National Indian Health Board

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

October 31, 2011

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G
Attention: CMS-9989-P
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

RE: NIHB Comments on CMS-9989-P: Establishment of Exchanges and Qualified Health Plans

The National Indian Health Board[1] (NIHB) is submitting the attached analysis and 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 July 15, 2011 in the *Federal Register* titled "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans" (CMS-9989-P or Proposed Rule). We appreciate the opportunity to comment on this Proposed Rule.

In October of 2010, NIHB provided written comments in response to the Request for Comments regarding Exchange-related provisions in Title I of the Patient Protection and Affordable Care Act published in the *Federal Register* on August 3, 2010 (CMS-9989-NC).[2] Those earlier comments provide additional background and context to the issues and

[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] *See* NIHB letter to the Office of Consumer Information and Insurance Oversight, dated October 4, 2010 submitted via electronic transmission via http/www.regulations.gov.

comments pertaining to this Proposed Rule. In the attached analysis and comments, the comments are presented in the order of the sections in the Proposed Rule, and each section is noted.

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

Federal Trust Responsibility

The Federal government has a unique responsibility and obligation to American Indians and Alaska Natives (AI/ANs), and this Federal Trust Responsibility is enshrined in Federal law[3] and guided by the government-to-government relationships between the Federal government and Tribes.[4] Historically, the Federal Trust Responsibility to provide health care services to AI/ANs has been carried out through Indian Health Care Providers, comprised of the Indian Health Service, Tribes and tribal organizations, and urban Indian organizations. Collectively, these entities are sometimes referred to as "I/T/U". Under provisions of the Indian Health Care Improvement Act (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[5] and the assistance to be provided to certain AI/ANs enrolled through an Exchange, an additional mechanism—although not a replacement mechanism—has been put in place to fulfill the Federal Trust Responsibility and achieve the policies set out by Congress.

Summary of Attached Analysis and Comments

In drafting these comments, a primary focus of NIHB is to ensure that this new additional avenue for carrying out the Federal Trust Responsibility is designed in a manner that creates real, workable options for AI/ANs that ensure AI/ANs will have timely access to the full range of needed health care services from their providers of choice. If as a Nation, we are successful in achieving this result, AI/ANs, Tribes, and the Federal government will each benefit:

- Additional resources for health care services will be brought to AI/AN communities, thereby furthering the fulfillment of the Federal Trust Responsibility;
- Demands on capped Federal appropriations will be lessened;
- AI/AN access to a full range of needed health care services will be expanded;

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[3] Most recently in Section 102 of the Indian Health Care Improvement Act, 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".)

[4] *See*, 25 U.S.C. § 1602(6).

[5] 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), are collectively referred to herein as the Affordable Care Act or ACA.

- I/T/U providers will be strengthened and further integrated into broader (non-I/T/U) provider networks;
- Substantial Indian-specific special benefits and cost-sharing protections will be afforded to AI/ANs, facilitating their access to needed care; and
- This new Exchange mechanism will offer an efficient way of securing more affordable health insurance coverage to supplement and support the existing, underfunded Indian health system.

In seeking to accomplish the goal of AI/ANs having timely access to a full range of needed health care services from their providers of choice, we recognize there is a tension between two approaches to implementation. CMS has worked to provide maximum flexibility to States, within the framework and constraints of the ACA. But for a finite number of Indian-specific provisions, efficient and effective implementation requires standardization, not flexibility and delegation to the States.

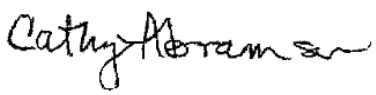
Recognizing the preference of CMS to grant maximum flexibility to States, we have limited our recommendations for greater standardization only to areas that are required by Federal law and/or would achieve substantially greater efficiency and effectiveness in carrying out the intended goal as a result of that standardization. In summary, NIHB offers the following primary recommendations –

- Require health plans, as a condition of participation in an Exchange, to offer to include Indian Health Care Providers as in-network providers in their health plans. (§ 155.1050; § 156.230; § 156.235)
- Require health plans offered through an Exchange to use an "Indian Addendum" with I/T/U providers to facilitate the identification and enforcement of Indian-specific provisions of Federal law. (§ 155.120; § 156.230)
- Facilitate Tribes and Tribal organizations in becoming financial sponsors for AI/ANs by requiring each Exchange to permit Indian Tribes, tribal organizations and urban Indian organizations to pay the unsubsidized portion of health plan premiums on behalf of Exchange enrollees they designate, through an aggregated payment process. (§ 155.240)
- Require and enforce tribal consultation by States and their Exchange-designated entities in the planning, implementation and operation of State Exchanges, and ensure adequate funding for the technical assistance provided to the States and Exchanges by AI/ANs and Tribal entities. (§ 155.100; § 155.105; § 155.130)

- Implement application of a definition of "Indian" that is consistent with the various provisions of the Affordable Care Act and captures the breadth of authorities under which individuals are identified as Indian, such as is contained in current CMS regulations,[6] but at a minimum recognize that the definitions under the Indian Self-Determination and Education Assistance Act and the Indian Health Care Improvement Act are operationally the same. (A detailed presentation on the definition of Indian will be provided by NIHB as a supplemental submission to these comments, as well as in our comments submitted in response to CMS-9974-P, "Exchange Functions in the Individual Market: Eligibility Determinations".) (§ 155.405; § 155.420; § 155.520; § 155.1000; § 156.250)

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 Comments on CMS-9989-P: Establishment of Exchanges and Qualified Health Plans

[6] As defined in section 447.50(b)(1) of title 42 of the Code of Federal 10 Regulations, as in effect on July 1, 2010.

National Indian Health Board

Establishment of Exchanges and Qualified Health Plans
Implemented Consistent with Title I of the Patient Protection and Affordable Care Act[1]
(CMS-9989-P; Proposed Rule)

Analysis of and Comments 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 these Comments on the Department of Health and Human Services' Proposed Rule, "Establishment of Exchanges and Qualified Health Plans," released July 15, 2011.

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

Preamble to Proposed Rule

Summary

The Proposed Rule Summary explains that the Centers for Medicare and Medicaid Services (CMS) of the Department of Health and Human Services (HHS or Department) intends to afford States substantial flexibility in the design and operation of Affordable Insurance Exchanges (Exchanges), but proposes "greater standardization… where required by the statute or where there are compelling practical, efficacy, or consumer protection reasons."[3] Where American Indian and Alaska Native (AI/AN) issues are considered, NIHB

[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), are collectively referred to herein as the Affordable Care Act or ACA.

[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 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.

[3] Proposed Rule, page 41867.

urges CMS to use the approach of greater standardization. NIHB notes that Indian law and programs are almost exclusively Federal; the pertinent Federal laws apply to all Tribes in all States; and these Federal laws and the associated implementing regulations have supremacy over State laws and regulations. Furthermore, a host of Federal laws and regulations govern Tribes and Indian Health Service, Tribal and Urban Indian health care providers (which are also referred to as Indian Health Care Providers or "I/T/U")[4] 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), the ISDEAA, the Federal Tort Claims Act (FTCA) and the Anti-Deficiency Act[5]) will impact State-operated and Federally-operated Exchanges alike.

American Indians and Alaska Natives are not the only ones that would benefit from standardization related to Indian health provisions. At an event sponsored by the Bipartisan Policy Center and the Kaiser Family Foundation on July 27, 2011, representatives of large insurance companies stated that it would be more difficult for them to work with 50 Exchanges with different rules and that they would prefer a more standardized approach. They also said that their biggest fear was adverse selection. Because of health disparities among the AI/AN population, there are incentives for issuers to avoid adverse selection by structuring plans to exclude AI/ANs. Requiring all plans to offer to include Indian health providers and to utilize the suggested addendum for Indian health system contracts – two recommendations presented later in these Comments – would level the playing field for issuers as well as assure network adequacy for AI/AN consumers.

To have all 35 States with Tribes negotiating the same points of Federal Indian law to reach the same conclusions already mandated by Federal law is inefficient and costly, particularly for those States that have few Tribes and where a very small portion of the population is AI/AN. In many States, it is the office of the State Insurance Commissioner that is responsible for planning Exchanges. While Indian Health Care Providers have established relationships with Medicaid Directors and directors of public health in their States, most have not developed relationships with insurance commissioners. Furthermore,

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[4] 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.

[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.

most Insurance Commissioners do not have knowledge about Federal Indian law and the structure of Indian health services.

Definition of "Indian"

In a number of locations in these Proposed Rules, and in other released and to-be-released proposed rules, there is a request for comment about the definition of "Indian" and various issues associated with the special benefits and protections afforded AI/ANs if they are determined to be Indian. In consultations with Tribes and in this and other pending proposed rules, CMS has noted that the ACA used multiple definitions of "Indian" that apply to different protections and benefits. CMS also asserted in the consultations and the Proposed Rules that it lacks the flexibility to reconcile the differences it believes are present or to settle on a single definition. Despite these assertions, in the preamble to the Proposed Rule and the Exchange Eligibility proposes rule (CMS-9974-P), CMS has actually narrowed the definition by opining that both the IHCIA and ISDEAA statutory provisions mean that an Indian is "a member of a Federally-recognized tribe." NIHB does not believe this conclusion is supported by the plain language of either statute and believes that it is contrary to general principles of Indian law.

Because of the central importance of this issue, NIHB has developed comprehensive comments on the definition of Indian. These comments are being made as a supplemental submission to these Comments and as an attachment to our comments in response to other proposed rules, including specifically, CMS-9974-P, "Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers," published in the *Federal Register* on August 17, 2011[6] and as an attachment to its comments in response to the Department of the Treasury, Internal Revenue Service's notice of proposed rulemaking published in the *Federal Register* on August 17, 2011 titled REG-131491-10, "Health Insurance Premium Tax Credit."[7] The attached supplemental submission on the definition of Indian (hereafter to be referred to as "NIHB's Supplemental Submission") comments on general principles of law that we believe require a different conclusion than that reached so far by CMS and other Federal agencies addressing this issue, but also on the specific sections of this Proposed Rule and the Exchange Eligibility NPRM (CMS-9974-P) in which this issue is presented.

NIHB is incorporating and attaching NIHB's Supplemental Submission by reference into these Comments.

I. Background

A. Legislative Overview

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

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

1. Legislative Requirements for Establishing Exchanges

As explained in this section of the preamble to the Proposed Rule, section 1321(c)(1) of the ACA requires the Secretary of HHS to establish and operate an Exchange in States that forgo establishing an Exchange, or, as determined by the Secretary on or before January 1, 2013, cannot establish an operable Exchange by January 1, 2014. This directive creates the imperative for the Secretary to establish the blueprint for Federal Exchanges, while subsection (a) of the same section provides the authority for the Secretary to establish standards and regulations applying to both Federal as well as State Exchanges. Section 1321(a)(2) also requires the Secretary to engage in consultation to ensure balanced representation among interested parties.

Because of the potential impact of Section 1321, in the context of operating a Federal Exchange and in the creation of a template and standard, NIHB urges CMS to consult with Tribes about the development of a Federal Exchange(s) and the specific requirements placed on the Qualified Health Plans (QHP) offered through a Federal Exchange(s). Some States with substantial AI/AN populations, such as Alaska, have already indicated that they are not planning to operate a state Exchange. Other States are also likely to not take on the responsibility of establishing and operating an Exchange. As such, NIHB believes that the Federal Exchange holds the potential to greatly impact health care options for AI/ANs. NIHB stresses that these Comments on this Proposed Rule should not serve as a substitute for CMS consultations with Tribes on the design and operation of a Federal Exchange.

2. Legislative Requirements for Related Provisions

The discussion offered in the Proposed Rule states that some of the special benefits and protections to AI/ANs are included in this Proposed Rule in Section 156, Subpart C, while other benefits and protections will be addressed in future rulemaking.

The addressing of AI/AN-specific benefits and protections in a series of proposed rules, without knowing the content of future proposed rules, makes it difficult to offer comments on potential omissions. NIHB recommends that CMS provide a table with the special AI/AN and I/T/U provisions in the ACA and indicate where these provisions will be addressed in the proposed rules.

B. Stakeholder Consultation and Input

According to the Proposed Rule, HHS has been holding weekly meetings with the National Association of Insurance Commissioners (NAIC). In many States, Insurance Commissioners are the entities charged with planning for State health insurance Exchanges.

NIHB strongly urges CMS to work with Tribes to undertake a thorough education of State health insurance commissioners on issues related to Indian law, the structure of the Indian health care delivery system, and protocols for consulting with Tribes.

These efforts are necessary and prudent. Tribes and Indian Health Care Providers have fairly well-developed relationships with State Medicaid Directors and State Public Health Directors, but most have no relationship or experience working with State insurance commissioners. Some Tribal representatives who have tried to contact their State's health insurance commissioner have reported that their phone calls are not returned, or that the health insurance commissioner knows nothing about Indian health programs, Tribes or Tribal consultation.

In addition to supporting a push to educate Insurance Commissioners, NIHB suggests that this evidence provides yet another reason to standardize requirements for AI/ANs in Federal regulations. Standardization would assure that the intent of the law is – efficiently and effectively – carried out with respect to participation by Indian consumers and Indian health providers.

SUBCHAPTER B – REQUIREMENTS RELATING TO HEALTH CARE ACCESS

A. Part 155 – Exchange Establishment Standards and Other Related Standards under the ACA

1. Subpart A –General Provisions

155.20 Definitions.

For reasons we discuss in more detail below, we believe that the definition of "Indian" should be added to the definitions and that definition should be used uniformly throughout this Proposed Rule. As such, a uniform definition of Indian would apply to the special monthly enrollment periods for Indians (ACA section 1311), the cost-sharing for Indians with income at or below 300 percent of the Federal poverty level (ACA section 1402(d)(2), and the cost-sharing for Indians who obtain health services from an Indian Health Care Provider).

Subpart B –General Standards Related to the Establishment of an Exchange by a State

155.100 Establishment of a State Exchange.

Section 1311(d)(6) of the Affordable Care Act requires Exchanges to consult with certain groups of stakeholders as they establish their programs and throughout ongoing operations. In §155.130, the Proposed Rule directs that each Exchange that has one or more Federally-recognized Tribes located within its geographic region must engage in regular and meaningful consultation with such Tribes and their officials. The Proposed Rule further clarifies that consultation is a government-to-government process with a key role being

filled by the State. The Proposed Rule encourages States to develop a Tribal consultation policy that is to be approved by the State, the Exchange, and Tribes.

The Proposed Rule at paragraph (b) of §155.100, will implement section 1311(d)(1) of the Affordable Care Act so that an Exchange must be a governmental agency or non-profit entity established by the State. Some States have passed legislation establishing Exchange governing bodies as independent public entities with minimal oversight by the State. These entities may report directly to consumer advisory councils or directly to State legislatures. In these circumstances, it may be difficult to require and monitor "regular and meaningful" consultation.

NIHB suggests that the Proposed Rule require HHS approval of a State's Tribal consultation policy before a State Exchange Plan can receive approval. This measure would ensure that requirements set out in §155.130 are met. Under our proposal, a Tribal consultation policy would be developed and approved by the State, the Exchange and by Tribal governments prior to the submission of a State Exchange Plan for approval by HHS.

NIHB suggests that the Proposed Rule reference the recent "Dear Governors" letter issued by Secretary Sebelius whereby the requirement for States to consult with Tribes is noted, and the letter emphasizes the importance of involving Tribes in the design as well as implementation of Exchanges.[8] In the letter, Secretary Sebelius notes,

> Since President Obama signed an Executive Order on Tribal Consultation in 2009, HHS has also updated its formal Tribal consultation policy. The updated policy includes the responsibility of states to consult with Tribes when HHS has transferred the authority and funding for programs to states that are intended to benefit Tribes. States must consult with Tribes to ensure the programs that they administer with federal funding meet the needs of the Tribes in that state. Tribes should be considered full partners by states during the design and implementation of programs that are administered by states with HHS funding. The requirement of states to consult with Tribes in the development of the Affordable Insurance Exchanges is an example of how states can proactively include and partner with Tribes during the planning stages of a program that has the potential to benefit Tribal members greatly.

If consultation requirements are not enforced, it is highly likely that governing bodies established to operate Exchanges will not fulfill requirements for Tribal consultation in a meaningful way. This has been the experience of Tribes nationally in the Medicaid program. Experience has demonstrated that States have often failed to establish viable mechanisms to ensure meaningful Tribal input into matters that affect them. To correct this situation, § 5006(e) of the American Recovery and Reinvestment Act (ARRA) amended

[8] Kathleen Sebelius, Secretary, Department of Health and Human Services, "Dear Governors" letter, September 14, 2011.

the Social Security Act at § 1902(a)(73), to require that States utilize a process to seek advice on a regular, ongoing basis from designees of the Indian Health Programs and Urban Indian Organizations concerning Medicaid and CHIP matters that have a direct effect on Indians, Indian Health Programs or Urban Indian Organizations. A similar requirement must be established in the final rules for Exchanges.

NIHB also recommends that CMS extend the authority and responsibility of the CMS Native American Contacts to include facilitating and interacting with the State Exchange governing and administrative bodies, as well as with Tribes on Exchange-related issues. In addition, we recommend that, as a component of the ongoing requirement for tribal consultation, Exchanges be required to establish an "Indian desk" with the lead person(s) identified and contact information made readily available.

155.105 Approval of a State Exchange.

This portion of the Proposed Rule sets out the State Exchange approval standards and the approval process. Noticeably absent is the requirement that States show they have complied with Tribal consultation mandates. Also absent is the requirement that States agree to comply with AI/AN-specific provisions under the rules and law. Although the Proposed Rule requires a State to show that its Exchange "is able to carry out the required functions of an Exchange" and that the exchange demonstrate "operational readiness," neither of these measures provide an assurance that the State will perform its responsibilities under AI/AN and Tribal provisions.

The HHS approval process for State health insurance Exchanges should include standards related to the Exchange's ability to identify AI/ANs and ensure that the benefits and protections in the law are carried out through the Exchange, including waiving cost sharing. Furthermore, as required under section 408 of the IHCIA and discussed later in these Comments, the approval process should ensure that States with I/T/U providers require health plans offered in an Exchange to offer to contract with all I/T/U providers in that State. Also, HHS approval should require States to demonstrate that they have carried out meaningful consultation with Tribes in the design of the Exchanges.

To ensure these requirements are met, NIHB recommends that HHS conduct an assessment of implementation of AI/AN provisions and tribal consultation as part of the 'readiness assessment' process and the grants monitoring process(for State planning and establishment grants). That assessment should include reporting on specific matters by the State officials responsible for designing health insurance Exchanges, and should also include a mechanism for the I/T/U to comment directly to HHS.

The Proposed Rule requests input and comments about the utilization of the State plan amendment process similar to the process for Medicaid and CHIP for significant changes to the Exchange Plan. It is imperative that a formal process be established for Exchanges to make such changes. We believe that the State plan amendment process can

serve as an effective mechanism for obtaining written approval. In instances when approval is not granted it can serve as a process for providing the Exchanges technical assistance in order to achieve approval and compliance. The process is well understood by State Medicaid programs and can serve as a model for the Exchange.

The Proposed Rule proposes that a State must notify HHS before significant changes are made to the Exchange Plan and receive written approval from HHS. The Medicaid and CHIP State Plan Amendment process is considered the model.

NIHB believes that the tribal consultation requirements for State Plan Amendments should also be applied to Exchange Plan amendments. In particular, the Recovery Act added a provision to the Social Security Act requiring States to solicit advice from I/T/U providers prior to submission of a Medicaid State plan amendment. The section reads as follows:

> [I]n the case of any State in which 1 or more Indian Health Programs or Urban Indian Organizations furnishes health care services, provide for a process under which the State seeks advice on a regular, ongoing basis from designees of such Indian Health Programs and Urban Indian Organizations on matters relating to the application of this title that are likely to have a direct effect on such Indian Health Programs and Urban Indian Organizations and that— ''(A) **shall include solicitation of advice prior to submission of any plan amendments, waiver requests, and proposals for demonstration projects likely to have a direct effect on Indians, Indian Health Programs, or Urban Indian Organizations.**[9] (emphasis added)

NIHB recommends that such a requirement be included with the general requirement for Exchanges to use a State Plan Amendment-like process. NIHB also recommends that HHS require Exchanges to complete a preprint form documenting Tribal consultation procedures similar the preprint required for State plan amendments, which was distributed in CMS-SMDL#: 10-001. Among the significant changes that should trigger an HHS review are any changes that would affect the ability of AI/ANs to access Exchanges and to receive the full benefits and protections under the law.

If HHS does not approve an Exchange in a State and elects instead to establish a Federally-facilitated Exchange, then HHS should consult with Tribes about the design of the Exchange to ensure that the benefits and protections for AI/ANs are included in the Exchange design, and that it is workable for the I/T/U.[10]

Finally, we suggest that HHS include an additional standard for approval of a State Exchange. This standard should assess the economic viability of the Exchange and ensure

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[9] American Recovery and Reinvestment Act, section 5006(e).

[10] See "Dear Governors" letter from Secretary Sebelius, dated September 14, 2011, regarding the expectation of HHS that Tribes will be consulted in the design and implementation of each Exchange.

that fees charged to issuers are not passed along to providers in the form of provider network participation fees. Such a fee on providers could pose a barrier to I/T/U providers participating in Exchange plan networks as in-network providers. In States with small populations, the diseconomies of scale combined with the Exchange requirements may create high administrative costs, with pressure to pass along these costs directly to providers. The budget and financing structure for the Exchange after January 1, 2015, should be part of the Exchange plan approval process.

155.106 Election to operate an Exchange after 2014.

As Exchange responsibilities are moved from Federal to State, or State to Federal, there should be Tribal consultation to ensure that AI/AN receive the benefits and protections prescribed by law, that there is appropriate communication with Indian consumers, and that the resulting changes do not disrupt services and payments to the I/T/U.

155.110 Entities eligible to carry out Exchange functions.

The Proposed Rule describes a partnership model between State and Federal governments with the sharing of information and ideas. NIHB believes that Tribal Governments should be included in the partnership model.

This portion of the Proposed Rule also sets out the requirements regarding conflict of interest. In response to the request for comments on conflict of interest requirements on contracting entities, NIHB offers several comments and suggestions.

NIHB supports transparency and clear rules about conflict of interest. With regard to Tribes specifically, NIHB urges that the rules acknowledge the multifaceted role that Tribal governments play. Tribes should be treated as governments that both provide services and advocate on behalf of their citizens. The rules should explicitly include Tribes as eligible for contracting portions of the Exchange operations that are contracted to non-profit organizations.

The proposed standards for membership on the governing board of an Exchange seem reasonable. However, NIHB recommends including designated seats for underrepresented populations, including AI/ANs. NIHB also recommends including AI/AN health care experts in section (c)(4) of the rule, to encourage boards to seek candidates with relevant experience in the Indian health care delivery system.

The Proposed Rule explains that Exchanges may establish contracting arrangements with outside entities. These arrangements could include outsourcing such activities as subsidy determinations or payer arrangements to issuers.

NIHB emphasizes that subcontracting does not relieve States from their obligation to conduct Tribal consultations for the operations subject to subcontracting. As part of the periodic review, NIHB recommends that HHS assess whether or not ongoing Tribal

consultation requirements are being met. Similarly, NIHB suggests that HHS use periodic reviews to ensure that the contracting entities meet all Federal requirements related to providing services to AI/AN people and coordinating arrangements with IHS and Tribally-operated health programs.

155.120 Non-interference with Federal law and non-discrimination standards.

The Proposed Rule indicates that States must comply with non-discrimination statutes and not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation. The regulations should explicitly acknowledge the unique category of "Indian"[11] and refer to Federal Indian law that generally limits access to programs of the IHS (including those carried out by Tribes, Tribal organizations, and urban Indian organizations) to AI/ANs and imposes additional requirements on the IHS or tribal health programs that may choose to serve non-AI/ANs.[12] Tribal health programs are also required to provide Indian preference in hiring and contracting.[13]

These Indian-specific rules are confusing to many States and will be even more so to issuers. NIHB believes it is the responsibility of HHS to assure that this confusion does not negatively affect participation by Indian Health Care Providers and access to health care,

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[11] As U.S. and state citizens, individual AI/AN possess the same constitutional rights as every other citizen, including the rights of equal protection. However, the term "Indian" does not always designate a racial category. In some situations, including the delivery of health care and carrying out other Federal programs for the benefit of Indians under the Snyder Act, the IHCIA, and the ISDEAA, "Indian" designates a political category, and does not trigger the heightened scrutiny that unequal treatment of racial categories would. Even when "Indian" does designate a racial category, compelling government interests (i.e. - upholding treaty promises, correcting historical discrimination) and narrowly tailored measures will defeat equal protection challenges. *See* Morton v. Mancari, 417 U.S. 535 (1974); United States v. Antelope, 430 U.S. 641 (1977); Means v. Navajo Nation, 432 F.3d 924 (9thCir. 2005).

[12] IHCIA Section 813, codified at 25 U.S.C. §1680c, and 42 C.F.R. Part 136.

[13] ISDEAA Section 7(b) and (c), codified at 25 U.S.C. § 450e(b) and (c), which provides that

> Any contract, subcontract, grant, or subgrant pursuant to [the ISDEAA]. . . or any other Act authorizing Federal contracts with or grants to Indian organizations or for the benefit of Indians, shall require that to the greatest extent feasible (1) preferences and opportunities for training and employment in connection with the administration of such contracts or grants shall be given to Indians; and (2) preference in the award of subcontracts and subgrants in connection with the administration of such contracts or grants shall be given to Indian organizations and to Indian-owned economic enterprises as defined in section 1452 of this title.

Also see, *Morton v. Mancari*, 417 U.S. 535, 554 (1974), holding that an Indian employment preference "is an employment criterion reasonably designed to further the cause of Indian self-government and to make the [employer] more responsive to the needs of its constituent groups.". *Accord Solomon v. Interior Reg'l Hous. Auth.*, 313 F. 3d 1194, 1199 (9th Cir. 2002) ("Congress' stated purpose in enacting the ISDEAA was to increase Indian tribal autonomy in running federally administered programs."); *Alaska Chapter, Associated Gen. Contr. v. Pierce*, 694 F. 2d 1162, 1168 (9th Cir. 1982) ("*Mancari* simply held that, as long as the special treatment is rationally related to Congress' unique obligation towards the Indians, the preference would not violate equal protection. If the preference in fact furthers Congress' special obligation, then *a fortiori* it is a political rather than racial classification, even though racial criteria might be used in defining who is an eligible Indian.").

employment and contracting opportunities for AI/ANs. NIHB believes that the most effective way to avoid confusion is by requiring Exchanges to use a standard "Indian Addendum" for contracts with issuers that has been developed by the Tribal Technical Advisory Group to CMS (TTAG), which is similar to the addendum used for Indian health pharmacy participation in the Medicare Part D program.

We commend CMS for including a discussion of the possible use of this "standard contract addendum containing all conditions that would apply to QHP issuers when contracting with Indian health providers." (Preamble, at §156.230, page 41900 of Proposed Rule.) The Proposed Rule goes on to note that –

> Such an addendum may be similar to the special Indian Addendum currently used in the Medicare Prescription Drug Program, which CMS requires all plans to use when contracting with Indian Health Service, tribal organization, and urban Indian organization (I/T/U) pharmacies and serve as a safe-harbor for all issuers contracting with Indian health providers, which would minimize potential disputes and legal challenges between Indian health providers and issuers.

As noted in the Proposed Rule, the CMS requirement on private plans offered under the Medicare program to use the standard I/T/U Addendum has been useful in facilitating participation by I/T/U providers and in ensuring enforcement of applicable Federal laws as they pertain to Indian Health Care Providers.

The Proposed Rule specifically cites intent to prohibit discrimination in areas such as marketing, outreach and enrollment. Again, NIHB believes it is essential, as well as lawful, to conduct specific marketing, outreach and enrollment programs for AI/ANs. Considering the historic under- enrollment in programs such as Medicaid, special approaches are needed to assure full participation of AI/ANs in Exchanges. To clarify that these activities are not discriminatory, the Proposed Rules should explicitly authorize these actions by Indian health care providers.

155.130 Stakeholder consultation

NIHB commends HHS for including Tribes as stakeholders in the Proposed Rule with whom Exchanges must consult on an ongoing basis. This requirement is consistent with the requirement under Executive Order 13175. Tribal consultation is essential to ensuring AI/ANs benefit from Exchange programs and other aspects of the Affordable Care Act. Indian Tribes play multiple roles in the health care system as governmental entities, direct care providers, employers, purchasers of health care and beneficiary advocates. This makes Tribes stakeholders in the health care system on multiple levels.

We note that the requirement is limited to Federally-recognized Tribes, as defined in the Federally Recognized Indian Tribal List Act of 1994. First, as we elaborate on in our discussion of the definition of Indian, the ACA does not anywhere in it rely on the Federally

Recognized Indian Tribal List Act for a definition of Tribe. Instead it relies on the definitions in the IHCIA and the ISDEAA. Secondly, Tribes are entitled to delegate certain functions, just as the Federal and State governments are. Pursuant to the ISDEAA, many Tribes have chosen to delegate health delivery functions to Tribal organizations. When they do so, consultation with the delegate should be required, not merely encouraged as the preamble to the Proposed Rule indicates. We suggest that the language in the Proposed Rule be revised, as follows:

> (f) Federally-recognized Tribes, as defined in the Federally Recognized Indian Tribe List Act of 1994, 25 U.S.C. 479a**, any other Tribe as that term is defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603) or Section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b), and any tribal organization or inter-tribal consortium as those terms are defined in the Indian Self-Determination and Education Assistance Act,** that are located within such Exchange's geographic area;

(Bold text added.)

NIHB recommends retention of the requirement for Exchanges to consult with Tribes at §155.130. We also advise that HHS require States to submit a Tribal consultation policy approved by the State, the Exchange, and Tribes as a condition to approve a State's Exchange Plan. This requirement will create the incentive to collaborate and build strong working relationships between Tribes and States in developing the Exchanges. Further, we encourage CMS to enforce this provision vigorously so as to have the effect of the consultation requirement codified at 42 U.S.C. 1396a(a)(73).[14]

155.140 Establishment of a regional Exchange or subsidiary Exchange.

This portion of the Proposed Rule sets out the requirements to establish and/ or participate in a regional Exchange. A regional Exchange may be an attractive option for States with relatively small populations and may be particularly welcome by both Tribes and States where a Tribe spans the borders of two or more States. The Navajo Nation provides a good example of this situation as the Nation's land lies in Arizona, New Mexico, and Utah. Although we believe regional Exchanges offer promising potential, NIHB is concerned about the way regional Exchanges would address tribal consultation, AI/AN protections and benefits, and relationships with the I/T/U.

We note the finding that tribal governments would not be able to operate a regional or subsidiary Exchange. However, the language of the Proposed Rule seems to leave open

[14] An October 1, 2010 Dear State Medicaid Directors letter from CMS to States indicated: "CMS cannot approve the [State Plan Amendment] until the required tribal consultation has occurred. To approve the SPA without the required consultation would violate Executive Order 13175 and the sec. 1902(a)(73) consultation requirements, as added by the Recovery Act."

the option of tribal governments carrying out some of the functions of an Exchange. The language states "the tribal government could work with the State as the State establishes an Exchange." NIHB believes that Tribes and tribal organizations could have a larger and more continuous role as contractors with the Exchange for such things as marketing, outreach, enrollment and other business functions. Some Tribes and tribal organizations are also incorporated as non-profit organizations. NIHB recommends revising the preamble text to clarify that the rules permit Tribal governments to carry out components of the Exchange.

155.150 Transition process for existing State health insurance exchanges.

We understand the impetus for deeming certain existing health insurance exchanges established before 2010 to be in compliance with the requirements set for new Exchanges under the Proposed Rule. The only condition being proposed in the Proposed Rule is that a certain population percentage be required to be covered. Those States that choose to rely on their existing exchanges must under subsection (b) "work with HHS to identify areas of non-compliance with the standards under this part."

It is a virtual certainty that any currently operating Exchange that is authorized to continue under the new rules will be out of compliance with the requirements of §155.130 with at least regard to consulting with Tribes. Given this and the likelihood that the Exchanges are largely unfamiliar with Tribes and Indian Health Care Providers, we believe that CMS should impose a further condition to require the State to consult with Tribes regarding the extent to which the pre-existing exchanges are compliant with all the standards being established under the new rules, how well the exchanges are meeting the needs of AI/ANs, and what, if any, barriers Indian Health Care Providers are experiencing in working with the Exchanges and the health plans to be offered through the Exchanges. The State should be required to submit a compilation of the information back to the Tribes and to CMS and take active steps to ensure the Exchanges will remedy any non-compliance with regard to AI/ANs, Tribes, and Indian Health Care Providers prior to January 1, 2014.

155.160 Financial support for continued operations.

To ensure that their Exchange has the necessary funding to be self-sufficient by January 1, 2015, the Proposed Rule allows a State to charge assessments or user fees on participating issuers. NIHB is concerned that these fees may be passed along to I/T/U providers or AI/AN consumers.

Not-for-profit I/T/U providers simply cannot absorb the cost of the fees to operate the Exchange. Furthermore, IHS funding should not be used to pay fees to support Exchanges. NIHB suggests adding language that states that the cost of issuer fees or assessments paid to an Exchange will count toward the 15 percent that QHPs may retain for administrative functions and not be allowed to be passed along as a supplemental charge to either consumers (as an addition to the premium amount) or to providers (as a fee for provider participation in a plan). The Exchange is assuming a significant degree of the

marketing, enrollment and underwriting (e.g. risk adjustment) functions and costs typically undertaken by health plans in the individual market. Counting the Exchange costs within the maximum allowable administrative costs of the plan is consistent with the intent of Congress to cap the administrative costs of health plans.

Section 155.160 paragraph (3) states that no Federal funds "will be provided" after January 1, 2015, to support continued operation of Exchanges. We presume this merely states the Federal government's intention with regard to further funding of Exchange-specific functions. Since Exchanges will also be performing eligibility and enrollment functions for Medicaid and CHIP, a portion of Federal Medicaid and CHIP administrative funding should be allowed to pay for those activities of the Exchanges. Furthermore, IHS funding could be used to support AI/AN enrollment assistance activities.

NIHB advocates for an HHS role in reviewing the rates and structure of fees for Exchanges operated by States. Similarly, an independent agency should review fees and fee structures for a Federal Exchange. We have recently seen new Medicare regulations that assess fees to providers and these fees have been passed along to the Indian health system, thereby reducing the amount of funding available to serve AI/ANs. This kind of cost-shifting should be avoided in implementation of the Exchanges.

The budget and financing structure for the Exchange should be part of the Exchange plan approval process to assure that fees are not excessive and that they are not passed along to providers and consumers.

Subpart C – General Functions of an Exchange

155.200 Functions of an Exchange.

We support the statements made in the preamble to the Proposed Rule regarding the obligation of Exchanges to establish "a system of streamlined and coordinated eligibility and enrollment through which an individual may apply for enrollment in a QHP, advance payments of the premium tax credit, cost-sharing reductions, Medicaid, and CHIP and receive a determination of eligibility for any such program. . . . [and] that the eligibility and enrollment function should be consumer-oriented, minimizing administrative hurdles and unnecessary paperwork for applicants."[15] We are concerned that they are inadequately conveyed in the actual rule, which in subsection (c) states only that "[T]he exchange must perform eligibility determinations." We are not convinced that the post-hoc quality activities required by subsection (f) will be sufficient to assure the full range of requirements listed in the preamble is actually accomplished. NIHB recommends that subsection (c) be amended to include the more specific requirements in the preamble.

155.205 Required consumer assistance tools and programs of an Exchange.

[15] Proposed Rule, p. 41875.

Section 155.205 (a) Call center. For call centers to be helpful for AI/ANs, the call center employees must be trained to understand the Indian health system and offer options that are consistent with the special benefits and protections under ACA, ARRA, CHIP and IHCIA available to AI/ANs and that include their I/T/U providers. One option is to have a special "Indian desk" to assist AI/AN consumers and I/T/U providers. Staffing for the Indian desk should include people who are not only knowledgeable about these issues, but also are empowered to fix problems. Call centers should establish relationships with I/T/U so they can refer people to I/T/U clinics for enrollment assistance and can support those I/T/U clinics in solving problems as they arise.

Section 155.205 (b) Internet Website. The website should make it easy for AI/ANs to find out whether I/T/U providers are included in QHPs.

Section 155.205 (c) Exchange calculator. Rules governing AI/AN cost-sharing are different from other populations. The website should have an identifiable path for individuals who think they qualify as AI/ANs for waiver of cost-sharing to determine whether will and the calculations / estimated costs should reflect this protection.

Section 155.205 (c)(4) Contact information. Contact information on the website should include consumer assistance services offered by one or more I/T/U that offer eligibility or enrollment assistance. We support the idea that information can be saved by people who are assisting in the enrollment process. However, we are concerned that this could lead to duplication of efforts and unscrupulous practices by those who profit from their role as Navigators.

Section 155.205 (d) Consumer assistance. We strongly support a consumer assistance function that assists with enrollment, and resolves issues and complaints. For this to be effective, the Exchange must have trained employees who understand the Indian health system and have the power to make decisions. For Medicare Part D, it was essential to have people empowered to correct mistakes and fix system problems specific to AI/AN consumers and Indian Health Care Providers.

Section 155.205 (e) Outreach and education. Exchanges should work closely with Tribes and the I/T/U to develop outreach and education efforts. Health insurance literacy is low among the general population in the United States, and it is less understood by AI/ANs who primarily have relied upon the Federal Indian health system over the years. Explaining how health insurance works should be done within a cultural and historic context, and should acknowledge and explain how the Federal trust responsibility and the requirements of Federal Indian laws affect and interact with new laws, rules and policy. The most trusted people to assume this task are people working for Tribes and the I/T/U. An effort conceived and directed exclusively from outside the AI/AN community is unlikely to succeed.

155.210 Navigator program standards.

Paragraph (b)(1)(iii) proposes that Navigators must meet licensing, certification or other standards prescribed by the State or Exchange, if they are applicable. NIHB recommends that the preamble to the Proposed Rule, at least, and better the Proposed Rule itself clarify that tribal Navigators need only meet with generally applicable requirements without actually being licensed or certified by the State.

There is a long history of jurisdictional problems associated with State licensing and certification of tribal employees. State control over this aspect of an Exchange is especially inappropriate when the Federal government is operating the Exchange. This requirement raises several concerns. First, a State or Exchange could see fit to impose licensing fees on Navigators serving only AI/AN populations. A State could require Navigators to serve everyone, which would take resources away from the already stressed Indian health system. Or, people working as alternate resource specialists in the I/T/U clinics and hospitals could be prohibited from assisting people in the enrollment process (even if they were not paid by the Exchange) if they were not licensed to be Navigators.

An alternative way to assure the safety and quality of Navigators is to offer a training program; the training program, in turn, could award credentials to identify individuals qualified to work as Navigators.

Conflict of interest, mentioned in paragraph (b)(1)(iv), can be problematic for Tribes. Tribal governments both provide services and advocate for tribal members. In many tribal communities there is a different perception of conflict of interest than in other places, in part because there are so few people and leaders must wear many hats. The rules should explicitly exempt I/T/U employees who serve as Navigators from conflict of interest limitations that arise from being employed by an Indian Health Care Provider if the perceived conflict of interest is a result of an employee performing multiple functions for an I/T/U. As a reference, under Medicaid conflict of interest concerns that may have arisen in similarly-structured arrangements were satisfactorily addressed so as to permit the I/T/U and its employees to perform multiple activities.

NIHB notes that the rules require the Navigator to provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange. NIHB fully endorses this requirement and urges its retention in the final rule.

Because one function of a Navigator is to "conduct public education activities," NIHB recommends that training and funding for this program begin 6 months or more in advance of the initial open enrollment period. We acknowledge the financial difficulty inherent in this recommendation since "establishment grants" cannot be used for this purpose and Exchanges would not yet be able to charge fees to issuers. This would shift the burden of funding to States. It is not clear how HHS would fund Navigator grants for Federally-operated Exchanges. NIHB recommends the drafters address this start-up funding issue in the final rule.

155.220 Ability of States to permit agents and brokers to assist qualified individuals, qualified employers or qualified employees enrolling in QHPs.

The language in Section 155.220 (b) implies that advertising for insurance agents and brokers could appear on Exchange websites. As States look for ways to defray the costs of the Exchange, and the costs of the Navigator grants in particular, the pressure to capitalize on advertising will intensify.

NIHB advises against permitting advertising. Allowing advertising creates the potential for a variety of abuses. Rather than using advertising to subsidize the costs of Exchanges, Exchanges could end up essentially subsidizing the advertising costs of a few vested interests. Advertising for brokers and insurance agents could create confusion for consumers already overwhelmed by the onslaught of information. Perhaps most importantly, it would add an element of commercialization to the Exchanges that would undermine their credibility. NIHB suggests that this provision be eliminated.

155.230 General standards for Exchange notices.

NIHB recommends including language requiring Exchanges to send duplicate notices to an individual or entity, including an I/T/U, if the individual applicant or enrollee so directs. This will assure that the individual has access to assistance and advocacy if the Exchange process is not understandable to the person.

NIHB also recommends including language allowing applicants and enrollees to designate an individual or entity, including an I/T/U, to receive additional information over the telephone and to respond to notices on behalf of the applicant or enrollee if the individual has authorized the response.

These additional steps may appear at first blush to increase costs, but we are convinced they will streamline the Exchange processes and significantly reduce errors and appeals. In the first few years of operation, it is inevitable that there will be confusion on everyone's part, including the employees of the Exchanges and the consumers. These steps will help resolve confusion and catch the errors early so access becomes as readily available as intended.

155.240 Payment of premiums.

Paragraph (b) states that "Exchange[s] may permit Indian tribes, tribal organizations and urban Indian organizations to pay QHP premiums on behalf of qualified individuals, subject to terms and conditions determined by the Exchange."[16] NIHB recommends that the "may" be changed to "shall" consistent with the requirements that Exchanges must accept payments by employers on behalf of employees. Under the SHOP Exchange, the ACA only requires Secretary to "to assist qualified employers in the State who are small

[16] Proposed Rule, p. 41916.

employers in facilitating the enrollment of their employees in qualified health plans offered in the small group market in the State", yet Exchanges are "required" under § 155.705(b)(4) to accept aggregated premiums from employers on behalf of employees. NIHB strongly urges CMS to create a parallel requirement here, tied to the new authority under IHCIA Sec. 402 for Tribes, tribal organizations, and urban Indian organizations to purchase health benefits coverage for IHS beneficiaries.[17]

NIHB strongly supports a requirement that an Exchange be required to aggregate premiums of I/T/U sponsors, as required under SHOP Exchanges for small employers. This is an essential efficiency for I/T/U as it is for employers. NIHB also urges eliminating the qualifier, "subject to the terms and conditions determined by the Exchange." This condition does not apply to employers in paragraph (c), who are subject only to the requirements of §155.705(b)(4). If the Exchange accepts aggregate payments from employers, it should also accept payment from Tribes, Tribal organizations, and urban Indian organizations for individuals they choose to sponsor on an equivalent basis. By giving State Exchanges the opportunity to impose terms and conditions, the intent is undermined.

To implement these recommendations, NIHB urges that § 155.240(b) be amended, as follows:

> (b) *Payment by tribes, tribal organizations, and urban Indian organizations.* The Exchange ~~MAY~~**shall** permit Indian tribes, tribal organizations and urban Indian organizations to pay QHP premiums on behalf of qualified individuals, **and shall accept aggregated premiums on terms consistent with the conditions in§155.705(b)(4)**~~SUBJECT TO TERMS AND CONDITIONS DETERMINED BY THE EXCHANGE~~.

(Bold text added, uppercase text deleted.) Doing so would impose no greater obligation on Exchanges with regard to Tribes, Tribal organizations, and urban Indian organizations who seek to cover qualified individuals, than is imposed on a SHOP under § 155.705(b)(4). And, establishing parallel requirements on Exchanges (pertaining to employers and I/T/U), although not required in the ACA for either, would further the goals of the ACA in both instances.

CMS notes that IHCIA Sec. 402 authorizes Indian Tribes, Tribal organizations, and urban Indian organizations to purchase health benefits coverage for "IHS beneficiaries,"

[17] The definition of IHS beneficiaries who qualify for Federal funds to be used to purchase premiums is fairly straight forward. Under Section 402 of the IHCIA, "Indian Tribes, tribal organizations and urban Indian organizations" may use Federal funds to purchase health benefits coverage. These Federal funds may be used to purchase coverage for IHS beneficiaries in any manner, including (but not limited to) through a tribally owned or operated health care plan, a State or locally authorized or licensed health care plan, a health insurance provider or managed care organization, a self-insured plan, or a high deductible or health savings account. In addition, Tribes, Tribal organizations, and urban Indian organizations may have other resources that they may choose to use to purchase premiums without regard to those restrictions.

notes that this class of individuals may be larger than the class of individuals who qualify as Indian for Exchange protections and benefits under the ACA (special enrollment and cost-sharing rules), and requests 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."[18] We discuss the definition of Indian in more detail in NIHB's Supplemental Submission to these Comments,[19] however we want to add a note here regarding paying of premiums.

Since IHCIA Sec. 402 authorizes payment of premiums and mechanisms exist for accepting aggregated premiums, NIHB recommends that "qualified individuals" in subsection (b) be interpreted to mean qualified to be enrolled in an Exchange plan. In the process of the individual enrolling, the issue of whether the individual is Indian for any particular protection or benefit will be addressed. It should not have any impact on the process by which a Tribe, Tribal organization, or urban Indian organization is allowed to pay premiums under these Proposed Rules, nor is it the responsibility of the Exchange to assess whether the payments are allowable under IHCIA Sec. 402.

NIHB notes an error in the discussion of this section regarding Tribal participation in the Medicare Part D Prescription Drug Program.[20] The preamble states that "under that program, Tribes offer a selection of plans from which their members may choose, thus limiting the members' options." In fact, Tribal members can elect to enroll in any insurance at any time, as long as they are willing to pay any applicable premiums. In some cases, such as Medicare Advantage, there may be no additional premiums for individuals. Tribes decide if they are going to pay premiums for some or all of their members and if the premium payments are for all or a subset of plans offered. This essentially *expands* the options of tribal members. If Tribes decide to pay premiums, they may find it necessary in order to reduce the administrative costs of enrollment management, improve coordination of care, and facilitate billing for services rendered to limit the number of plans or insurance companies with whom they do business.

155.260 Privacy and security of information.

In the discussion of this section, CMS suggests a requirement that Exchanges "implement some form of authentication procedure for ensuring that all entities interacting with Exchanges are who they claim."

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[18] Proposed Rule, p. 41879.

[19] In a number of locations in the Proposed Rule, clarification of the definition of Indian is requested. These include § 155.240 on payment of premiums, § 155.350 on cost sharing, and § 155.420 on special enrollment period. As noted in our introductory comment regarding definition of Indian, because of the importance of this issue and the complexity of the discussion we have addressed it comprehensively in the NIHB Supplemental Submission.

[20] Proposed Rule, p. 41879.

NIHB cautions that some document requirements could create barriers for AI/ANs. Some AI/ANs may lack the required documents, and a general distrust of government may cause other individuals to resist requests to provide personal information not specific to the application process. In addition to this note of caution, NIHB urges the inclusion of a provision that would allow AI/ANs to designate another individual to represent them in submitting information through the Website. *See*, comment regarding §155.230.

Subpart E – Exchange Functions in the Individual Market: Enrollment in Qualified Health Plans

Enrollment in QHPs in the Individual Market Exchanges must seamlessly and simultaneously provide both 1) individuals an enrollment process that is simple, user-friendly and protective of personal information, and 2) the ability to handle the complex eligibility determination and enrollment data. Successful operation of this Exchange function rests on the consumer experience and quality control.

155.400 Enrollment of qualified individuals into QHPs.

Subsection (b)(1) of this section states that the Exchange must send eligibility and enrollment information to QHP issuers on a timely basis.

NIHB recommends revising the text to read: "[t]he Exchange must send eligibility and enrollment information to QHP issuers on a **real time or near real time basis.**" (Bold text added.)

The current language is vague and would allow for unacceptable delays in submitting the qualified individual's enrollment information to the selected QHP. NIHB's suggested language addresses this problem.

155.405 Single streamlined application.

NIHB supports the use a single streamlined application to determine eligibility and to collection information necessary for enrollment for QHPs, advance payments of premium tax credits, cost-sharing reductions, and Medicaid, CHIP, and/or the Basic Health Plan (BHP). This streamlined process will ensure that AI/ANs receive the additional AI/AN-specific protections and benefits under the ACA, Medicaid, and CHIP. Collecting the correct information regarding AI/ANs will also assist with the reporting for FMAP payments.

We cannot help but note that the statutory requirement for a single streamlined application implemented in this section reveals best the need for a single definition of Indian for the purposes of the Exchange and related tax provisions and for Medicaid expansion. As our more comprehensive discussion of this issue in NIHB's Supplemental Submission addresses in more detail, failing to reconcile the definitions will make the applications considerably cumbersome for all applicants and more difficult for AI/ANs since enough information will have to be provided to the applicant to ensure their status is correctly determined based on the differing requirements. We also note here that simply

restating the statutory definition applicable to certain benefits and protections will be insufficient to provide guidance to either the Exchange or Medicaid agency or the applicant about whether the applicant is an Indian for the various purposes. It is crucial that more detail be included in the final Exchange regulations, such as including something comparable to the level of detail in the Medicaid rules. Absent that State Exchanges simply won't have the necessary information.

NIHB supports a requirement that any alternative application forms must be approved by HHS. We believe such forms should be the subject of Tribal consultation by the Exchange and State Medicaid agency to assure that it adequately captures information regarding AI/AN status to assure the correct application of AI/AN benefits and protections.

NIHB recommends codifying an additional requirement to strengthen privacy protections. The Proposed Rule should state that applicants need not answer questions irrelevant to the eligibility and enrollment process. For instance, an AI/AN individual should not have to answer whether or not the AI/AN individual lives on tribal lands.[21] This information would not affect eligibility or enrollment in Medicaid, CHIP, or eligibility for premium tax credits.

NIHB also strongly supports the requirements in subsection (c) regarding accepting applications from authorized representatives or someone acting responsibly for the applicant and providing for alternate means of filing, including in person.

155.410 Initial and annual open enrollment periods.

An adequate initial open enrollment period is critical to ensure Exchange success. NIHB believes the proposed duration of the initial open enrollment period (of five months) is sufficient.

NIHB notes that outreach and education efforts will play a big role in capturing new enrollees. A dedicated public information campaign will also be necessary to inform individuals about coverage and assistance available to individuals.

Related to both of these observations, NIHB stresses the importance of providing adequate notice of the annual open enrollment periods. In subsection (d), NIHB recommends including a requirement that notice of open enrollment be sent no later than 30 days before the start of the annual open enrollment period.

With regard to subsection (f), comment is requested regarding whether to require Exchanges to automatically enroll individuals who received advance payments of the premium tax credit and then are disenrolled from a QHP because the QHP is no longer

[21] *See pg. 14* Carol Korenbrot, PhD and James Crouch MPH (December 2010). *American Indians and Alaska Natives: Medicaid State Data Collection for the Centers for Medicare and Medicare Services Tribal Technical Advisory Group (TTAG).* Retrieved from http://crihb.org/files/0_Medicaid-AIAN-State-Survey-Final-12-8-10.pdf

offered and the individual has not selected an alternative QHP. NIHB recommends requiring the automatic enrollment with three caveats: (1) notice should be provided to the individual; (2) the individual should have the option to disenroll or change QHPs to one of his or her own choice for a period of at least 30 days after receipt of notice; and (3) no penalties should be assessed for payment of the premium tax credit during periods in which automatic enrollment occurred prior to the end of the period described in (2).

An adequate initial open enrollment period is critical to ensure Exchange success. NIHB believes the proposed duration of the initial open enrollment period (of five months) is sufficient.

NIHB notes that outreach and education efforts will play a big role in capturing new enrollees. A dedicated public information campaign will also be necessary to inform individuals about coverage and assistance available to individuals.

Related to both of these observation, NIHB stresses the importance of providing adequate notice of the annual open enrollment periods. NIHB recommends including a requirement of 30 day notice before the start of the annual open enrollment.

155.420 Special enrollment periods.

§155.420(d)(8) incorporates the statutory requirement of the special monthly enrollment periods in the Exchange for Indians (as defined in Section 4 of the IHCIA).

NIHB urges the drafters to retain this provision in the final rule, although, as will be addressed in more detail in our discussion of the definition of Indian in NIHB's Supplemental Submission, NIHB has a number of specific concerns that respond to the request for comment on the process for verifying Indian status. First, we note that while the Proposed Rule merely recites the statutory provision, the preamble asserts that "the IHCIA defines 'Indian' as a member of a Federally-recognized tribe."[22] While it is true that members of Federally-recognized tribes are "Indians" under Section 4 of the IHCIA, there are many other individuals who also qualify expressly under that Section, including Alaska Natives enrolled in a regional or village corporation established pursuant to the Alaska Native Claims Settlement Act (ANCSA), California Indians, and others. Secondly, we reiterate our concern that merely citing the statutory definition will not provide sufficient guidance to Exchanges.

The preamble also requests comment on verification of Indian status. We incorporate by reference here our discussion of this topic in NIHB's Supplemental Submission. We merely emphasize here that there must be enough information provided in the enrollment process to assure that individuals are able to determine whether they are entitled to this special benefit, that self-attestation should be sufficient to trigger the special enrollment, and that any verification should not impose unreasonable burdens on the applicant.

[22] Proposed Rule, page 41884.

NIHB recommends that the Proposed Rule not permit a waiting period following enrollment into a qualified health plan under the special monthly enrollment period for Indians.

Several factors support this position, most notably the practical needs of the AI/AN population and Congressional intent. Congress established the special enrollment period for Indians to address the gaps and differences in health coverage provided by the Indian Health Service, Tribes and tribally-operated programs, and urban Indian health organizations. Congress included this mechanism to mitigate the coverage gaps AI/ANs regularly experience when they migrate between reservations and between rural and urban areas to access employment or educational opportunities. Requiring a waiting period would defeat the specific Congressional intent regarding AI/AN enrollment and frustrate the general purpose behind the Exchange provisions of the law.

Section 155.420 (f) sets out the limits on changing plans under special enrollment periods. This subsection limits an enrollee's choice to plans at the same level of coverage (i.e., gold, silver, bronze). This restriction is not required by law and should not be imposed by regulation. The discussion explains that a newborn child would have to be enrolled in the same level plan as the parent. However, two parents may have different levels of enrollment, or one or both parents may be ineligible to enroll in an Exchange plan. Furthermore, a new born is not previously enrolled, so enrollment should not be restricted to a particular plan level.

155.430 Termination of coverage.

See section 155.410 on ability to cancel coverage when auto-enrolled.

Subpart H –Exchange Functions: Small Business Health Options program

NIHB supports the Small Business Health Options Program (SHOP). Although most tribes and tribal organizations are large enough that they will not fall within the definition of a small employer, there are many very small tribes or tribal organizations that will. For them, the opportunity to obtain health insurance for their employees at affordable rates will make them more competitive and improve economic activity.

NIHB wishes to make some recommendations that bridge more than one of the new sections in the Proposed Rule. We do so here.

Tribes and tribal organizations carrying out programs of the Department of the Interior or the IHS under the ISDEAA are subject to the requirement that preference in employment shall be given to Indians.[23] These same AI/ANs are entitled to receive health care from the United States pursuant to the special Federal trust responsibility owed to them and often will obtain their health care from an IHS or tribal provider where they incur

[23] ISDEAA Sec. 8(b)(1), 25 U.S.C. § 450e(b)(1).

no costs. In addition, under ACA §§ 1411(b)(5)(A) and 1501(e)(3), they are exempt from tax penalty for failure to maintain minimum essential coverage.[24] Because of these special provisions, many of the employees of a Tribe or tribal organization have little incentive to pay premiums to acquire health insurance. The tribal employer, though, does have an incentive to offer insurance to its employees, not all of whom will be Indian, and will still need the opportunities presented by SHOP since the number of employees likely to participate may be so small as to make private insurance options unaffordable.

For these reasons, NIHB recommends that Indian employees of a Tribe or tribal organization carrying out Federal programs under the ISDEAA not be included in the count of employees for determining whether such a Tribe or tribal organization meets the threshold eligibility requirement as an employer[25] seeking to obtain coverage through a SHOP under § 155.710(b)(1) and that AI/AN employees who do not choose to participate in coverage not be counted in determining whether the employer meets the minimum participation threshold to the extent one is imposed under § 155.705.

NIHB is aware of the concerns embedded in the discussion of SHOP, and elsewhere in the Proposed Rule, about adverse selection. We do not believe, however, that the small number of AI/ANs can or will have any statistical impact on the Exchanges or QHPs under them.

155.705 Functions of a SHOP.

Minimum Participation. Comments have been requested on whether minimum participation rules should be imposed and, if they are, how the rate should be calculated, what it should be, and whether it should be established in Federal regulations.[26] NIHB believes that the opportunity for small employers to offer coverage is extremely important and SHOP is critical to this. Accordingly, we recommend that no minimum participation rate be established. In addition, given the maximum number of employees a "small employer" can employ, the decisions of just a few employees could skew access for everyone. The statistical basis for setting rates of participation is highly suspect when the total number of employees must be fewer than 100 and even worse if the number is 50.

Should a rate be set, as noted above, NIHB recommends that AI/AN employees of Tribes and tribal organizations carrying out Federal programs under the ISDEAA who choose not to participate be exempt from the determination of the rate. As we note, AI/ANs often have little incentive to pay premiums and may, in fact, view doing so as a violation of the special Federal trust responsibility of the United States to them.

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[24] Exactly who is exempt is, of course, subject to the outcome of final rulemaking that addresses the definition of Indian about which NIHB is providing detailed comments, which we incorporate here to the extent applicable.

[25] Proposed Rule, page 41887.

[26] Proposed Rule, pages 41886-87.

§ 155.705(a)(5). NIHB does not object to this exemption since the provisions of § 155.240 are unrelated to employer coverage of employees.

§ 155.705(b)(4) Premium Aggregation. NIHB strongly supports the requirement that a SHOP be required to aggregate premiums. This is an essential efficiency for employers and particularly small employers.

155.710 Eligibility standards for SHOP.

For the reasons discussed in our general comments, NIHB recommends that AI/AN employees of a Tribe or tribal organization carrying out Federal programs under the ISDEAA not be included in the count of employees for determining whether such a Tribe or tribal organization meets the threshold eligibility requirement as a small employer (whether at 50 or 100 or some other defined number of employees) for obtaining coverage through a SHOP under § 155.710(b)(1).

Although it is not completely apparent in the Proposed Rule, the preamble clarifies that a small employer must offer coverage to its full-time employees and may at its option include part-time employees.[27] However, all of the employees must be counted in the number of employees for the purposes of determining whether the employer qualifies to participate in SHOP. Because we believe this coverage option is very important to expanding access to this important employee benefit, NIHB recommends that only full-time employees (as is done under section 4980H of the Internal Revenue Code as added by section 1513 of the ACA) or at least "full-time equivalent employees" be counted for the purposes of determining eligibility. Otherwise, many small employers or employers whose workforce is made up a many part-time employees who may secure coverage through a spouse or as a dependent under a parent's plan will be excluded from access.

155.715 Eligibility determination process for SHOP.

Consistent with the recommendations about excluding certain AI/AN employees from determinations that may be required under §§ 155.705 and .710, NIHB recommends that under subsection (c)(1) the SHOP must accept an employer attestation regarding the number of potentially qualified employees who are AI/ANs and therefore exempt from certain counts for determination of employer eligibility.

155.730 Application standards for SHOP.

Again, consistent with the recommendation about excluding certain AI/AN employees from determinations that may be made under §§ 155.705 and .710, NIHB recommends that subsection (b)(4) provide for Tribes and tribal organizations carrying out Federal programs under the ISDEAA to identify potentially qualified employees who are AI/ANs and therefore possibly exempt or to clarify that the exempt employees need not be listed at all.

[27] Proposed Rule, pages 41887-88.

Subpart K –Exchange Functions: Certification of Qualified Health

155.1000 Certification standards for QHPs.

NIHB supports the overall structure of Section 155.1000 and the requirement that Exchange Plans only offer Qualified Health Plans that have been certified by the Exchange. NIHB also supports the establishment of mandatory certification criteria for QHPs. Specifically, we support the inclusion of minimum certification requirements outlined in subpart C of part 156 of the proposed regulations. As discussed below in our comments on that section, we believe that those minimum certification requirements must contain certain Indian-specific provisions in order to ensure that AI/ANs, among the nation's most medically-underserved populations, can meaningfully participate in the Exchanges as intended by Congress.

NIHB recommends that the Exchanges be required to seek Tribal consultation on the certification criteria it adopts. As the more specific comments regarding this subpart reflect, if QHPs are not well-informed and responsive regarding Indian provisions, AI/ANs will not have the extent of access to which they are entitled under the ACA.

We also note that in the preamble to the Proposed Rule (at 41891), the Office of Personnel Management (OPM) will enter into contracts with health insurance issuers to offer at least two multi-State QHPs through each Exchange in each State. Pursuant to Federal policy, and as is currently being done in the design and implementation of section 409 of the IHCIA pertaining to the access of Tribes, tribal organizations and urban Indian organizations to coverage under the Federal Employees Health Benefits program, we anticipate an announcement requesting tribal consultation on the implementation of section 1334 of the ACA will be made soon by OPM, possibly in conjunction with CMS. NIHB urges OPM to include in the multi-State QHP all I/T/U providers who are willing to participate and to use the proposed Indian Addendum (discussed in our comments on Part 156) for provider contracts with the QHPs.

Under the Proposed Rule, Exchanges have the option of being active purchasers in a selective contracting process or offering a place on the Exchange to any qualified plan. NIHB advises, for both limited and open Exchanges, that all plans offered through an Exchange, including the multi-state plans, be required to offer to include I/T/U providers in the plan’s network. Exchanges should also be required to make information readily available and easily searchable so that AI/AN consumers can identify plans that include I/T/U providers.

155.1010 Certification process for QHPs.

As noted in our comments regarding §155.1010, NIHB recommends that Exchanges must include among the procedures for certification of QHPs that the QHP adopts a standardized, Federally-approved Indian Addendum and be required to offer to include all

I/T/Us in its plan network. This is very important to assuring network adequacy, which we discuss further with regard to §155.1050.

155.1040 Transparency in coverage.

Subsection (b) Plain Language. NIHB appreciates the requirement in subsection (b) under which QHPs are required to use plain language. Given the special population on whose behalf we advocate, NIHB is especially sensitive to this requirement.

Subsection (c) Cost Sharing Transparency. NIHB recommends that the Exchanges be required to monitor the quality and accessibility of information available from QHPs to AI/ANs for whom there are special cost-sharing protections under ACA § 1402(d). If these are not identified, it will substantially impair access by AI/ANs who may be discouraged from purchasing coverage that would otherwise seem affordable.

155.1050 Establishment of Exchange network adequacy standards.

We support the concept in the Proposed Rule at §155.1050 that the Exchange "must ensure that the provider network of each QHP offers a sufficient choice of providers for enrollees." This requirement is mandated by Section 1311(c)(1)(B) of the Affordable Care Act. Without more specificity, however, this requirement is insufficient to ensure that AI/ANs will be able to utilize the Exchange coverage in a meaningful way. As discussed below in §156.230 on network adequacy standards, there are compelling policy reasons for including I/T/U providers in plan networks as this would benefit both the underserved AI/AN populations and the QHPs themselves. And, most specifically, I/T/U providers are required by Federal law (under IHCIA section 408(a)) to be included in QHPs if an I/T/U requests to be included.

In brief, Section 408(a) of the Indian Health Care Improvement Act requires health care programs that receive Federal funding to accept I/T/U providers. It requires any:

> Federal health care program to accept an entity that is operated by the Service, an Indian Tribe, tribal organization, or urban Indian organization as a provider eligible to receive payment under the program for health care services furnished to an Indian on the same basis as any other provider qualified to participate as a provider of health care services under the program if the entity meets generally applicable State or other requirements for participation as a provider of health care services under the program.[28]

[28] We note that Section 408(a)(2) of the IHCIA makes it clear that any licensing requirement imposed by a state will be deemed to have been met by the I/T/U provider if it meets the standards required for licensing regardless of whether a license is obtained, and Section 221 of the IHCIA provides that licensed professionals at an I/T/U facility do not have to be licensed in the state in which they are located provided they are licensed in any state.

This provision of Federal law is not optional. Rather, section 408 establishes a new requirement on all Federal health care programs to require health plans operating under these Federal programs to accept I/T/U providers that are interested in doing so.

To improve the consistency, efficiency and effectiveness of enforcement of IHCIA section 408, NIHB recommends that §155.1050 be modified to read as follows:

> An Exchange must ensure that the provider network of each QHP offers a sufficient choice of providers for enrollees. **An Exchange is to ensure that each QHP include any Indian Health Service, Tribe and tribal organization, and urban Indian organization (I/T/U) providers as in-network providers when requested to do so by an I/T/U for purposes of providing health services to AI/ANs as required under section 408(a) of the IHCIA.**

(Bold text added.) Again, additional discussion of section 408 is contained in §156.230 below.

It is reasonable to assess whether implementation of this Federal requirement will place an undue burden on QHP operating in an Exchange. In "Figure 1: Number of Health Facilities Operated by Indian Health Care Providers", the total number of I/T/U facilities and programs are identified. Nationally, there are 690 such facilities, with 159 of those Alaska village clinics.

**Figure 1: Number of Health Facilities Operated by Indian Health Care Providers:
Indian Health Service, Tribes and Tribal Organizations, and Urban Indian Organizations (I/T/U)**

	Hospitals	Health Centers	Health Stations	School Health Centers	Urban Indian Programs	**Subtotal**	Alaska Village Clinics	Total
IHS	32	57	32	1		122		122
Tribal	18	248	97	9		372	159	531
Urban Indian Programs					37	37		37
Total	50	305	129	10	37	531	159	690

Sources: DHHS, Indian Health Service, Final IHS CMS Facility List, 2010; National Council of Urban Indian Health (NCUIH), Web site, October, 2011

On average, there are only 15.2 I/T/U facilities or programs in the 35 States that have an Indian Tribe, excluding Alaska village clinics. It is likely that only a subset of the total number of I/T/U in each State would contract with each QHP in that State. As such, the actual average number of I/T/U under contract with each QHP would be even lower than the 15.2 average.

See "Figure 2. Distribution of Indian Health Care Providers, by State" for a state-by-state count of the number of health facilities, shown by health care facility type, operated by the Indian Health Service, Tribes and tribal organizations, and urban Indian programs.

Figure 2: Distribution of Indian Health Care Providers, by State:
Indian Health Service, Tribes and Tribal Organizations, and Urban Indian Programs (I/T/U)

HEALTH FACILITY TYPE	AK	AL	AZ	CA	CO	FL	IA	ID	IL	KS	LA	MA	MD	ME	MI	MN	MS
INPATIENT																	
Hospital	7		12													2	1
AMBULATORY CARE																	
Health Center	37	1	16	49	2	4	2	4		4	2	1		5	11	9	
School Health Center			5														1
Health Station	4		18	23	1			2		1	2				1	12	3
Alaska Village Clinic	159																
Urban Indian Programs			3	10					1	1		1	1		1	1	
Totals	207	1	54	82	3	4	2	6	1	6	4	2	1	5	13	24	5

HEALTH FACILITY TYPE	MT	NC	ND	NE	NM	NV	NY	OK	OR	RI	SC	SD	TX	UT	WA	WI	Total
INPATIENT																	
Hospital	3	1	2	1	8			9				4					50
AMBULATORY CARE																	
Health Center	16	1	4	4	12	8	4	40	11	1	1	8	3	4	27	14	305
School Health Center		1						1				2					10
Health Station	7	3	8	3	11	6	2		1	1		6		4	9	1	129
Alaska Village Clinic																	159
Urban Indian Programs	5		1			1	1	2	1			1	2	1	1	2	37
Totals	31	6	15	8	31	15	7	52	13	2	1	21	5	9	37	17	690

Sources: DHHS, Indian Health Service, Final IHS CMS Facility List, 2010; National Council of Urban Indian Health (NCUIH), Web site, October, 2011

As shown in Figure 2, in Alaska there are a total of 209 I/T/U facilities when the 159 Alaska village clinics are combined with the other I/T/U facilities in the State. Given the great expanse of area to be served by these I/T/U facilities, the I/T/U facilities in the State of Alaska represent only 3.5 health facilities for every 10,000 square miles.

Given the level of need, the paucity of non-I/T/U health care providers operating in many of the areas served by I/T/U providers, the limited number of I/T/U facilities nationally, and the low average number per State, requiring QHPs to offer to contract with I/T/U providers will not create an undue burden on QHPs.

Without the enforcement of IHCIA section 408(a), the network adequacy standards included in the Proposed Rule are insufficient to protect the access of AI/ANs to health care in general and I/T/U facilities in specific. Although the preamble to the Proposed Rule provides some elaboration, the only proposed regulatory requirement is that QHPs are required to include a sufficient choice of providers. The preamble invites comments on establishing standards for QHP service areas to be established in a way that does not exclude high utilizing, high cost or medically underserved populations. We learned from experience when States converted their Medicaid programs to managed care, that some managed care organizations whose service area included the entire State assigned AI/AN enrollees to primary care providers in areas that required driving 3-5 hours to access care, while excluding I/T/U providers from their networks. Thus, defining a large service area is not sufficient to assure access to care. Because of market conditions in areas with low population density, there is no way to assure access to care for many AI/ANs other than, at a minimum, requiring the inclusion of I/T/U providers in QHP networks. It would help everyone if this was done in a straightforward manner, rather than finding less than satisfactory proxies for this requirement.

The discussion in the Proposed Rule states that "an Exchange may want to consider the needs of American Indians and Alaska Natives residing in remote locations." While we appreciate the fact that the needs of AI/ANs were recognized in the preamble to the Proposed Rule, this does not go nearly far enough. We believe that the Federal government should take a stronger role. Exchanges may <u>not</u> want to consider the needs of AI/ANs for a variety of reasons, including a history of antagonism between State governments and Tribes, exclusion of I/T/U representation on the governing boards of Exchanges, ignorance on the part of State Insurance Commissioners with regard to American Indians and Federal Indian law, and State constitutions and laws that are interpreted to prohibit considering the needs of AI/ANs. The U.S. Constitution grants to the Federal government the role of creating Indian policy, and this should not be ceded to State governments or Exchanges. The Federal government has a duty to protect and this duty should be exercised clearly and decisively by HHS through these regulations.

While the discussion section considers the need for a broad definition of primary care for the purposes of network adequacy, this is not reflected in the wording of the proposed regulation. An endorsement of midlevel providers

through the example of nurse practitioners is an encouraging start. However, if costs of health care are going to be controlled, there should be payment for a wide range of midlevel practitioner services which have been pioneered through the Indian Health Service, including Community Health Practitioners and Dental Therapists. Particularly as CMS moves forward to use these rules to design Federally-operated Exchanges in places such as Alaska, these issues should be addressed.

155.1055 Service area of a QHP.

NIHB endorses the objectives of the standards for QHP service areas proposed in § 155.1055. We are concerned, however, that subsection (b) may lead to precisely the wrong result in States with Indian reservations or communities. Indian reservations and former reservation areas often span more than one county, and, and often more than one State. For example, the Navajo Nation extends into four States: Arizona, New Mexico, Utah, and Colorado. While a QHP that is available only in a single State might not resolve the issues presented by tribes in multiple States, the service area rules should attempt to address the needs of those in multiple counties.

NIHB is especially concerned about subsection (b), which requires that service areas be "established without regard to racial, ethnic, language, [and] health status-related factors . . .." Reservations and former reservation areas are established politically. Being Indian for the purposes of the ACA and other special rights arising from the historical relationship between the United States, tribal governments, and AI/ANs are political in nature and not "racial, ethnic, [or] language" based. While preventing discrimination on the basis that the population is ethnically or racially Indian or has poorer health status must be avoided, the service areas of QHPs should be drawn to avoid dividing tribal communities and reservations and former reservations into different service areas. We recommend that the Proposed Rule specifically state that "service areas of QHPs should be drawn to avoid dividing tribal communities and reservations and former reservations into different service areas."

NIHB is also concerned about the absence of a requirement on Exchanges to ensure there are a sufficient number of health plans available in all geographic areas of an Exchange. Many AI/ANs reside in remote areas of a State, where health plans with adequate provider networks are scarce. The provision under § 155.1055(a) that permits QHP to serve a geographic area that is less than the entire area of an Exchange (i.e., "the service area of a QHP") recognizes the business practices of certain health plans, but it also confirms our concern that certain parts of a State may not have adequate plan participation.

Related to this concern over a potentially insufficient choice of Exchange plans in certain areas of a State, the reference premium that will be used for purposes of determining the level of premium assistance that will be provided to AI/ANs and non-

AI/ANs Exchange enrollees alike is based on the second lowest cost silver plan available in the "rating area in which the taxpayer resides."[29] The Department of the Treasury (Treasury) has issued proposed rules defining the "rating area" for purposes of calculating the premium tax credit amount.[30] NIHB prepared a comprehensive and detailed review of this issue in "NIHB Analysis of Notice of Proposed Rulemaking: Health Insurance Premium Tax Credit (IRS REG-131491-10)", and we direct your attention to that document for consideration. As proposed by Treasury, "rating area" is defined as the "Exchange service area" as defined in this Proposed Rule by HHS. In § 155.20, "Exchange service area means the area in which the Exchange is certified to operate…"

To the extent that the service area of a QHP (at least for the lowest and second lowest cost silver plans for which the premium tax credit amount is based) is not aligned with the entire Exchange service area, the benchmark premium may not be an amount that is sufficient to permit enrollment of an AI/AN in a QHP that serves an AI/AN without payment of premium amounts in excess of the stated premium protections in section 1401(a) of the ACA. Stated differently, there is a concern that there may not be sufficient affordable plan options in certain parts of a State given (1) the potential for a limited number of health plans being offered, (2) the service areas of the plans that are offered being less than the full Exchange service area, and (3) the Federal premium assistance being 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, and the premium assistance amount may be inadequate to secure coverage in a plan that does cover the where the enrollee resides. Finally, unless required to do so, the Exchange plans available at the "applicable benchmark premium," if any, may not include I/T/U providers as in-network providers.

At a minimum, although this would not be adequate to fully address this concern, all health plans offered through an Exchange must be required to offer to contract with I/T/U providers in their service area to ensure that those QHP that are available in an area at least include the traditional and preferred choice of providers to many AI/ANs. This requirement should be also imposed on any multi-State plans offered in an Exchange. Otherwise, given the potential for a limited number of Exchange plans serving some parts of an Exchange area, AI/ANs could be confronted with having few or no plans that contract with I/T/U providers.

155.1075 Recertification of QHPs.

NIHB believes that an essential component of recertification is obtaining public feedback about the QHP's performance. NIHB recommends that the QHP recertification process include a requirement that Exchanges consult with Indian Tribes with regard to

[29] ACA Sec. 1401(a) / IRC Sec. 36B(b)(3)(B).

[30] Department of the Treasury, Internal Revenue Service Notice of Proposed Rulemaking, "Health Insurance Premium Tax Credit" published August 17, 2011 in the *Federal Register* (IRS REG-131491-P).

their experience with a QHP subject to recertification. NIHB further recommends that Indian Tribes and tribal organizations be encouraged to notify AI/ANs about the opportunity to comment.

155.1080 Decertification of QHPs.

Subsection (e) Notice of decertification. NIHB recommends adding a requirement that all providers enrolled in a network operated by a QHP be added to the list of entities and individuals entitled to notice under this subsection. Having a plan cease to do business is very disruptive to health providers.

B. Part 156 – Health Insurance Issuer Standards Under the Affordable Care Act, including Standards Related to Exchanges

Subpart C – Qualified Health Plan Minimum Certification

156.200 QHP issuer participation standards.

We recommend that all of the requirements that we have proposed for QHP, including network adequacy standards under § 156.230, should be imposed on the issuers of QHP, including the issuers of multi-State plans.

156.220 Transparency in coverage.

Section 156.220 (d) Enrollee cost-sharing transparency. Information for consumers should accurately portray the special cost-sharing protections for AI/ANs. *See*, comment to § 155.1040.

156.230 Network adequacy standards.

Application of, and Maintaining Compliance with, Section 408 of the IHCIA

Including I/T/U providers in Exchange plan networks is required by Federal law. Section 408(a) of the Indian Health Care Improvement Act requires health care programs that receive Federal funding to accept I/T/U providers.[31] It requires any:

> Federal health care program to accept an entity that is operated by the Service, an Indian Tribe, tribal organization, or urban Indian organization as a provider eligible to receive payment under the program for health care services furnished to an Indian on the same basis as any other provider qualified to participate as a provider of health care services under the program if the entity meets generally

[31] Section 408 of the IHCIA was added to the IHCIA in 2010 with the passage of the Affordable Care Act.

> applicable State or other requirements for participation as a provider of health care services under the program.[32]

The term "Federal health care program" is defined elsewhere in Section 408 by reference to Section 1128B(f) of the Social Security Act, 42 U.S.C. 1320a-7b(f). The Social Security Act broadly defines "Federal health care program" to include:

> any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government (other than the health insurance program under chapter 89 of title 5, United States Code). 42 U.S.C. §1320a-7b(f).

This definition also includes "any State health care program, as defined in section 1320a–7(h) of this title." *Id*. Under this broad definition, any "plan or program" that provides health benefits "through insurance or otherwise" that is funded directly "in whole or in part" by the United States must include I/T/U providers.

There is no doubt that the ACA and the related QHPs meet the definition of "Federal health care program" which must accept I/T/U providers under Section 408 of the IHCIA. As a general matter, States have received Federal funds to develop Exchanges, and the Federally-operated Exchanges are also being planned with Federal dollars. Moreover, Federal funds will be used to offer premium assistance in the form of tax credits for people up to 400 percent of the Federal poverty level. In addition, Federal funds will be provided to Exchange plans to offset the cost-sharing that may be required under an Exchange plan.

As a "Federal health care program," ACA has specific requirements regarding AI/ANs that show Congressional intent that AI/ANs are to be served by the Exchange plans. For example, the Secretary is directed by law to pay the plans directly to offset the cost-sharing exemptions for AI/ANs under Section 1402(d)(3) of the ACA. Section 1402(d)(3) provides that "[t]he Secretary shall pay to the issuer of a qualified health plan the amount necessary to reflect the increase in actuarial value of the plan required by reason of this subsection [the Indian cost-sharing exemption]." Unlike other Federal funds available for the development of Exchanges which have a sunset date, the Secretary is directed to provide Federal funding under Section 1402 of the ACA for Exchange plans serving AI/ANs in perpetuity. Accordingly, with regard to AI/ANs the ACA provides direct Federal funding of

[32] We note that Section 408(a)(2) of the IHCIA makes it clear that any licensing requirement imposed by a state will be deemed to have been met by the I/T/U provider if it meets the standards required for licensing regardless of whether a license is obtained, and Section 221 of the IHCIA provides that licensed professionals at an I/T/U facility do not have to be licensed in the state in which they are located provided they are licensed in any state.

the type that results in a mandate that I/T/U providers be included in Exchange plan networks under Section 408 of the IHCIA.[33]

The language in Section 408(a) of the IHCIA "on the same basis as any other provider qualified to participate as a provider of health care services under the program" means the I/T/U would function like other providers in the network for the QHP. It does not mean that the Federal laws and regulations for AI/ANs and the I/T/U would cease to apply. Rather, it is a given that the I/T/U facility would continue to operate as an I/T/U facility while providing services to AN/AN who are enrolled in the plan. Because the I/T/U is unique, contracts that are offered by QHPs would have to be modified to achieve the two objectives of (1) allowing the I/T/U to participate as a provider in a QHP, and (2) upholding the Federal laws and regulations that govern the I/T/U. Based on experience with Medicare Part D, the best way to accomplish these two objectives is for the Federal government to approve a standard amendment that QHPs can use—and we recommend would be required to use—with contracts that are offered to the I/T/U.

We commend CMS for including a discussion of the possible use of this "standard contract addendum containing all conditions that would apply to QHP issuers when contracting with Indian health providers." (Preamble, at §156.230, page 41900 of Proposed Rule.)

Creation and Use of an "Indian Addendum" to Exchange Contracts

Setting out applicable Federal law in a single comprehensive Indian Addendum will reduce administrative cost for States, Exchanges, issuers, and I/T/U facilities and minimize the need to duplicate this effort in different settings. The requirements to be included in the addendum to contracts with I/T/U providers include:

- A Tribe or IHS may limit who is eligible for services (without imposing limits on those that may serve individuals who are not eligible for IHS services);
- I/T/Us are non-taxable;
- The Federal Tort Claims Act applies to IHS and Tribal programs, and to those urban Indian organizations that have achieved FTCA coverage through PHSA Sec. 224(g)-(n), to eliminate any QHP requirement to carry professional liability insurance or to otherwise indemnify a QHP;

[33] We also note that elsewhere in the regulations, the Department recognizes that Congress mandated that certain "essential community providers" be included in any provider network. As mandated by the ACA, the Department has proposed that "essential community providers" include the providers defined in Section 340B(a)(4) of the PHS Act, which includes "Federally qualified health care centers," which is defined in Section 1905(l)(2)(B) of the Social Security Act to include both outpatient health programs and facilities operated by Tribes and tribal organizations under the Indian Self-Determination Act or urban Indian organizations receiving funds under title V of the Indian Health Care Improvement Act. Accordingly, tribal facilities and urban Indian organizations must independently be included in provider networks under this provision as well. As discussed in our comments in the next section, we believe that Indian Health Service facilities must also be included as well.

- All Indian health providers have the right to recover from third party payers up to the reasonable charges billed for providing health services or, if higher, the highest amount the insurer would pay to other providers under IHCIA Sec. 206;
- QHP must offer to include all I/T/U as in-network providers under the new IHCIA Sec. 408(a);[34]
- Employees of the IHS and Tribal programs are not required to hold a license issued by the State in which the program operates as long as they are licensed in any State;[35]
- The IHS and Tribes may exercise Indian Preference in employment decisions per the statute and case law;[36]
- I/T/U health programs are not required to obtain a license from the State as a condition of reimbursement by any Federal health care program so long as the I/T/U meets "generally applicable State or other requirements for participation as a provider of health care services under the program."[37] "A Federal health care program" means "any plan or that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly in whole or in part, by the United States Government," including health insurance programs under chapter 89 of title 5; and any State health care program, which includes Medicaid, and CHP, as well as any program receiving funds under certain other provisions of Federal law. Thus, a QHP cannot require licensing in the State as a condition for network provider status nor as a condition for payment for services;
- Special disputes resolution process and recognition of governing law;
- Any medical quality assurance requirements must be subject to new IHCIA Sec. 805;
- Compliance with ACA Sec. 1402(d)(2) prohibiting assessment of cost-sharing on any AI/ANs enrolled in a QHP;
- I/T/Us must be permitted to establish their own days/hours of operation so that any different QHP requirements do not impose barriers to participation; and
- Nothing in a QHP network provider agreement shall constitute a waiver of Federal or tribal sovereign immunity.

This type of Indian Addendum has been used with great success for many years in connection with Prescription Drug Program contracts under Medicare Part D. CMS

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[34] 25 U.S.C. § 1647a.

[35] IHCIA Sec. 221, enacted into law by Sec. 10221 of the ACA.

[36] 25 U.S.C. § 450e(b) and (2) *Morton v. Mancari*.

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

regulations *require* Part D plans to offer network contracts to I/T/U pharmacies using an Indian addendum containing those provisions. These Medicare Part D Addenda have proven to be efficient, effective and easy to use for both Part D plan sponsors and Indian health pharmacies. It is now a standard component of the Part D program.

We were encouraged to see that the Department has solicited comments on special accommodations that must be made when contracting with Indian health providers, and the Department's request for comments on use of a standardized Indian health provider contract addendum for QHP issuers. We believe that the use of such a contract addendum will reduce costs and ease administrative burdens for issuers and ensure meaningful participation by AI/ANs in Exchange plans. Indeed, the use of an Indian contract addendum will be critical to achieve both goals.

This direct approach for the Exchange establishment regulations to require that all I/T/U facilities be offered a contract with an approved Indian Addendum is, we believe, the only practical and efficient way to assure network sufficiency for AI/ANs. Sufficient choice of providers is not defined in the Proposed Rule, but it is recognized in the preamble to the Proposed Rule (76 Fed. Reg. at 41894) that there are several components to this, including geographic accessibility, ensuring that a provider is able to deliver the care needed by the insured, and the ability to offer culturally competent care.

Indian hospitals and clinics are located in some of the most isolated, sparsely populated and poverty-stricken areas of the United States. For many Indian people, these hospitals and clinics are their only source of health care. The Bristol Bay Area Health Corporation, for example, is located 329 air miles from the nearest non-I/T/U facility in Anchorage, Alaska. In most instances, the only way to ensure a "reasonable proximity of participating providers" for AI/AN enrollees is for QHPs to offer to contract with I/T/U providers. Given that these I/T/U providers are often the only provider in the area, it is not sufficient for the Federal government to merely state in the preamble to the rule that an Exchange "may want to consider" the needs of AI/ANs in remote locations. Unless the Federal government mandates that QHPs include I/T/U providers in their networks, as has proven to be the case in the past, the AI/ANs in these areas may have no in-network provider at all or (as discussed below) no in-network provider that is able to provide culturally competent care.

Geography is not the only barrier to care for AI/ANs, however. In many cases, the I/T/U provider is the only facility with the capacity to serve AI/ANs in a culturally competent manner even in areas where other providers may be available. Federal health care is a right long held by AI/ANs, and many AI/ANs simply will not seek health care from any provider other that an I/T/U provider. Whether because of lack of trust, a history of abuse and discrimination, or because I/T/U providers are the only providers able to offer needed services to their AI/AN populations in a culturally appropriate and competent manner, many AI/ANs will not participate in an Exchange plan unless they can use their I/T/U provider.

AI/ANs will benefit from I/T/U being in-network providers in other ways as well. For example, including I/T/U providers in Exchange plan networks will ensure network access to other providers, and make it more efficient to refer patients to other providers. It will also minimize duplication of services that may result from AI/ANs receiving services from in-network and out-of-network (I/T/U) providers alike.

Inclusion of I/T/U providers in QHP networks will also benefit the QHP. Under Section 206 of the IHCIA, I/T/U providers have a Federal right to receive reimbursement for the services they provide whether they are in-network or not. Under Section 206, I/T/U providers have the right to recover the "reasonable charges billed … or, if higher, the highest amount [a] third party would pay for care and services furnished by providers other than governmental entities…" The Secretary has the responsibility under the Act to enforce this provision. If I/T/U providers are not included in Exchange plan networks, there may be more expensive transaction costs incurred by both the I/T/U provider and the QHP. Alternatively, if the requirement for I/T/U providers to be reimbursed by health plans is not effectively enforced, then the QHPs may realize a potential windfall by collecting premiums for AI/AN enrollees – most likely paid for with Federal dollars – and not making full payment for the health services their Indian enrollees receive from I/T/U providers.

There is no doubt that Congress intended for AI/ANs, who are among the most medically underserved populations in the United States, to benefit from full and meaningful participation in the Exchanges. Congress enacted Section 1402(d) of the ACA, for example, which provides that AI/ANs whose family income is at or below 300 percent of the Federal poverty level to be protected from any cost-sharing under an Exchange Plan, and AI/ANs who receive services at an Indian Health Care Provider be protected from any cost-sharing regardless of income. These provisions were enacted for the benefit of AI/ANs alone. In addition, the ACA provides general premium assistance to AI/ANs and non-AI/ANs alike on a sliding scale to persons whose family income extends from 133 percent of the Federal poverty level to 400 percent of the Federal poverty level. Because an estimated 82 percent of AI/ANs are in families with income at or below 400 percent of the Federal poverty level, many could benefit from this assistance as well. This assistance is only available through the Exchange plans and reflects a Congressional desire to further the United States' trust responsibility to provide health care services to AI/ANs through the Exchange plans in the ACA.

Several structural barriers must be overcome for AI/ANs to take advantage of these provisions, however. There are several key factors that will lead private insurers to have little incentive to seek to enroll AI/ANs in their health plans or include I/T/U providers in their networks. First, AI/ANs comprise just one percent of the non-elderly population in the United States. While AI/ANs may constitute a majority of the population in some areas, in general they constitute a relatively small percentage of the general population of a QHP's service area.

Second, AI/ANs have greater health care needs than the general population. Even with the risk adjustment mechanisms to be put in place, QHPs would likely avoid enrolling these high risk individuals unless they are required to do so. AI/ANs have the highest rate of many health conditions.[38] About 1 in 5 (18%) AI/AN individuals have two or more chronic conditions. This compares to a rate of 1 in 10 (10%) for non-Hispanic whites. In addition, the prevalence of diabetes among AI/ANs (12%) is at least twice that of any other racial and ethnic group, with the exception of blacks (8%). AI/ANs have higher rates of obesity compared to individuals of any other racial and ethnic group. AI/ANs have higher rates of certain behaviors that can negatively impact health. More than one-quarter (27%) of AI/ANs are current smokers, which is a higher rate than any other racial or ethnic group.

Third, there is potential pent up demand for needed services in Indian country that would create another disincentive for QHPs to enroll AI/ANs. According to a recent Kaiser Family Foundation study, nearly half (47%) of uninsured AI/AN adults do not have a usual source of care, which may make it more difficult for them to receive preventive services and timely care for acute health problems.[39] In addition, the study notes that "[w]hile most adults who only have access to care through the Indian Health Service do have a usual source of care, they are about as likely as the uninsured to have had no contact with a doctor or other health professional in the past two years. This is partially the result of budgetary constraints and the IHS system of rationing of care."[40] Taken together, these factors are likely to result in QHPs either neglecting to take proactive outreach efforts to enroll the AI/AN population or even actively working to avoid enrolling AI/ANs. One of the most effective ways for QHPs to ignore AI/ANs and discourage their enrollment is to exclude I/T/U providers from their networks.

In order to overcome these barriers, the network adequacy criteria mandated for QHPs must include a requirement that QHPs offer to contract with I/T/U providers through the use of an Indian addendum.

To improve the likelihood and consistency of access to culturally competent care for AI/ANs, NIHB recommends that §155.1050, pertaining to the establishment of Exchange network adequacy standards, be modified to read as follows:

> An Exchange must ensure that the provider network of each QHP offers a sufficient choice of providers for enrollees. **An Exchange is to ensure that each QHP include any Indian Health Service, Tribe and tribal organization, and urban Indian organization (I/T/U) providers as in-network providers when requested to do so by an I/T/U for**

[38] Kaiser Family Foundation, "Race, Ethnicity and Health Care, Issue Brief: A Profile of American Indians and Alaska Natives and Their Health Coverage", September 2009, page 1.

[39] Kaiser Family Foundation, "Race, Ethnicity and Health Care, Issue Brief: A Profile of American Indians and Alaska Natives and Their Health Coverage", September 2009, page 9.

[40] Kaiser Family Foundation, "Race, Ethnicity and Health Care, Issue Brief: A Profile of American Indians and Alaska Natives and Their Health Coverage", September 2009, page 9.

purposes of providing health services to AI/ANs as required under section 408(a) of the IHCIA.

(Bold text added.) This addition would then be cross-referenced in §156.230(a)(2).

156.235 Essential community providers.

We support the Proposed Rule's definition of essential community provider to include all health care providers defined in section 340B(a)(4) of the PHS Act and providers described in section 1927(c)(1)(D)(i)(IV) of the Act. This is mandated by Section 1311(c)(1)(C) of the ACA. Section 340B(a)(4) of the PHS Act includes "Federally qualified health care centers," which are defined in Section 1905(l)(2)(B) of the Social Security Act to include both outpatient health programs and facilities operated by Tribes and tribal organizations under the Indian Self-Determination Education and Assistance Act or urban Indian organizations receiving funds under title V of the Indian Health Care Improvement Act. Accordingly, we believe that tribal outpatient health programs and tribal facilities as well as urban Indian organizations should be specifically referenced in the regulations as "essential community providers" that QHPs must include in their provider networks.

We also appreciate the fact that the Department "continues to look at other types of providers that may be considered essential community providers to ensure that we are not overlooking providers that are critical to the care of the population that is intended to be covered by this provision," and is soliciting comment on the extent to which the definition should include other providers that provide the same services to the same predominantly low-income, medically underserved populations as the providers listed in Section 340B(a)(4) of the PHS Act. 76 Fed. Reg. at 41899. The facilities of the Indian Health Service certainly fit this bill. IHS facilities serve the same populations as tribal facilities and urban Indian organizations, and in many areas of the country where Tribes do not operate facilities under the ISDEAA, the IHS facilities are the only facilities serving the AI/AN population. Accordingly, the same rational that led to the inclusion of Section 340B(a)(4) providers, and within that category the inclusion of outpatient health programs and facilities operated by Tribes and tribal organizations and urban Indian organizations, holds for inclusion of IHS facilities as essential community providers as well.

We take issue, however, with the Department's interpretation of Section 1311(c)(1)(C) of the ACA to only require QHPs to only contract with a subset of essential community providers. In the preamble to the Proposed Rule, the Department states that the Act "does not require QHP issuers to contract with or offer contracts to all essential community providers." 76 Fed. Reg. at 41899. The Department is incorrect in this regard. Section 1311(c)(1)(C) requires QHP issuers to contract with all "essential community providers, where available." The "where available" language means simply that QHPs are not required to contract with essential community providers if no essential community providers are available. If there are no essential community providers in the area, the "where available" language means that QHP plans may be certified without entering into a contract with any essential community provider. It does not "suggest," as the Department

states, that QHPs may only contract with a subset of essential community providers. Although we recognize that overarching policy considerations may have led the Department to such an interpretation, it cannot overcome the plain language of the statute.

Even if the Department chooses to maintain this interpretation, I/T/U providers must be included in any "subset" of essential community providers the Department believes QHPs must offer to contract with for all of the policy reasons explained in our comments to the network adequacy standards in Section 156.230 above. Doing so is necessary to ensure meaningful participation by AI/ANs in the Exchanges, and will benefit I/T/U providers and the QHPs equally. I/T/U providers will benefit from inclusion in provider networks, and QHPs will benefit from the safe harbor offered by the Indian Addendum and up front inclusion of the payment requirements of Section 206 of the IHCIA, which the Department correctly recognizes applies to QHPs. (*See* Proposed Rule page 41900.)

In the discussion portion of the Proposed Rule, the rationale provided for not requiring that contracts be offered to all ECPs is that "such a requirement may inhibit attempts to use network design to incentivize high quality, cost effective care by tiering networks and driving volume towards providers that meet certain quality and value goals." It should be noted that AI/AN populations are so small that it makes no sense to consider "driving volume" toward providers. While this rationale may have merit in areas where there are competing facilities, it does not apply to remote rural and tribal areas where market forces do not operate in the way described. Geographic access to care is a basic and fundamental issue that must be addressed first or, at a minimum, at least on par with considerations to lowering QHP premiums. Furthermore, we do not see the required offer of inclusion of I/T/U providers as in-network providers as inhibiting improvement in the quality of care delivered. For one, cultural competency must be considered as a component of quality, and second, a QHP may impose quality standards on in-network providers which has the potential to increase the quality of care provided by all the in-network providers.

Although Congress included important incentives for AI/ANs to participate in Exchange plans, discussed in the previous section on network adequacy, those incentives alone will not be sufficient to overcome several significant structural barriers to meaningful AI/AN participation in the Exchanges. In order to assure that AI/ANs can meaningfully participate in the Exchanges, the Federal regulations must require that QHPs offer to contract with I/T/U providers using an Indian Addendum.

In the discussion in the Proposed Rule under subpart C--Qualified Health Plan Minimum Certification Standards, subsection (f), there is a request for comment on the interchange between IHCIA section 206 which establishes that all Indian health providers have the right to recover from third party payers up to the reasonable charges billed for providing health services or, if higher, the highest amount the insurer would pay to other providers, and the essential community provider payment requirement described in section 1311(c)(2) of the ACA.

First, we appreciate the inclusion of the statement indicating the applicability of IHCIA section 206 to Exchange (and other) plans. We encourage HHS/CMS to retain a similar discussion on the requirements of Federal law under IHCIA section 206 in the final rule. Doing so would greatly facilitate the implementation and enforcement of the section 206 provision.

Second, we believe that under the section 206 authority, Indian Health Care Providers have the option of 1) requiring payment for services rendered to a plan's enrollee according to the payment formula in section 206 or 2) agreeing to another payment mechanism and/or amount with the provider, including payment under section 1302(g) of the ACA[41] or section 408(a) of the IHCIA.[42] Section 1302(g) requires that a qualified health plan issuer reimburse Federally-Qualified Health Centers (FQHCs) at each facility's Medicaid prospective payment system rate.[43] Conversely, we believe Indian Health Care Providers have the discretion to not request reimbursement pursuant to either section 1302(g) of the ACA or section 408(a) of the IHCIA and rather require payment based on section 206 of the IHCIA.

156.245 Treatment of direct primary care medical homes.

As part of our on-going effort to improve the delivery and integration of primary care and other health care services at I/T/U facilities, we seek to engage with CMS on this provision of law and how is may best be applied to I/T/U facilities.

156.250 Health plan applications and notices.

The ACA requires the Secretary to develop and provide to each State a single, streamlined form for enrollment. The discussion states that this application is being "developed by HHS with recommendations from the NAIC." While the National Association of Insurance Commissioners should be consulted in the development of the application, Tribes should also be consulted. With the potential for variations in the definition of Indian for Exchanges and Medicaid, it is particularly important to have a system that integrates the

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41 ACA section 1302(g) was added by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152),

42 Under IHCIA section 408(a)(1), I/T/U are to be treated as "a provider eligible to receive payment under the program for health care services furnished to an Indian on the same basis as any other provider qualified to participate as a provider of health care services under the program."

43 ACA section 1302(g) reads,

> (g) PAYMENTS TO FEDERALLY-QUALIFIED HEALTH CENTERS.— If any item or service covered by a qualified health plan is provided by a Federally-qualified health center (as defined in section 1905(l)(2)(B) of the Social Security Act (42 U.S.C. 1396d(l)(2)(B)) to an enrollee of the plan, the offeror of the plan shall pay to the center for the item or service an amount that is not less than the amount of payment that would have been paid to the center under section 1902(bb) of such Act (42 U.S.C. 1396a(bb)) for such item or service.

provisions and protections for AI/ANs in the most simple and straightforward manner. NAIC does not have experience dealing with Indian health and Indian law and should not serve as experts in this aspect of application development. *Also see*, comments regarding §§ 155.405 and .420.

156.260 Enrollment periods for qualified individuals.

See, comments submitted regarding §§ 155.405 and .420.

156.265 Enrollment process for qualified individuals.

Section 156.265 (e) Enrollment information package. In addition to a general information package, it would be helpful for AI/ANs to have a special enclosure that explains their specific benefits and how to access them. It might be confusing to insert this in the publication that goes to the general public. Nothing in the regulations prohibits this and ensuring the information is available to AI/ANs to have the information is critical to their effective participation.

Section 156.265 (e) Summary of benefits and coverage document. This document should contain specific information for AI/ANs.

156.270 Termination of coverage for qualified individuals.

NIHB recommends that in addition to the notice required under subsection (b) to the Exchange and the enrollee, the QHP also be required to give notice to any authorized representative of the enrollee. *See*, comments to § 155.405(c).

156.280 Segregation of funds for abortion services.

We are pleased that the Proposed Rule does not exceed the restrictive statutory language of §1303 related to abortion coverage. However, we urge clarifications of several parts of the Proposed Rule so that abortion coverage may remain in private health insurance and so that consumers will not be deterred from enrolling in the plan best suited to their needs.

Under the current system of employer-sponsored health insurance, many plans offer coverage of abortion services. This benefit is critical to women who cannot afford to pay out of pocket for an abortion procedure on top of the premiums and other cost-sharing they may already expend towards their health care needs. Women who require abortion care may be forced to wait until later in their pregnancies for financial reasons if the service is not included in their insurance plan. Many AI/AN women already face barriers to reproductive health care such as geographic isolation, cultural stigma related to sexual health, domestic violence, and lack of basic health insurance coverage. For these women, maintaining insurance coverage of abortion services is essential. These issues are compounded for persons with limited English proficiency, who may not understand that

abortion care can be provided safely and legally in the United States if abortion care is inexplicably segregated from their health care coverage.

§156.280(c) Voluntary choice of coverage of abortion services. Consistent with §1303 of the ACA, QHPs have the option to include abortion coverage in their plans. For these reasons, we recommend that §156.280 make clear that a QHP is neither required *nor prohibited* from including abortion services for which public funding is prohibited, in the absence of a State law barring such inclusion, and so long as the QHP is in compliance with the applicable provisions of the ACA.

§156.280(e)(2) Establishment of allocation accounts. The ACA prohibits the use of Federal funds to pay for abortions for which public funding is prohibited, if a QHP opts to include those services in the benefit package. The Proposed Rule should make clear that the insurance plans, not the enrollees, are responsible for segregating the funds that cover the portion of the premium for abortions for which public funding is prohibited. The term "separate payment" in §156.280(e)(2)(i) should be interpreted as allowing individuals to make their separate payments in one transaction and/or in one instrument. This will ensure that the funds are maintained separately without placing the burden of producing payment by two transactions or instruments on the enrollee. Requiring two separate transactions or instruments would ultimately compromise the streamlined process with which the ACA endeavors to make coverage accessible and available to consumers. We urge CMS to make clear that insurers can meet this requirement by collecting the funds in the same transaction or instrument by submitting an itemized bill to the enrollee. An itemized bill would delineate the portion of the funds to be used for abortion coverage and for other coverage. This practice is standard in the insurance industry, for example, when a consumer purchases auto and homeowners insurance from the same carrier, and can pay the entire insurance bill in one transaction."

§156.280 (f) Rules relating to notice. Notice of coverage, and subsequent changes in coverage, should be made accessible for those who have limited English proficiency. Language access is one aspect of cultural competence that is essential to quality care. We recommend CMS incorporate our suggestions in §155.230 regarding notice requirements. QHPs must ensure that their members understand what services are covered under the plan purchased. If there are changes to the plan, QHPs must be responsible for ensuring that members understand those changes.

156.285 Additional standards specific to the SHOP.

NIHB requests that its comments regarding Subpart H—Exchange Functions: Small Business Health Options Program (§§ 155.705 and .730) be incorporated herein.

156.290 Non-renewal and decertification of QHPs.

NIHB recommends that each notice requirement imposed on a QHP that is not renewing certification or is otherwise subject to decertification have added to it a

requirement that the QHP notify each provider in its network. This is important to assure no disruptions in services to patients or in the financial stability of the providers. *Also see,* comments to § 155.1080.

Attachment: "NIHB Supplemental Submission, 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;

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

[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 —Indian 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 ~~"g~~roup or community" which was and is now recognized as eligible for the programs provided by the United States for Indians ~~"b~~ecause 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 ~~"I~~ndian 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]

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[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]

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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 "a 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

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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

[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.