therefore recommend that CMS clarify § 155.310(b), which allows an individual to decline an eligibility determination for insurance affordability programs and proceed directly to selecting and enrolling in a QHP. This provision should note that an AI/AN would still be eligible for a waiver of cost-sharing for services delivered in by the I/T/U or referred through CHS. We suggest language such as the following:

(b) Choice to request determination of eligibility for insurance affordability programs.

The Exchange must permit an applicant to decline an eligibility determination for the programs described in paragraphs (c) through (g) of §155.305 of this subpart; however, the Exchange may not permit an applicant to decline an eligibility determination for a subset of the programs listed in those paragraphs. The decision by an Indian to decline an eligibility determination, as provided in this subsection, shall not affect the application of the § 155.350(b).

(d) Determination of eligibility.

(2) Special rules relating to advance payments of the premium tax credit.

(i) The Proposed Rule permits an enrollee to accept less than the full amount of advance payments of the premium tax credit for which he or she is determined eligible. In the discussion of the rule, the Proposed Rule suggests that this provides an avenue by which individuals can avoid having to pay back the advanced tax credit if their income by the end of the year is greater than at the beginning of the year. NIHB believes that this suggestion is not very helpful for low-income people. Beyond the issues surrounding uncertainty in their income to begin with, this course of action basically requires low-income individuals to pay out-of-pocket for a portion of his/her premium. This, in turn, may make health insurance unaffordable.

This alternative also complicates the arrangements that sponsors would have to make to pay the unsubsidized portions of premiums. For example, this would create year-end reconciliation problems for Tribes that sponsor individuals by paying the unsubsidized portion of the premiums. One option that might make it more workable is to allow individuals to sign over their tax credits to a sponsoring organization, including Tribes, at the time of enrollment.

(g) Notice of an employee's eligibility for advance payments of the premium tax credit and cost-sharing to an employer.

We renew our recommendation that AI/ANs be exempt from the rules regarding employer-sponsored coverage, and that their employers should not be penalized for this exemption. We assume the notice requirement in this § 155.310(g) is intended to inform the employer of its potential liabilities. To the extent that the employee has provided information to the Exchange in good faith, even if it contains an error that is ultimately corrected by the employer, NIHB urges no action by the Exchange or the employer against the employee be permitted other than possible recalculation of benefits available to the

employee.   Otherwise, innocent mistakes made during a complicated process could result in devastating consequences for the employee/Exchange applicant.

Sec.155.315 Verification process related to eligibility for enrollment in a QHP through the Exchange.

(a) General requirement.

This portion of the rule sets out the requirement that the Exchange must obtain and verify information to determine eligibility for QHPs. One option for accessing information pertaining to status as an "Indian" is potential use of an Indian Health Service-generated list of IHS users. To the extent that data matching occurs with the Indian Health Service patient registration information, NIHB urges the use of a probabilistic matching algorithm that assumes an error in data entry was made if most of the information matches. If a consumer realizes that there is an error or inconsistency, there should be a quick and easy way to correct the error through attestation. This model should probably be used with data matching with other systems to avoid misidentifications. We comment on the IHS system only because we are most familiar with it.

(b) Verification of citizenship, status as a national or lawful presence.

A paragraph should be added to § 155.315(b) providing that documentation sufficient to satisfy the requirements of 42 U.S.C. § 1396b(x)(3)(B)(v) regarding proof of citizenship shall be sufficient for an Indian to verify citizenship. This will permit tribal enrollment cards or other such materials to serve as documentation of United States citizenship for individuals who do not have a social security number.

(c) Verification of residency.

Attestation is the most reasonable approach to use with residency.

(d) Verification of incarceration status.

Attestation is the most reasonable approach to use regarding incarceration.

(e) Inconsistencies.

There is a high likelihood that data sets will have inconsistencies. A probabilistic model allows reasonable assumptions about errors in data entry and should be used whenever possible to resolve inconsistencies. Most inconsistencies should be resolved using attestation and should not require documentation. For example, an error on a birth date in a data base should not require proof through a birth certificate as long as other information is consistent and the month or the day or the year is correct. Attestation should allow a person to explain any known reason for an inconsistency. The concept of verifying attestation undermines the value of using attestation. There should be a simple

process that either accepts or rejects attestation, and an appeal process for those whose attestation is rejected.

We have a specific concern in proposed (e)(4)(ii), in that we do not believe that repayment of tax credits should be required for people who cannot produce documentary evidence to resolve inconsistencies, as long as the person acted in good faith and there is no evidence of fraud. We continue to express our concern that people won't understand the concept of advanced tax credits. The fact that the insurance company received the advanced payment and the taxpayer may have received no benefit from the insurance company will make this extremely confusing. Trying to explain this to people with low literacy levels and exceptionally low "health insurance literacy" will be very difficult. Navigators could help explain the issue, but without specific guidance, they may not address it. Obtaining a signature that says the client understands the rule may be treated as meaningful by Navigators and others involved in the enrollment process when in reality they represent nothing more than another form that the individual applicant is told to sign during the enrollment process.

Sec.155.320 Verification process related to eligibility for insurance affordability programs.

(b) Verification of eligibility for minimum essential coverage other than through an eligible employer-sponsored plan.

(1) The rule does not state what types of coverage are being checked. We reiterate that Indian Health Service (IHS) is not considered minimum essential coverage for this provision and should not be checked for this purpose.

(c) Verification of household income and family/household size.

(1) Data. If certain AI/AN income is not reportable for income tax purposes, not counted toward the MAGI and not included in calculations of eligibility for insurance affordability programs, then the application process should not request information about that income and there should be no verification of that income by the Exchange.

(ii) Data Regarding MAGI-based Income

We believe that this section requires a number of clarifications. First, in proposed 45 C.F.R. § 155.320(c)(1)(i)(A), CMS specifies that requests for tax return data will be made directly from the Exchange to the Secretary of the Treasury, thus relieving individuals of the burden of providing this information themselves. By referencing proposed 42 C.F.R. § 435.948(a), which places the responsibility gathering MAGI-related data on State Medicaid agencies, proposed 45 C.F.R. § 155.320(c)(1)(ii) similarly requires coordination between the Exchanges and the Medicaid agencies when

gathering MAGI data for the purposes of duel enrollment. We appreciate this streamlined effort and agree that it is necessary to promote synergy between Medicaid and the Exchanges.

However, the tax return regulation explicitly states that Exchanges will request information from the Treasury. For MAGI, this is done by reference to a separate regulation. To a layperson, then, or even to an Exchange or Medicaid employee unfamiliar at first glance with 42 C.F.R. § 435.948(a), it appears that the individual applicant herself must provide any relevant data relating to MAGI. This will be confusing to all parties involved and could lead to erroneous data requests to individuals and to delays in enrollment. We therefore recommend that CMS clarify that individual applicants are not required to be the original source of MAGI-related data and documentation, and that this is instead a collaborative effort between Medicaid and the Exchanges.

We also note that this section does not discuss proposed 42 C.F.R. § 435.603(e)'s AI/AN-specific MAGI exemptions at all. NIHB believes that CMS should explicitly mention these exemptions in proposed 45 C.F.R. § 155.320(c)(1)(ii). Specifically, we reiterate our earlier comment that AI/ANs should not have to disclose any materials related to non-taxable income or MAGI-exempt income. As such, CMS should clarify that any relevant State agencies need not request records related to the MAGI-exempt income set out in § 435.603(e), and should also include a list of examples to help clarify what kind of income this could be.

Finally, CMS is soliciting comments as to the scope of the AI/AN MAGI income exemptions in proposed 42 C.F.R. § 435.603(e). We have commented that these exemptions should be read broadly to encompass a wide range of AI/AN income in order to effectuate both the ARRA and the ACA's goals of expanding AI/AN access to Medicaid. If they are, this could mean that an individual AI/AN's MAGI could actually decrease for the purposes of Medicaid in the near future. CMS should ensure that Medicaid agencies and the Exchanges are aware of these facts when requesting any data or attestations for the purposes of 45 C.F.R. § 155.320(c)(1)(ii).

We believe that these recommendations will minimize the burden on individuals and the overall complexity of the enrollment process. These are critical considerations for AI/ANs in light of their culturally-specific needs and the numerous exemptions to which they are entitled that might be fairly difficult for a layperson to navigate.

(2) Verification Process for Medicaid and CHIP.

(i) Household Size. It will be very confusing for consumers to understand the distinction between household size (for the purposes of determining eligibility for Medicaid and CHIP) and family size (for the purposes of determining eligibility for premium tax credits). There will need to be a lot of outreach and education about these terms, how they are defined, and how they make a difference in the calculations for insurance affordability programs. The computer program will need to be very clear about this because it would be easy for a person to start out answering questions about people in the household and then think that those are the same answers that should be given when asked about the family. This could cause inconsistencies in the application that would then lead to unnecessary remedial work and demands for verification. Furthermore, AI/AN households can be very complex. The terms-- family and household -- may be understood differently by AI/ANs. The rules' assumptions about these concepts should be field tested to make sure that they are understood in different cultural contexts.

Currently, Medicaid and CHIP eligibility workers are trained to know the rules and apply them, asking further questions and clarification when something seems to be missing. In the future, a computer program operated by the Exchange will be applying the rules. This change creates the potential for miscommunication and error. Individuals providing the information to the computer may not understand the definitions and distinctions that are involved in such things as reporting who lives in a household. Instead of relying on Medicaid and CHIP eligibility workers, the proposed system will require Navigators and people who work in Exchanges to understand all the nuances of these definitions and be able to answer questions for the consumer.

With Medicaid Expansion, it would seem that there could be an easier way to determine income eligibility for Medicaid and CHIP. For example, if parents are below a certain income level, they and their children would qualify without consideration for household size.

(ii) Verification process for MAGI-based household income. This section requires the Exchanges to verify an individual's MAGI for the purposes of Exchange eligibility. We note that proposed 42 C.F.R. § 603(e) includes a number of new AI/AN exemptions to MAGI for the purposes of Medicaid, which is the standard used by the Exchanges.

It is very likely that many AI/AN will not know about and/or understand the scope of their new exemptions, and how specifically this will apply to them and their Exchange eligibility. As a result, especially in the first few years

following its implementation, it is likely that either Exchange employees, Medicaid employees, or AI/ANs will mistakenly include exempt income in an AI/AN's MAGI determination. We therefore suggest that CMS ensure that the verification process includes safeguards for flagging exempt income that is listed in a MAGI determination, particularly with regard to AI/ANs.

(3) Verification process for advance payments of the premium tax credit and cost-sharing reductions. Throughout this paragraph terms such as family size, household income, and family's household income are used. We have earlier cautioned about the need to keep the reading level of all the application material as simple as possible. However, here we are concerned that the effort to do so by using words that may have different meanings to different people will result in delays or errors. To the extent that these terms are tied to tax returns or tax definitions, we suggest being very precise about what is being requested in order to avoid the confusion we have discussed that can arise from different understandings about what constitutes a family or household.

(d) Verification related to enrollment in an eligible employer-sponsored plan.

Attestation is a reasonable approach.

(e) Verification related to eligibility for qualifying coverage in an eligible employer-sponsored plan.

We discussed our concerns about verification of eligibility for qualifying coverage in an eligible-employer sponsored plan above beginning on page 8 of this comment. We incorporate those comments here.

A central issue is, if an individual is eligible for services from IHS or is identified on a data match that shows the individual is an active user of an IHS or tribal health program, then there should be no verification or attestation step regarding eligibility for employer-sponsored plans, as the AI/AN individual should be considered exempt from the requirement that they enroll in employer-sponsored plans.

The information required about employer-sponsored health plans related to minimum essential coverage and cost may be very difficult for an applicant to provide. Many employees are very confused and overwhelmed about the insurance options presented to them. Many will make a choice based on a factor that is meaningful to them (such as being able to continue to see their primary or specialty doctor), and then, will not retain the rest of the information presented. Any information that is not included on a weekly, bi-weekly or monthly pay stub will be difficult for a person to report on an Exchange application. Asking consumers to apply standards of minimum essential coverage seems unlikely to result in consistent and reliable reporting.

Since employers are already required to report this information, NIHB recommends that the Exchange should get this information directly from the employer instead of asking the employee to provide it. Alternatively, the Exchange could require employers to provide a statement to the employee (that includes such things as the Employer Identification Number) annually, and at other times, as circumstances change. The taxpayer would be able to use this statement for purposes of applying for advanced tax credits. The idea of a template, proposed in the discussion section of the Proposed Rule, is reasonable, but the employee should only be required to review the information provided by employers, not to submit it. Under this scheme, the failure of an employer to provide the information in a timely way should not delay the application of an employee for advanced premium tax credits.

Sec. 155.330 Eligibility redetermination during a benefit year.

(a) General requirement.

It will be helpful for some people to use the Exchange to process changes reported by enrollees during the benefit year, including changes to income and family size, which could affect determinations of advance tax credit amounts and thereby make adjustments which would avoid having to pay the IRS at the end of the year. It would also be helpful for people to use the computerized system to calculate their tax credits at the end of the year for purposes of reconciliation. NIHB recommends that the system allow people to explore different options at any time with or without having the Exchange accept and process changes.

(b) Requirement for individuals to report changes.

The requirement to report changes with regard to eligibility standards within 30 days applies to changes in citizenship, incarceration, residency, family members living outside the service area of the Exchange of the primary taxpayer, etc.

The current language of the Proposed Rule requires reporting of non-income changes in eligibility status within 30 days. We encourage CMS to design the Proposed Rule so that reliance on an enrollee to report changes is minimized and use of alternative, automated data sources is maximized. These alternative data sources rely on automated data systems that can report changes to an Exchange, which in turn, could notify the enrollee. The individual could review the reports and do nothing if there is agreement with the change, or contact the Exchange if the information is erroneous.

For instance, because insurance companies receive the advanced tax credits and other benefits from the ACA, they should bear some of the responsibility for assuring that residency information is updated in the Exchange. New address information could be

checked at each visit to a provider and updated in the Exchange data system. The incarceration admission and discharge process should include a step to notify the Exchange rather than counting on the individual to act. Likewise, the Department of Homeland Security should be responsible for reporting changes in immigration status to the Exchange. Employers could have a procedure that allows people to disenroll from QHPs and discontinue or recalculate advanced tax credits when they enroll an employee in an employer-sponsored plan or when an employee's income increases beyond a given threshold. If a person dies, a death certificate should be sent to the Social Security Administration and they should report the death to the Exchange and the IRS. Exchanges should not require that births be reported, although there are incentives for consumers to do so as it may help them qualify for Medicaid, CHIP or a larger advanced tax credit.

Sec. 155.335 Annual eligibility redetermination.

Notices regarding annual eligibility redetermination may be extremely confusing to many consumers. NIHB agrees that people should not be disenrolled from Medicaid, CHIP, a Basic Health Plan, or a QHP for failure to return a signed form. However, people should not receive an advanced tax credit that requires reconciliation at the end of the year without their explicit permission. That permission must use a form that is understandable for a person with a low literacy level and little experience with taxes and insurance. If the Exchange and the IRS continue to provide an advanced tax credit to the insurance company without the annual permission of the taxpayer, then the taxpayer should not be liable to repay this amount to the IRS.

Because some elderly people and those living in rural areas find it difficult to collect or keep up with their mail, we believe that CMS should include some flexibility to ensure that enrollees have the option of designating a duplicate notice to be sent to a representative at the enrollee's request. This will ensure that these notices are monitored accordingly. We therefore suggest that the current (c) be renumbered as (c)(1), and a new (c)(2) be added that reads:

> The enrollee shall have the option of designating a representative to receive a duplicate copy of the annual redetermination notice. The copy shall be sent concurrently to both the enrollee and his or her representative.

Further, we note that the Proposed Rule requires that the annual redetermination notice include the "data used in the enrollee's most recent eligibility determination." To the extent that any of that data constitutes protected health information, CMS must ensure compliance with applicable privacy laws during the disbursement of these duplicate copies.

Sec.155.340 Administration of advance payments of the premium tax credit and cost-sharing reductions.

(a) Requirement to provide information to enable advance payments of the premium tax credit and cost-sharing reductions.

Determination of cost-sharing categories for AI/AN should be independent of determination of eligibility for Medicaid, CHIP and advanced tax credits. An individual should be able to decline eligibility determination for insurance affordability programs, enroll in a QHP and still receive the designation of no cost-sharing for services provided by the I/T/U or referred through the Contract Health Services program. To receive the additional protection of no cost sharing when an AI/AN seeks care in the private sector without a CHS referral, an income eligibility determination may have to be made by the Exchange using information such as Social Security numbers and MAGI. AI/AN cost-sharing categories need to be clearly defined.

NIHB agrees that it is important to transmit information about an enrollee's category of cost-sharing reduction to the QHP issuer. Equally important, providers need to know that AI/AN do not pay cost sharing at some income levels for services provided outside the I/T/U. We are particularly concerned about cases where this lack of information has an immediate, negative consequence. (For example, if a parent goes to a pharmacy to get a prescription for a sick child and the pharmacy doesn't know that there is no cost-sharing. The pharmacy's refusal to provide the medicine without a co-pay could result in the inability of the family to treat the child's illness.) It is not enough for the issuer to give enrollees cards showing their cost-sharing status, it must also be in computer systems for point-of-sale billing.

The Proposed Rule requests comment on whether enrollment and eligibility information could be used by HHS to support any reporting necessary for monitoring, evaluation, and program integrity. NIHB believes that it is important to know whether AI/ANs are participating in the programs that Congress has designed to improve their access to care. In particular, because the proposed regulations contain provisions that may be obstacles to AI/AN participation, NIHB believes that monitoring is essential for the Administration to know when they need to make adjustments in their approaches. At the same time, individual information should be protected.

(b) Requirement to provide information related to employer responsibility.

For the reasons discussed with regard to employer-sponsored minimum essential coverage, we believe that if an individual is eligible for the IHS or is identified on a data match that shows the individual is an active user of an I/T/ facility, then no attestation or verification should be required regarding eligibility for employer-sponsored plans, as the AI/AN individual should be considered exempt from the requirement that they enroll in employer-sponsored plans. For AI/AN exempted from this provision, the Exchange should not be required to transmit information to HHS regarding the employer not providing

minimum essential coverage, or providing coverage that is unaffordable, or not meeting the minimum value.

NIHB believes that CMS should exempt any individual who is eligible for IHS services, or who is identified on a data match that shows the individual is an active user of an IHS or Tribal health program, from the requirement that they enroll in employer-sponsored plans in order to qualify for the premium tax credit. We therefore suggest that CMS adopt the following addition to 45 C.F.R. § 155.320(b)(1):

> (1) The Exchange must verify whether an applicant is eligible for minimum essential coverage other than through an eligible employer-sponsored plan, Medicaid, CHIP, or the Basic Health Program, using information obtained by transmitting identifying information specified by HHS to HHS. <u>This requirement shall not apply to any individual who is determined eligible for health programs operated by an Indian Health Program (as that term is defined in section 4(12) of the Indian Health Care Improvement Act) or an urban Indian organization (as that term is defined in section 4(29) of the Indian Health Care Improvement Act) that receives funding from the Indian Health Service pursuant to Title V of the Indian Health Care Improvement Act.</u>

(Additions shown in underline.) This will ensure that AI/ANs are not penalized for their deserved eligibility for Federal health programs.

Sec.155.345 Coordination with Medicaid, CHIP, the Basic Health Program, and the Pre-existing Condition Insurance Program.

<u>(a) Agreements</u>

NIHB supports the proposal that HHS will provide model agreements for Exchanges to use for purposes of sharing data. NIHB notes that this approach is similar to our request that HHS provide an Indian Addendum that Exchanges can provide to QHPs to use when offering contracts to I/T/U providers. With the Indian Addendum, however, we recommend that Exchange establishment rules require QHPs to offer to contract with the I/T/U providers using the Indian Addendum.

<u>(b) Responsibilities related to individuals potentially eligible for Medicaid based on other information or through other coverage groups.</u>

While waiting for Medicaid coverage, the individual should be offered advance payments of the premium tax credit and cost-sharing reductions, but the Proposed Rule makes it appear that the individual has no choice about enrolling in the QHP. The

discussion section of the Proposed Rule states that the individual would not be liable to repay the advanced tax credits if the individual is determined to be eligible for Medicaid. If the individual is determined to be not eligible for Medicaid, then one would presume that the individual would be liable for the advanced tax credits. Asking an individual to accept contingent liability without a new opportunity to decide not to participate in the Exchange creates risks for some applicants.

NIHB suggests that the rules provide that a person deemed eligible for Medicaid awaiting final determination accrues no liability if ultimately determined not eligible for Medicaid.

Sec.155.350 Special eligibility standards and process for Indians.

The definition of Indian is discussed in the preamble to our comments on this Proposed Rule. Specifically, we believe that CMS has made an error of law by interpreting the definition of "Indian" to be limited to members of Federally-recognized Tribes, and an error in both law and policy in arguing that CMS has no flexibility to draft a uniform, detailed definition of the term "Indian" for the purposes of implementing the ACA. CMS has already determined that a wide scope of individuals count as "Indians" for the purposes of Medicaid enrollment. Because Medicaid and the Exchanges are required to have a streamlined application process, CMS's current interpretation would require the enrollment forms to account for individuals who are "Indian" for the purposes of Medicaid cost-sharing, but not for Exchange cost-sharing. This would be unwieldy, inefficient, and tremendously confusing. We therefore urge CMS to consider and implement our suggestions on this point.

(a) Eligibility for cost-sharing reductions.

(1) (i) Our comments on this issue have been provided under Section 155.305(a).

(b) Special cost-sharing rule of Indians regardless of income.

NIHB concurs with this interpretation of the law.

(c) Verification related to Indian status.

The Proposed Rule states that "to the extent that an applicant attests that he or she is an Indian, the Exchange must verify such attestation. . ." However, in most cases related to this Proposed Rule, verification is required only if there are inconsistencies in information collected through attestation. It is our understanding that the statutes only require verification of citizenship. Every other aspect of eligibility can be determined through attestation. NIHB believes that attestation should be sufficient with regard to Indian status if questions on the application are presented in a way that can determine eligibility. For example, it would not be sufficient to merely ask someone if they are American Indian or Alaska Native. That could be a threshold question that then could be

followed up with additional questions, if answered in the affirmative. Some of the types of follow-up questions that could be asked are:

- What is the name of the Tribe or band in which you are enrolled or affiliated?
- Are you an enrolled member?
- Do you have a Certificate of Degree of Indian Blood?
- Are you or one of your parents, grandparents a stockholder in an Alaska Native Corporation formed under the Alaska Native Claims Settlement Act?
- Do you receive services from the Indian Health Service or a program of the Indian Health Service operated by a Tribe or tribal organization?
- Are you eligible to receive services from the Indian Health Service or a program of the Indian Health Service operated by a Tribe or tribal organization?
- Have you ever received any cash or title to land from the Federal government, including allotments, because of your status as an American Indian or Alaska Native?
- Do you hold trust interests in public domain, national forest, or Indian reservation allotments in California?
- Is your name listed on the plans for distribution of the assets of California rancherias and reservations under the Act of August 18, 1958 (72 Stat. 619), or are you a descendant of such Indian.
- Have you ever received a loan or a scholarship from the Federal government that was designated for American Indians or Alaska Natives?

With effective Tribal consultation, the list of questions could be refined to assure that they are comprehensive and complete.

(1) The provisions in Section 155.315(e) instruct Exchanges to make reasonable efforts to resolve inconsistencies in the application where attestation is used. NIHB believes that this should also be the standard for documentation regarding Indian status. Unnecessary verification processes could lead to delays in enrollment and may undermine the intent of these regulations to make the eligibility and enrollment functions "consumer-oriented, minimizing administrative hurdles and unnecessary paperwork for applicants." There should be no need for verification, unless there are inconsistencies that cannot be resolved through simple explanation and attestation by the applicant, or if there is some indication of fraud on the part of the individual.

(2) If electronic data sources are used to verify Indian status, the only reasonably accurate source is the registration data base used by Indian Health Service and Tribes. The IHS and many Tribes use the government-developed "RPMS" system; however, some Tribes use other electronic health records systems. The limitations of these systems, including the IHS registration data base, must be acknowledged.

First, there is a high likelihood that data sets will have inconsistencies. A probabilistic model allows reasonable assumptions about errors in data entry and should be used whenever possible to resolve inconsistencies. Most inconsistencies should be resolved using attestation and should not require documentation. For example, an error on a birth date in a data base should not require proof through a birth certificate as long as other information is consistent and the month or the day or the year is correct. Attestation should allow a person to explain any known reason for an inconsistency. The concept of verifying attestation undermines the value of using attestation. There should be a simple process that either accepts or rejects attestation, and an appeal process for those whose attestation is rejected.

Second, some Tribally-operated health programs do not use RPMS, so there would need to be a process to access their patient registration systems. To do so may require solving problems of compatibility of data systems and addressing privacy concerns. At the present time, there is no funding or effort to combine these data systems into a single data system.

Third, many of the people who are Indian by definition have never used an Indian health facility and would not be represented in that data base. Furthermore, the IHS active user population data base usually only includes people who have used IHS-funded health services in the past three years. This could exclude a lot of people who would be eligible. Also, records that are older than 3 years are likely to contain outdated, erroneous information (ie.-- residency) that would create inconsistencies in the application process and would require additional work to resolve.

(3) If an electronic data base is used, such as RPMS, it would only suffice for approximately 50 percent of the people who meet the definition of Indian. For the remaining 50 percent, defining and processing documentation would be a formidable job for the Exchanges which would likely require additional funding and staffing. NIHB recommends requiring documentation only in cases of appeal or when there appears to be a possibility of fraud.

Sec.155.355 Right to appeal.

<u>(a) Individual appeals.</u>

NIHB notes that the appeal process will be the subject of future rule making. We urge that those rules require that the appeal process be explained in a simple and

straightforward way. Additionally, the rules should require reasonable deadlines for responses to appeals.

In NIHB's responses to CMS 9989-P, regarding the establishment of the Exchanges, NIHB made a number of comments on the interaction between the SHOPs, AI/ANs, and Tribal employers. We reiterate those comments here, where appropriate.

One specific issue is that proposed § 157.205(c) requires that qualified employers disseminate relevant information to qualified employees. In our previous comment, NIHB recommended that because many AI/ANs will not enroll in a SHOP in light of the Federal government's trust responsibility to provide them with health care, AI/AN employees not be counted towards the employer's minimum level of qualified employees. We want to note here that even if CMS adopts this recommendation, AI/ANs should still count as "qualified employees" for the purposes of § 157.205(c) and any other provisions requiring outreach towards or benefits for "qualified employees."

Attachments

- "NIHB Analysis of and Comment on Definition of 'Indian' in Proposed Rules to Implement Provisions of the Patient Protection and Affordable Care Act," October 31, 2011
- "NIHB Analysis of and Recommendations on IRS REG-131491-01: Health Insurance Premium Tax Credit," October 31, 2011

National Indian Health Board

Delivered via electronic submission to: http://www.regulations.gov

October 31, 2011

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

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

The National Indian Health Board[1] (NIHB) is submitting the attached analysis and recommendations (Comments) to the Department of the Treasury (Treasury), Internal Revenue Service (IRS) in response to the notice of proposed rulemaking published August 17, 2011 in the *Federal Register* titled "Health Insurance Premium Tax Credit" (IRS REG-131491-10) (Proposed Rule). The Proposed Rule is primarily aimed at implementing the new Internal Revenue Code section 36B established under section 1401(a) of the Patient Protection and Affordable Care Act.[2]

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

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

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

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

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

Summary of Primary Recommendations

- Clarify, along with HHS, the eligibility requirements for premium tax credits, the eligibility requirements for purchasing health insurance coverage in the individual market through an Exchange, and the eligibility requirements for cost-sharing assistance. (ACA § 1312; ACA §§ 1401 and 1501; Proposed Rule § 1.36B-2; ACA § 1402)

- Modify the definition of the "applicable benchmark plan" and "the second lowest cost silver plan offered through an Exchange in the rating area where the taxpayer resides" to ensure that the lowest and second lowest cost silver plans referenced are qualified health plans that serve the area in which the taxpayer/enrollee resides. (ACA § 1401(a) / IRC § 36B(b)(3)(B); Proposed Rule § 1.36B-3)

- Confirm that premiums that may be made by Tribes, tribal organizations, and other entities on behalf of a taxpayer/enrollee will be counted for purposes of determining the number of "coverage months" in calculating the premium tax credit amount. (Proposed Rule §§ 1.36B-3(c)(1)(ii) and (c)(2))

- Retain the policy that eligibility for the Indian Health Service does not constitute eligibility for government-sponsored minimum essential coverage. (Proposed Rule § 1.36B-2(c)(2))

- Exempt AI/AN from the requirement to enroll in employer-sponsored coverage.

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

(Proposed Rule § 1.36B-2(c)(3))

- Provide, at least on an interim basis, a "safe harbor" exemption from the requirement to make a payment in the amount of any excess premium assistance payments made by the Federal government to a plan on behalf of an AI/AN to the extent that the initial determination of premium assistance was based on a good faith estimate of annual household income. (Proposed Rule § 1.36B-3(d))

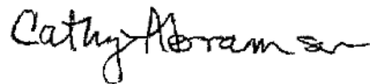
- Clarify, along with HHS, that any payments of cost-sharing assistance made by the Federal government to a plan on behalf of an AI/AN or any other enrollee under ACA §§ 1402 or 1412 that may be subsequently evaluated to be in excess of the amount an individual is eligible to receive will not be required to be paid by the enrollee to the plan, Exchange, or to the Federal government. (ACA §§ 1402 and § 1412)

- Consider the attached presentation on the definition of Indian as IRS/Treasury proceeds to integrate implementation of the ACA with HHS.

- Engage in continued consultation with Tribes on these and other matters pertaining to the implementation of the Affordable Care Act in order to fully, efficiently and effectively carry out the Federal Trust Responsibility.

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

Sincerely,



Cathy Abramson
Chairman, National Indian Health Board

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

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

National Indian
Health Board

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

Analysis of and Recommendations on Proposed Rule by the National Indian Health Board[1] (Comments)

October 31, 2011

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

In these Comments, NIHB provides analysis and recommendations on provisions specific to American Indians and Alaska Natives (AI/ANs) as well as to provisions generally applicable to all Americans. Furthermore, these Comments discuss the applicability to and impact on the Indian Health Service, Tribes and Tribal organizations, and urban Indian organization health care providers (which are referred to as Indian Health Care Providers or I/T/U).[2] The Patient Protection and Affordable Care Act[3] as well as a host of other Federal

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

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

[3] Refers collectively to the Patient Protection and Affordable Care Act (Pub.L. 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), and referred to herein as the Affordable Care Act or ACA. Section 36B, contained in section 1401 of the ACA, was subsequently amended by the Medicare and Medicaid Extenders Act of 2010 (Pub. L. 111-309), the Comprehensive 1099 Taxpayer

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laws and regulations govern Indian Health Care Providers and impact the structure and policies of such providers. These Federal laws and regulations (including, but not limited to, the Snyder Act, the Indian Health Care Improvement Act (IHCIA),[4] the ISDEAA, the Federal Tort Claims Act (FTCA) and the Anti-Deficiency Act[5]) also impact the range of functions, policies, and operations of an Affordable Health Insurance Exchange (Exchange) through which premium assistance will be accessed.

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

1. Background

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

With the addition of section 36B to the Internal Revenue Code (IRC), health insurance coverage secured in the individual market through an Exchange is made more affordable to enrollees who have household income under 400 percent of the Federal poverty line[6] by reducing an individual's premium costs. This is accomplished through premium tax credits provided by the Federal government, with the Exchange making an advance determination of credit eligibility for individuals enrolling in coverage through an Exchange and the amount of the advance payments. IRS provides the advanced payment of the premium tax credits directly to the Exchange plan selected by the taxpayer/enrollee(s).

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

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

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

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

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

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

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

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

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

2. Federal Trust Responsibility

The Federal government has a unique responsibility and obligation to American Indians and Alaska Natives. This Federal Trust Responsibility is enshrined in Federal law[8] and guided by the government-to-government relationships between the Federal government and Tribes.[9] Historically, the Federal Trust Responsibility to provide health care services to AI/ANs has been carried out through the Indian Health Care Providers. Facilitated by provisions in the IHCIA, Medicare and Medicaid have become important additional means through which the resources to fulfill the Federal Trust Responsibility have been made available. Now, with the passage of the Affordable Care Act and the assistance to be provided to certain AI/ANs enrolled through an Exchange, Congress established an additional mechanism—although not a replacement mechanism—to fulfill the Federal Trust Responsibility and to achieve the national Indian health policy reconfirmed by Congress in § 103 of the Indian Health Care Improvement Act, which was enacted as part of the ACA.[10]

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

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

[9] *See*, 25 U.S.C. § 1602(6).

[10] 25 U.S.C. § 1602.

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

3. Tribal Consultation

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

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

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

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

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

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

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

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

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

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

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

[12] ―Memorandum for the Heads of Executive Departments and Agencies," November 5, 2009, requiring implementation of Executive Order 13175, ―Consultation and Coordination with IndianTribal Governments," November 6, 2000.

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

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

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

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

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

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

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

15 IHCIA § 408.

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

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

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

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

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

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

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

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

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

[17] ACA § 1312(f)(1) and (3).

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

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

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

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

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

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

This language is repeated in the preamble to the Proposed Rule[19] and contained in the proposed § 1.36B-3(c)(1)(ii)[20] without further elaboration. However, in the proposed § 1.36B-3(c)(2), clarification is added that premiums may be paid by someone other than the taxpayer.

[19] 76 Fed.Reg. 50933.

[20] 76 Fed.Reg. 50943.

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

NIHB supports the clarification that payments by some other person will be treated as a payment "by the taxpayer." For purposes of AI/AN, the ability to credit coverage paid for on behalf of the taxpayer is important. Since AI/ANs are entitled to free health care through the Indian Health Care Providers, as a general rule, they are understandably reluctant to pay premiums directly. Consistent with § 402 of the IHCIA, the Exchange Establishment proposed rule[22] created an option to allow and facilitate the payment of premiums on behalf of AI/AN by Tribes or tribal organizations.

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

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

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

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

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21 *Id.*

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

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

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

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

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

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

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

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

> _Census Bureau definition of health insurance coverage removed IHS programs._[25]
>
> The Census Bureau collects data about different types of health insurance coverage and broadly classifies the types into either Private (non-government) coverage and Government-sponsored coverage. At one time, the "major categories of government health insurance" included programs operated by the IHS. The Census Bureau definition was subsequently revised, and for over a decade

[24] ACA § 1302.

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

> the definition of health insurance coverage used by the Census Bureau has not included programs operated by the IHS.
>
> A footnote to the "CPS Health Insurance Definitions" reads: "After consulting with health insurance experts, the Census Bureau modified the definition of the population without health insurance in the Supplement to the March 1998 Current Population Survey, which collected data about coverage in 1997. Previously, people with no coverage other than access to the Indian Health Service were counted as part of the insured population. Subsequently, the Census Bureau has counted these people as uninsured. The effect of this change on the overall estimates of health insurance coverage was negligible."[26]
>
> Due to the limitations on annual appropriations, the IHS does not provide guaranteed access to a defined set of covered services for the eligible population. As indicated above, the IHS is funded for only a fraction of the level required to provide guaranteed access to a standard set of covered services. As is the case with other health care programs operated by governments at the Federal, State or local level, health care programs that do not provide guaranteed access to a defined and comprehensive set of services—such as is the case with the IHS programs—should not be included in the definition of "creditable coverage" for purposes of implementing the PCIP.

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

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

In fact, because of the funding shortfall, IHS estimated the extent of health service denials at $130 million in 2008.[28] As a comparison, per capita spending for IHS medical care in 2003 was only slightly more than 50% of the per capita amount spent for Federal prisoners.[29]

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[26] http://www.census.gov/hhes/www/hlthins/methodology/definitions/cps.html

[27] Congressional Budget Office, *"Key Issues in Analyzing Major Health Insurance Proposals," at 127 (Dec. 2008).*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[30] *See* discussion and recommendation under ―7. Reconciling the Premium Tax Credit with Advance Credit Payments".

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

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

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

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

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

NIHB recommends that IRS and HHS give consideration to simplifying the Proposed Rule on computing the premium tax credit amount. Although taxpayers/enrollees will have the assistance of the Exchange tools as well as Navigators[32] in determining their eligibility for tax credits and the amount of the premium tax credit, these individuals will need to be able to compute their actual eligibility and tax credit amount on their annual tax filing the IRS. Every effort should be made to enable individuals to be able to use the most simplified tax forms and minimal calculations in order to minimize confusion and uncertainty on the part of taxpayers. For AI/ANs, we anticipate that the greater the degree of uncertainty and confusion around their eligibility for, and the amount of, the premium tax credit the lesser the likelihood that AI/ANs will be willing to access the premium tax credits by enrolling in comprehensive health insurance coverage through an Exchange.

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

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

[31] 76 Fed.Reg. 50938.

[32] ACA § 1311(i).

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

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

> (B) APPLICABLE SECOND LOWEST COST SILVER PLAN.—
> The applicable second lowest cost silver plan with respect to any applicable taxpayer is the second lowest cost silver plan of the individual market in the rating area in which the taxpayer resides which—
>> (i) is offered through the same Exchange through which the qualified health plans taken into account under paragraph (2)(A) were offered, and
>> (ii) provides—
>>> (I) self-only . . .
>>> . . .
>>> (II) family coverage in the case of any other applicable taxpayer.
>>> . . .

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

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

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

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

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

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

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

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

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

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

> (2) RATING AREA.—
>
> (A) IN GENERAL.—Each State shall establish 1 or more rating areas within that State for purposes of applying the requirements of this title.
>
> (B) SECRETARIAL REVIEW.—The Secretary shall review the rating areas established by each State under subparagraph (A) to ensure the adequacy of such areas for purposes of carrying out the requirements of this title. If the Secretary determines a State's

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

35 ACA § 1311(f)(2).

36 ACA § 1311(f)(1).

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

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

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

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

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

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

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

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

> § 155.1055 Service area of a QHP.
>
> The Exchange must have a process to establish or evaluate the service areas of QHPs to determine whether the following minimum criteria are met:
>
> (a) The service area of a QHP covers a minimum geographical area that is at least the entire geographic area of a county, or a group of counties defined by the Exchange, unless the Exchange determines that serving a smaller geographic area is necessary, nondiscriminatory, and in the best interest of the qualified individuals and employers.
>
> (b) The service area of a QHP has been established without regard to racial, ethnic, language, health status-related factors listed in section 2705(a) of the PHS Act, or other factors that exclude specific high utilizing, high cost or medically-underserved populations.[40]

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

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

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

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

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

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

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

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

(Bold indicates addition.)

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

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

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

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

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

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

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

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

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

43 *See* discussion at ~~–5~~.4 Safe Harbor for Initial Estimate of Annual Income" above.

44 IRC § 5000A.

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

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

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

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

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

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

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

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[46] ACA§ 1401(a) / IRC 36B(f)(2)(A).

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

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

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

8. Cost-Sharing Reductions

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

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

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

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

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

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

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

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

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

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

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

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

Under § 1.36B-5(b) "Time and manner of reporting," NIHB recommends that taxpayers should be able to go to the Exchanges at any time (electronically or in-person) and print out a record of the tax credits that they have received. Exchanges should also have a simple way to recalculate premiums and tax credits for people whose circumstances change and for people who stop their insurance or re-enroll in Exchange coverage. For example, if an AI/AN enrolls, disenrolls, and later reenrolls in health plans offered through an Exchange as permitted during the Special Enrollment periods[49], the individual's tax credits should be recalculated by the Exchange and a running total of advance payments made should be available to the taxpayer and IRS at any time. The Exchange should be able

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

[49] ACA§ 1311(e)(6)(D).

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

10. Definition of Indian

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

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

National Indian Health Board

National Indian Health Board

-- Supplemental Submission –

Analysis of and Comment on Definition of “Indian” in Proposed Rules to Implement Provisions of the Patient Protection and Affordable Care Act[1]
(“Analysis and Comment”)

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

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

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

October 31, 2011

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

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

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

> Congress declares that it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians—
>
> (1) to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy;
>
> (2) to raise the health status of Indians and urban Indians to at least the levels set forth in the goals contained within the Healthy People 2010 initiative or successor objectives;
>
> (3) to ensure maximum Indian participation in the direction of health care services so as to render the persons administering such services and the services themselves more responsive to the needs and desires of Indian communities;
>
> (4) to increase the proportion of all degrees in the health professions awarded to Indians so that the proportion of Indian health professionals in each Service area is raised to at least the level of that of the general population;

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

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

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

1. Statement of the Problem.

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

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

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

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

[3] ACA § 1311(c)(6)(D).

[4] ACA § 1402(d).

[5] ACA §§ 1411(b)(5)(A) and Internal Revenue Code (―IRC") § 5000A(e)(3), as enacted by ACA § 1501(b).

[6] Hereafter referred to as ―Exchange Establishment NPRM" or CMS-9989-P.

[7] Hereafter referred to as ―Exchange Eligibility NPRM" or CMS-9974-P.

[8] Hereafter referred to as ―Premium Tax Credit Proposed Rule" or IRS REG-131491-10.

[9] 25 U.S.C. § 1603.

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

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

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

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[10] 25 U.S.C. § 450b(d).

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

[12] 76 Fed. Reg. 41884.

[13] 75 Fed. Reg. 51205.

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

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

[16] 76 Fed. Reg. 14884 and 51205.

More simply put,

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

2. Recommended Solutions.

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

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

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

Finally, the statutory definitions should be operationalized in the final rules so that people not steeped in Indian law can easily determine whether an individual is an Indian for the purposes of the ACA, preferably and most correctly, as the definition is set forth in 42 C.F.R. § 447.50.[17] CMS promulgated Section 447.50 to implement the AI/AN-specific

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[17] This definition of “Indian” is:

> any individual defined at 25 USC 1603(c)[IHCIA Sec. 4(13)], 1603(f) [IHCIA Sec. 4(28) , or 1679(b) [IHCIA Sec. 809], or who has been determined eligible as an Indian, pursuant to Sec. 136.12 of this part. This means the individual:
>
> (i) Is a member of a Federally-recognized Indian tribe;
>
> (ii) Resides in an urban center and meets one or more of the following four criteria:

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

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

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

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

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

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

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

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

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

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

[18] Pub. L. 111-5.

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

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

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

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

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

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

> The term ―Indian tribe" means any Indian tribe, band, nation, pueblo, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act, which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status of Indians.
>
> IHCIA Sec. 4(14), ISDEAA Sec. 4(d), AND IRC Sec. 45A(c)(6)
> IRC Sec. 45A(c)(6) only
> IHCIA Sec. 4(14) only

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

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

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

22 25 U.S.C. § 450b(d).

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

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

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

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

The Alaska Native Claims Settlement Act (―ANCSA")[25] was enacted in 1971 in order to settle land claims by Alaska Natives. Although ANCSA had the effect of extinguishing the Indian reservations in Alaska[26] and transferring title of selected lands to Alaska Native regional and village corporations, it did not eliminate the special trust relationship of the United States to Alaska Natives.

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

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

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

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

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

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

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

3.1.2 Other Organized Groups and Communities – California Indians.

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

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

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

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

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

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

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

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

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

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

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

3.1.3 Other Organized Groups and Communities – Urban Indians.

In keeping with the Federal government‘s obligation to provide services to AI/ANs and its policy of Indian self-determination, Title V of the IHCIA established the use of Indian controlled, non-profit corporations to serve as the surrogate over the welfare and special health programs for the benefit of Indians in certain defined metropolitan areas. The principle of Indian self-determination was at the core of this approach by providing that the responsibility to aid urban Indians was to be fulfilled by an Indian community-represented Board of Directors. To assure that the welfare of Indians was paramount in this transformation, the Board is required to be representative of the community by assuring that the majority of Board members are of AI/AN heritage. In order to ensure a broad scope of urban Indian eligibility, Congress created a more inclusive definition[37] taken from the 1934 Johnson-O‘Malley Indian Education Act.

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

[36] The federal regulations implementing the ISDEAA define the term ―Indian Contractor" as follows:

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

25 C.F.R. § 900.181.

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

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

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

Courts have specifically held that the definition of Indian found in the IHCIA and ISDEAA is not limited to members of Federally-recognized Tribes. For example, courts have specifically held that this definition can under some circumstances include state-recognized tribes[38] and, in certain cases, even entities that are *not* eligible for special programs.[39]

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

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

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

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

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

[40] *Schmasow*, 978 P.2d at 304.

[41] *Id.* at 308.

[42] *Id.* (emphasis added).

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

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

3.1.5 Canons of Statutory Construction.

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

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43 *Schmasow*, 978 P.2d at 308.

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

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

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

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

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

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

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

> **(7)** the term “Indian” means a member of an Indian tribe;
>
> **(8)** the term “Indian tribe” has the meaning given that term in section 450b of Title 25.[52]

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

3.2 The Snyder Act.

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

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

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

52 20 U.S.C. § 80q-14(7)-(8).

The Snyder Act is the primary statute authorizing the Federal government to provide health care to Indians and implementing the unique Federal obligations to Indians. It directs and authorizes HHS[53] to ―direct, supervise, and expend such moneys as Congress may from time to time appropriate, for the benefit, care, and assistance of the Indians throughout the United States" for the ―relief of distress and conservation of health."[54] The statute was enacted for the ―special benefit of Indians and must be liberally construed in their favor."[55]

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

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

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

[54] 25 U.S.C. § 13.

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

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

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

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

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

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

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

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

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

> Services will be made available, as medically indicated, to persons of Indian descent belonging to the Indian community served by the local facilities and program.
>
> . . .
>
> Generally, an individual may be regarded as within the scope of the Indian health and medical service program if he/she is regarded as an Indian by the community in which he/she lives as evidenced by such factors as tribal membership, enrollment, residence on tax-exempt land, ownership of restricted property, active participation in tribal affairs, or other relevant factors in keeping with general Bureau of Indian Affairs practices in the jurisdiction.[60]

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

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

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

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

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

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

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

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

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

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

62 *Id.* at § 458aaa-4(b)(2)(D).

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

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

5.1 The Transfer Act.

The Transfer Act provided

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

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

5.2 Judicial Deference to Agency Regulations.

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

[65] Pub. L. 83-568.

[66] Sec. 3 of Pub. L. 83-568.

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

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

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

Judicial deference is even required when the court disagrees with the agency‘s interpretation.[70]

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

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

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

5.3 Statutory Ambiguity Should Be Resolved by Regulations.

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

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

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

72 694 F.2d 1162 (9th Cir. 1982).

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

74 24 C.F.R. § 805.102.

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

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

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

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

The reliance on three different statutory references (or none) for the definition of ―Indian" in the ACA creates an inherent ambiguity that requires resolution. For example, § 1311(c)(6)(D) of the ACA[81] creates ―special monthly enrollment periods for Indians (as defined in section 4 of the Indian Health Care Improvement Act)." By comparison, §

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

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

[78] 467 U.S. 837 (1984).

[79] *See*, Section 3 of this Analysis and Comment.

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

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

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

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

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

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

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

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

[84] *See*, ARRA § 5006.

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

[86] 76 Fed. Reg. 51223.

[87] Exchange Eligibility NPRM § 155.315(c).

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

5.3.2 The Ambiguity Should Be Resolved in Regulations.

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

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

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

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

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

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

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

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

As noted earlier, HHS officials have suggested that HHS may not adopt the definition in § 447.50 promulgated under ARRA for the purposes of the ACA because the agency‘s regulatory authority under ACA is different than under ARRA. They note that ARRA did not specifically define ―Indian” and suggest that the Snyder Act of 1921[91] authorized HHS to craft the definition in § 447.50 to fill in the gap left by the statute. By comparison, these officials worry that Congress‘s inclusion of statutory definitions of ―Indian” in the ACA does not leave room for administrative interpretation, and that only Congress may reconcile the ACA‘s multiple definitions of the term.

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

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

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90 *Id.* at 842–843.

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

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

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

94 *Malone*, 38 F.3d at 438.

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

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

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

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

5.3.3 Documentation Requirements Should Be Simple and Readily

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

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

[97] 415 U.S. 199 (1974).

[98] *Id.* at 230-31.

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

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

Accessible.

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

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

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

6. Summary of Argument

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

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

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

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

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

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

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

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