

# National Indian Health Board



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CC:PA:LPD:PR (REG-148500-12)  
Room 5203  
Internal Revenue Service  
PO Box 7604  
Ben Franklin Station  
Washington, DC 20044

## **RE: Comments on REG-148500-12; Shared Responsibility Payment for Not Maintaining Minimum Essential Coverage**

I write on behalf of the National Indian Health Board<sup>1</sup> (NIHB) to comment on Internal Revenue Service notice of proposed rulemaking on REG-148500-12, Shared Responsibility Payment for Not Maintaining Minimum Essential Coverage (Proposed Rule). We appreciate the opportunity to provide comments.

On Thursday, February 21, 2013, the Department of the Treasury, Internal Revenue Service (IRS), in conjunction with the Department of Health and Human Services (HHS), Center for Medicare and Medicaid Services held a Tribal consultation session on the Proposed Rule as well as on the CMS issued companion proposed rule CMS-9958-P (Eligibility for Exemptions; Miscellaneous Minimum Essential Coverage Provisions). We are providing these comments as a supplement to the input provided by Tribal Leaders, Tribal Technical Advisory Group members, and other Tribal representatives at the Tribal consultation session. In addition, on March 18, 2013 the NIHB submitted comments to CMS on CMS-9958-P. These comments are consistent with the comments submitted to CMS, and the NIHB comments to CMS on CMS-9958-P are attached here and incorporated by reference.

### **BACKGROUND**

The Proposed Rule defines the circumstances that would exempt individuals from a “shared responsibility payment,” or tax penalty, for not having health insurance coverage. But AI/ANs have

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



already pre-paid for their health care through treaties that transferred millions of acres of land to the United States. The federal trust responsibility to provide health care for AI/ANs is established in law and carried out through the Indian Health Service, an agency of the Federal government. Congress has authorized funding for Indian health services to be provided directly through the IHS and other Indian Health Care Providers, and by billing other programs, including Medicaid, Medicare and plans offered in the new Health Benefit Exchanges established under this and other regulations with authorization from the Patient Protection and Affordable Care Act (Affordable Care Act or ACA).

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

In these comments, the NIHB is addressing issues arising from the narrow interpretation held by HHS and the IRS of the definitions of Indian for various Indian specific provisions of the ACA, including the exemption from the tax penalty. In addition, we are recommending a mechanism to streamline the process for verifying eligibility for the Indian-specific exemption.

## **ESTABLISHMENT OF AND ELIGIBILITY FOR INDIAN-SPECIFIC PROTECTIONS**

Under section 1501 of the Affordable Care Act (which established IRC § 5000A),<sup>2</sup> a “shared responsibility payment” is required from (nonexempt) individuals who do not maintain minimum essential coverage (MEC). AI/ANs, as defined under IRC § 45A(c)(6), are exempt from payment of the penalty under ACA § 1501/IRC § 5000A(e)(3). But under the current narrow interpretations by HHS and the IRS of the statutory provisions that define who is an “Indian” for purposes of the ACA, some AI/ANs who are eligible for services from the Indian Health Service are *not* eligible for the Indian-specific exemption from the tax penalties for not maintaining MEC,<sup>3</sup> and will therefore be subject to a tax penalty under IRC § 5000A beginning in 2014. This annual tax penalty could be substantial and would likely increase over time.<sup>4</sup>

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

<sup>3</sup> See *NIHB, Analysis of and Recommendation on Proposed Rule, Exchange Functions in the Individual Market*, CMS-9972-P, October 31, 2011.

<sup>4</sup> The shared responsibility payment amounts for a household are calculated as follows: Under § 5000A(c) of the IRC, as added by § 1501(b) of the ACA and amended by § 10106 of the Reconciliation Act, the tax penalty for not maintaining minimum essential coverage is equal to the greater of: (1) 2.5% of household income in excess of the threshold amount of income required for income tax return filing under section 6012(a)(1); or (2) \$695 per uninsured adult in the household (and

## Summary of Recommendations

We recommend that the IRS, in conjunction with CMS, modify the Proposed Rule to provide protection from the tax penalty to AI/ANs who are eligible to receive their federal right to IHS services, but who may not qualify for the Indian exemption under the HHS and IRS current statutory interpretation of IRC 45A(c)(6).<sup>5</sup> Because of the discretion afforded the Secretaries of Treasury and HHS and because the Proposed Rule anticipates that some people may be eligible for more than one type of exemption from the tax penalty, it is our understanding that CMS and IRS have the authority to establish such an exemption.<sup>6</sup> Specifically, we are recommending –

- Recommendation #1: Pursuant to the HHS Secretary’s authority under IRC § 5000A(f)(1)(E), and in consultation with the Secretary of the Treasury, designate eligibility for “a medical care program of an I/T/U” as minimum essential coverage *solely* for purposes of IRC § 5000A coupled with a statement in IRS and HHS regulations confirming that the designation does not impact the determination of a “coverage month” under IRC § 36B(c)(B)(i) pertaining to eligibility for premium tax credits and cost-sharing assistance.<sup>7</sup>

In addition to achieving the benefit of extending the exemption to a broader number of AI/ANs, implementing this recommendation would also facilitate the use of a more efficient mechanism to verify eligibility for the Indian-specific exemption from the tax penalties. If adopted, this recommendation would enable the Federal government to use the IHS registration data base as an efficient way to identify a significant percentage of the AI/AN persons who would be eligible for the exemption from the tax penalties. As such, the NIHB proposes the following additional recommendation –

- Recommendation #2: Enter into discussions through the NIHB and through formal tribal consultation to fashion an approach under 45 C.F.R. § 155.350<sup>8</sup> to provide electronic data

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½ this amount for each child), capped at three times the applicable dollar amount (e.g., \$695). The shared responsibility payment amount may not exceed an amount equal to the national average premium for bronze-level coverage offered through Exchanges for the applicable family size involved. The penalty will be phased in from 2014–2016. For 2014, the penalty will be the greater of 1% of household income over the filing threshold or \$95; for 2015, it will be the greater of 2% of household income over the filing threshold or \$325; and for 2016 it will be the full 2.5% or \$695 amount.

<sup>5</sup> In the Dear Tribal Leader letter jointly issued by IRS and CMS on February 1, 2013 explaining this Proposed Rule and CMS-9958-P, IRS indicated “This definition of Indian Tribe is consistent with the definition of Indian, as referenced in the ACA, used for eligibility determinations regarding zero cost-sharing and special monthly enrollment period provisions outlined in the CMS Exchange final rule.” In addition, in the preamble to the proposed rule for CMS-9958-P, CMS stated “We note that the definition of Indian used in the statute for this exemption is the same as is used for the cost-sharing and special enrollment provisions in subparts D and E, respectively.” (78 Fed Reg 7353)

<sup>6</sup> In addition to this recommendation being made to the IRS to designate an additional type of minimum essential coverage but to do so solely for purposes of the tax penalty and not with regard to determining eligibility for premium tax credits and cost-sharing assistance through an Exchange, the NIHB, in comments submitted to CMS on March 18, 2013, recommended that pursuant to the HHS Secretary’s authority under ACA § 1501 \ IRC 5000A(e)(5), designate “Indian, as defined in 42 CFR § 447.50” as a hardship category.

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

<sup>8</sup> 77 Fed Reg 18461.

matching with an IHS data base as one means of verifying Indian status for the recommended Indian-specific exemption from the tax penalties.<sup>9</sup>

*It is vitally important that any remedy enacted does not create other unintended consequences, such as a result that would bar AI/ANs from accessing the premium tax credits and cost-sharing assistance otherwise available in the individual market through an Exchange. NIHB and tribal leaders would oppose such an approach.*

## **Discussion of Recommendation #1**

### Establishing an interim remedy to an unintended outcome

We understand the IRS is aware of the critical problem created by the drafting and implementation of the Affordable Care Act, which defines “Indian” by reference in such a way so that not all AI/ANs who are eligible for health care services from an I/T/U as a result of their status as Indians are considered eligible for the other Indian-specific benefits and protections under the ACA. In prior communications with CMS and the IRS, the NIHB and numerous tribal organizations have recommended various remedies to this issue. The IRS and HHS have responded that a correction must be made through a change in federal law, and the IRS and HHS have voiced support for legislation that would accomplish this.<sup>10</sup> Given the Administration is in support of the legislative fix but recognizing the current political climate may make it difficult to amend the definition of Indian in time for orderly implementation of the ACA, Tribes recently recommended that the Administration exercise the authority and flexibility granted to it under the ACA to issue uniform operational guidance for the implementation of the three ACA-related Indian-specific benefits and protections, but to do so only on a temporary basis.<sup>11</sup>

The recommendations made here address one ramification of the definitional problem, namely that some AI/ANs will be subject to tax penalties for failing to pay for a health insurance product – even though they are entitled to free health care arising from the United States’ special trust responsibility to them and they may access a health program operated by an I/T/U for their health care needs. AI/ANs have a longstanding federal right to access care through the I/T/Us, and many will not be aware of the fact that they could be subject to a tax penalty for failing to purchase health insurance coverage. Moreover, the streamlined and consolidated Medicaid and Exchange plan application may reinforce the perception that they are not at risk of a tax penalty since the Medicaid program relies on a regulatory definition of “Indian” that encompasses all the people who are considered IHS beneficiaries.<sup>12</sup> We are concerned that

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

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

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

<sup>12</sup> See, 42 C.F.R. § 447.50(b)(1).

a manifest injustice will result if these AI/ANs are subject to a tax penalty for continuing to rely on their federal right to access care through the I/T/U system. If either or both of the approaches we are recommending to the IRS and CMS are not acceptable, we believe it is incumbent on the agencies to identify other approaches to remedying this problem. *But, it is vitally important that any remedy enacted does not create other unintended consequences, such as a result that would bar AI/ANs from accessing the premium tax credits and cost-sharing assistance otherwise available in the individual market through an Exchange.*

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

Under ACA §1501/IRC § 5000A(e)(3), AI/ANs are exempt from a tax penalty for not maintaining minimum essential coverage (MEC). But the problem for AI/ANs arises in that the HHS and IRS interpretation<sup>13</sup> of who is an “Indian” for purposes of ACA §1501/ IRC § 5000A(e)(3) is different from the eligibility standard for who is eligible as an Indian for services from an I/T/U. The result is that some AI/ANs who are eligible for access to services from I/T/Us will, effective January 1, 2014, become subject to a tax penalty if they do not also purchase redundant health insurance.

The problem of differing eligibility determinations is significant both individually and in the aggregate. For example, an individual AI/AN family of four could be subject to an annual tax totaling \$2,085 (or more depending on the family’s income) once the tax penalty is fully phased-in in 2016. In the aggregate, it is estimated that roughly 37,500 of the 150,000 AI/ANs in California who are currently active users of the I/T/U system will be ineligible for the tax exemption under the HHS and IRS interpretation of IRC § 45A(c)(6).<sup>14</sup> A similar result will occur in Alaska, where thousands of descendants of the original Alaska Native Claims Settlement Act village and regional corporation shareholders may not be considered “members” and therefore not “Indian” for the purposes of the ACA.<sup>15</sup>

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<sup>13</sup> See 78 Fed Reg 7351 wherein CMS indicates it intends to define “Indian tribe” in the same manner as in 26 CFR 1.5000A-3g of the Treasury Department / IRS proposed rule (REG 148500-12). And see 78 Fed Reg 7353 wherein CMS noted: “We note that the definition of Indian used in the statute for this exemption is the same as is used for the cost-sharing and special enrollment provisions in subparts D and E, respectively.”

<sup>14</sup> Testimony of James Crouch, Executive Director, California Rural Indian Health Board, at the joint HHS / Treasury Tribal Consultation, February 21, 2013.

<sup>15</sup> Both CMS and IRS have recognized that [members of ANCSA corporations are included within the definition of Indian](#). *See, e.g.*, Shared Responsibility Payment for Not Maintaining Minimum Essential Coverage, 78 Fed. Reg. 7,314, 7,316 (Feb. 1, 2013) (“Section 5000A(e)(3) provides that an individual is exempt for a month that the individual is a member of an Indian tribe as defined in section 45A(c)(6). Section 45A(c)(6) describes certain Federally recognized Indian tribes (including any qualified Alaska Native village or regional or village corporation.”); *accord* Patient Protection and Affordable Care Act; Exchange Functions: Eligibility for Exemptions; Miscellaneous Minimum Essential Coverage Provisions, 78 Fed. Reg. 7,348, 7,351 (Feb. 1, 2013) (“We propose to define ‘Indian tribe’ in the same manner as in 26 CFR 1.5000A-3(g) of the Treasury proposed rule, published elsewhere in this issue of the Federal Register, which in turn references the definition in section 45A(c)(6) of the Code. We note that section 45A(c)(6) of the Code describes certain federally-recognized Indian tribes (including any qualified Alaska Native village or regional or village corporation.”).

In the preamble to the companion proposed regulations issued by CMS (CMS-9958-P), when discussing the rationale for designating “self-funded student health insurance plans” and three other programs as minimum essential coverage, CMS stated that “individuals who wish to remain in these plans should not be subject to the shared responsibility payment under section 5000A of the Code.”<sup>16</sup> Likewise, AI/ANs who are eligible for services from an I/T/U should be able to rely on that coverage without having to pay a penalty or purchase a commercial health insurance policy. CMS further stated that the

“intent of this rule is to implement the relevant provisions while continuing to afford states substantial discretion in the design and operation of an Exchange, with greater standardization provided where directed by the statute or where there are compelling practical, efficiency, or consumer protection reasons.

In the recommendations offered here, we have attempted to adhere to this general guide, and we believe that our recommendations enable continued State flexibility while providing standardization that facilitates consistent determinations of eligibility for AI/ANs. The standardization we are seeking is for eligible AI/ANs to be consistently determined eligible for the Indian-specific benefits and protections, no matter the state in which their Tribes is located nor in which each such AI/AN currently resides.

To accomplish this, we are proposing that pursuant to the authority established under 45 C.F.R. § 155.350(c)(2),<sup>17</sup> and in conjunction with implementation of Recommendation #1, an existing data base that is maintained by the Indian Health Service be made accessible to all State-based and Federally-facilitated Exchanges and to CMS and the IRS (either directly or through the federal data services hub) for the purpose of electronic verification of eligibility for this Indian-specific protection from the tax penalties. Although we recognize that this database does not contain the names of all potentially eligible AI/ANs and cannot provide the exclusive means of verification, the IHS data base would provide an efficient means of electronic verification for a substantial number of eligible AI/ANs that can be supplemented by other means.

In Attachment A, a table is provided that lists the exemption categories contained in the Affordable Care Act as well as the “hardship” exemption categories established by the Secretary in the Proposed Rule pursuant to ACA § 1501/IRC 5000A(e)(5). The table also indicates the method that may be used to claim an exemption.<sup>18</sup>

**The NIHB has recommended that the Secretary of HHS, in coordination with the Secretary of the Treasury, designate eligibility for coverage under “a medical care program of the Indian Health Service (IHS), a Tribe or Tribal organization, or urban Indian**

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<sup>16</sup> 78 Fed Reg 7361, February 1, 2013.

<sup>17</sup> 77 Fed Reg 18461-2, March 27, 2012.

<sup>18</sup> We recommend that the IRS publish such a table, with any modifications that are warranted, in the Federal Register or through a guidance document so as to provide further clarification of these provisions.

**organization” as minimum essential coverage (MEC) solely for purposes of and applicable to the exemption from tax penalties under IRC 5000A, and further indicate that the designation would not be applicable for purposes of determining a coverage month under IRC § 36B(c)(B)(i).** The terms “Indian tribe”, “Tribal Organization”, and “Urban Indian Organization” have the meaning given those terms in Sec. 4 of the IHCA, 25 USC §1603. We wish to highlight, though, that it is critical that the IRS implement the designation of “a medical program of an I/T/U” as minimum essential coverage in a way so as to not block otherwise eligible AI/ANs from accessing premium tax credits and cost-sharing assistance through an Exchange. In the preamble to the proposed rule on CMS-9958-P,<sup>19</sup> CMS states: Under section 36B of the Code, individuals eligible to enroll in minimum essential coverage other than coverage in the individual market are generally not eligible for the premium tax credit. Recognizing that some of the categories of coverage designated by the Secretary may be widely available, the Treasury Department will consider providing appropriate rules in guidance under Code section 36B to address when individuals are treated as eligible to enroll in various types of coverage designated by the Secretary.

For purposes of designating eligibility for “a medical care program of an I/T/U” as minimum essential coverage, we believe that “providing appropriate rules in guidance under Code section 36B” is necessary and warranted in this instance. Without such a clarification in IRC § 36B that the designation of “a medical program of an I/T/U” does not apply for purposes of determining a coverage month under IRC § 36B(c)(B)(i), some IHS beneficiaries who are eligible for I/T/U services, but who wish to purchase health insurance through an Exchange, could be barred from accessing the premium tax credits and Indian-specific cost-sharing protections that would otherwise be available through the Exchange. This result could have detrimental impacts on AI/AN individuals and families. In structuring the ACA, Congress recognized and addressed this issue by 1) allowing AI/ANs to access either or both IHS services and premium and cost-sharing assistance through an Exchange and 2) by providing AI/AN individuals a monthly enrollment option so that AI/ANs would have access to health care coverage under the Exchange to supplement their eligibility for services from an I/T/U.

*We reiterate that if both Recommendation #1 and #2 cannot be adopted in tandem, the NIHB does not support the adoption of Recommendation #1 if it would result in blocking AI/AN access to premium and cost-sharing assistance through an Exchange.*

Prior consideration of designating a medical care program of an I/T/U as MEC

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<sup>19</sup> 78 Fed Reg 7360.

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

In comments to CMS from the National Indian Health Board (NIHB) in October of 2011, NIHB concurred with CMS in *not* identifying Indian health care programs as minimum essential coverage<sup>20</sup> so as to ensure that eligibility for I/T/U services would not bar I/T/U-eligible persons from accessing the Indian-specific cost-sharing protections (or the premium tax credits and other cost-sharing protections) through an Exchange.<sup>21</sup> In response to comments from NIHB to the IRS on the proposed premium tax credit regulation (REG-131491-10), the Internal Revenue Service confirmed that eligibility for I/T/U services is not considered minimum essential coverage for these purposes.

At the time that NIHB submitted these earlier comments, the rationale for agreeing with CMS in not identifying I/T/U programs as minimum essential coverage was twofold: 1) AI/ANs were understood to be (or would be made to be) protected from the tax penalty under § 1501/5000A(e)(3) and so additional protections were unnecessary; and 2) designation of I/T/U services as “minimum essential coverage” could prevent AI/ANs from accessing the premium tax credits and cost-sharing assistance otherwise available through an Exchange. In other instances, though, NIHB has supported federal regulations that appropriately do consider I/T/U coverage as minimum essential coverage or an equivalent designation. For example, in the regulations for the Medicare Prescription Drug Plan,<sup>22</sup> eligibility for IHS services is identified as meeting “minimum essential coverage” or “creditable coverage” standards, and IHS beneficiaries are considered to have creditable coverage<sup>23</sup> If an IHS beneficiary decides to enroll in Medicare Part D, he or she may enroll in a Medicare Prescription Drug Plan without incurring a late

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

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

<sup>22</sup> Referred to as Medicare Part D coverage.

<sup>23</sup> “42 CFR § 423.56 Procedures to determine and document creditable status of prescription drug coverage. (a) *Definition*. Creditable prescription drug coverage means any of the following types of coverage listed in paragraph (b) of this section only if the actuarial value of the coverage equals or exceeds the actuarial value of defined standard prescription drug coverage as demonstrated through the use of generally accepted actuarial principles and in accordance with CMS actuarial guidelines. (b) *Types of coverage*. The following coverage is considered creditable if it meets the definition provided in paragraph (a) of this section:... (9) Coverage provided by the medical care program of the Indian Health Service, Tribe or Tribal organization, or Urban Indian organization (I/T/U).”...



enrollment penalty.<sup>24</sup> It is important to note that in each of the instances where there has been advocacy to treat I/T/U coverage as minimum essential coverage, it was in order to expand options for AI/ANs to access health care services, not to restrict options.

However, due to 1) the failure to achieve an interpretation from HHS and/or IRS of the references to “Indian” under the ACA in a manner consistent with the identification of Indians for IHS eligibility and Medicaid purposes (i.e., the failure to secure a uniform operational definition of Indian for health care purposes), 2) the failure to, as of yet, secure a legislative fix, and 3) because the effective date for the tax penalty is approaching, there is a need for the IRS to reconsider its approach on this issue. Moreover, the IRS is demonstrably vested with the authority to do so: in the final rule on premium tax credits, the IRS indicated its ability and willingness to permit eligibility for one type of minimum essential coverage to not bar an individual from accessing health insurance premium tax credits through an Exchange.<sup>25</sup> The IRS indicated that it was able, for “administrative convenience,” to permit eligibility for veteran’s programs to not bar an individual from accessing health insurance premium tax credits through an Exchange.<sup>26</sup> Just as the IRS exercised its flexibility to protect America’s veterans from becoming an unintended casualty of unclear drafting, it should exercise similar flexibility to uphold the federal government’s special trust responsibility and maximize opportunities for AI/AN health care access.

In the case of AI/ANs, the ability to enroll in an Exchange plan, secure premium tax credits and cost-sharing protections, and *continue to access I/T/U services is consistent with* – and central to – the design of the Affordable Care Act as it pertains to AI/ANs. For example, under ACA § 1402(d), AI/ANs enrolled through an Exchange are provided full cost-sharing protections when receiving services at I/T/Us whether or not the AI/ANs are eligible for or secure premium tax credits through an Exchange. Again, enrollment of AI/ANs in health plans through the individual market in an Exchange with assistance from the premium tax credits and cost-sharing assistance otherwise available is designed to occur under the ACA with AI/ANs continuing to use I/T/U providers. This combination is central to the

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<sup>24</sup> IHS, Draft “Important Notice to IHS Beneficiaries, Subject: Your Prescription Drug Plan (PDP) Coverage under Medicare Part D and the Annual Creditable Coverage Letter (42 CFR §423.56)”, viewed on IHS Web site, 9/20/2012. IHS is considered a Creditable Coverage provider and IHS beneficiaries are considered to have creditable coverage. This means that if AI/ANs should decide to enroll in a Medicare Part D Prescription Drug Plan, they may enroll without incurring a late enrollment penalty.

<sup>25</sup> 77 Fed Reg 30377 (May 23, 2012).

<sup>26</sup> 77 Fed Reg 30379. “B. Definition of ‘Eligible’ The proposed regulations provide that an individual is eligible for government sponsored minimum essential coverage when an individual meets the requirements for coverage under the program. For administrative convenience, however, because the standards for eligibility in veterans’ programs do not allow Exchanges to identify everyone who may be eligible for veterans’ coverage at the time he or she is seeking an eligibility determination for advance payments of the premium tax credit, the proposed regulations provide that an individual is eligible for minimum essential coverage under the veteran’s health care program authorized under chapter 17 or 18 of Title 38, U.S.C. only if the individual is enrolled in a veteran’s health care program identified as minimum essential coverage in regulations issued under section 5000A. The final regulations conform the rules to amendments to section 5000A that delete the word “veteran’s” in describing health care programs under chapter 17 or 18 of Title 38. Thus, the special rule for veterans’ coverage may apply to individuals who are not veterans but are eligible for the Civilian Health and Medical Program of the Department of Veterans Affairs (VA) or the VA’s spina bifida program.”

structure provided by Congress for AI/ANs under the Affordable Care Act, and not in conflict with the intention of Congress or the ACA.<sup>27</sup>

#### Justification for designation of a medical care program of an I/T/U as MEC

We believe designating a medical care program of an I/T/U as minimum essential coverage solely for purposes of and applicable to the exemption from tax penalties under IRC 5000A, and not for purposes of determining a coverage month under IRC § 36B(c)(B)(i), is warranted for the following reasons:

- AI/ANs who are eligible to receive health care services from an I/T/U, paying for health insurance or an annual tax penalty for themselves and their family members may create a financial hardship.
- The drafting of the ACA and the subsequent failure to reconcile the definition of “Indian” as it applies for CMS and IHS programs with the definitions under the ACA, create an unintended consequence of the law whereby some AI/ANs who are eligible for I/T/U services are eligible for an exemption from the tax penalty and others are not. Like the hardship exemption HHS provided to address another unintended consequence of the ACA (*i.e.*, the unaffordable “affordable” employer offered coverage), so should the “definition of Indian” problem be addressed.
- Implementing this exemption would provide relief to a group of AI/ANs during a transition period while amendments are made to the Affordable Care Act to fix the discrepancies in the eligibility for various Indian-specific benefits and protections under the ACA. This is similar to the hardship exemption granted to people living in states where Medicaid Expansion is not being implemented
- Effectively extending the current Indian-specific exemption (as defined under IRC § 45A(c)(6)) to the broader category of AI/ANs who are eligible for I/T/U services would reduce the administrative complexities to Tribes and to Exchange staff of identifying a subset of AI/ANs and improve the timeliness and accuracy of the verification of Indian status. Granting this

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<sup>27</sup> The approach taken by the IRS for persons eligible for veteran’s services and the recommended approach here (where eligibility for a medical care program of an I/T/U is designated as minimum essential coverage for purposes of protection from the tax penalty but not for determining eligibility for financial assistance through an Exchange) are even more parallel than may initially appear. Because I/T/U programs are the payer-of-last resort pursuant to 25 U.S.C. § 1623(b) and other law, coverage under an Exchange plan would be the “primary” coverage for an AI/AN who is enrolled in an Exchange plan. The I/T/U would bill the Exchange plan for services rendered that are within the plan’s health benefits package and, as such, are reimbursable under the Exchange plan. This will have a very beneficial effect on the funding of I/T/U providers and allow them to expand their service capacity, including preventive services and other services that may not be covered under the insurance plans. Moreover, it will create access to care that AI/ANs would otherwise not be able to access at all because of the terrible funding limitations of the contract health services program.

exemption would also facilitate use of an electronic verification mechanism for many of the eligible persons.

- The distinctions between definitions of Indian that are used for Medicaid, CHIP, ACA, IHS and other federal programs are not going to be readily understood in AI/AN communities (or by State Medicaid programs or State and Federal Exchanges). People who have never been expected to purchase health insurance are not going to know what this is all about, and it is virtually certain that there will be insufficient resources to reach everyone to explain the distinctions, choices and consequences. Furthermore, it is possible that plans offered on the Exchanges will not have or will not have sufficient numbers and types of providers in or near Indian communities to serve people who do purchase insurance.

### **Discussion of Recommendation #2 -- Rely upon an Indian Verification Data-Mart for electronic verification of Indian-Status**

As discussed briefly above, we also recommend that HHS and CMS enter into discussions with the NIHB and through formal Tribal consultations to fashion an approach under 45 C.F.R. § 155.350, which was referenced in § 155.615 of the companion proposed rule from CMS (CMS-9958-P),<sup>28</sup> to provide electronic verification of eligibility for persons meeting IHS eligibility requirements under 42 C.F.R. § 447.50.<sup>29</sup> We are referring to this mechanism as an Indian Verification Data-Mart. As we have indicated in prior comments, we do not believe an electronic verification source on its own is sufficient to verify the status of *all* AI/ANs who are eligible for the Indian-specific exemption, and that other forms of verification must be allowed as well. However, the electronic database we describe below would provide one efficient mechanism for verifying the AI/AN status of a significant percentage of eligible persons.

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

Providing a means for the real-time, electronic verification of Indian status for a significant percentage of AI/ANs would increase the likelihood that 1) AI/ANs (and only AI/ANs) are determined eligible for the Indian-specific benefits and protections that they are eligible to receive and 2) the verification for

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<sup>28</sup> 77 Fed Reg 18461.

<sup>29</sup> Once established, the electronic verification of Indian status could also apply to verifying eligibility for the Indian-specific cost-sharing protections under Medicaid (45 CFR § 155.350) and potentially for other purposes.

these AI/ANs of their Indian status can be accomplished without the costs and delays associated with AI/ANs re-submitting paper documentation that they previously provided to the I/T/U.

We anticipate that few AI/ANs will enroll in Exchange plans unless there are Indian-specific accommodations in the Exchange (such as aggregate payment for Tribal Sponsorship, network adequacy standards that include I/T/U providers, an Indian Addendum for contracts, etc.) We also anticipate that a significant number of AI/ANs (under IRC § 45A(c)(6)) who do not have health insurance provided by their employer or a government program will apply for the Indian exemption for the tax penalty. Without some electronic data match the cost of “Indian” verification will be significant to all participants: the AI/AN person, Tribes, the Exchanges, and the Federal agencies that will be pulled in to the process. These costs are avoidable is a substantial percentage of AI/ANs status as “Indian” can be verified by accessing an electronic database for this purpose, such as the IHS data base that we are recommending.

As might be evident from this NIHB recommendation to use electronic matching as one means to verify Indian status for an Indian-specific exemption as requested above, we differ with the statement made at 78 CFR 7359 in the preamble to the companion proposed rule issued by CMS. The statement reads: “Further, with the exception of income, we are unaware of electronic data sources with which it would be useful to conduct data matching for purposes of eligibility for exemptions.” As noted above, an electronic data base is currently maintained by the IHS that could enable real-time electronic data matching as one source to verify eligibility for the Indian-specific hardship exemption. This data source could also be valuable as one means of verifying eligibility for the Indian-specific cost-sharing protections under Medicaid. And depending upon the outcome of the legislative change being sought on this issue, this data source might also have use as a means of verifying Indian status for the Indian-specific cost-sharing protections and the Indian-specific special enrollment periods available through Exchange-facilitated coverage.<sup>30</sup>

It is possible that an Indian Verification Data Mart could be established, maintained, and made accessible with minimal additional effort on the part of IHS and Tribes. This data mart could accurately identify AI/ANs who meet the eligibility criteria under 42 C.F.R. § 447.50. An example of how one State-based Exchange is utilizing this data is in Oregon. The Cover Oregon exchange will allow Tribal health programs to upload their RPMS<sup>31</sup> or other registration data for the purposes of determining AI/AN eligibility for Medicaid premium and cost sharing exemptions and eligibility for ACA benefits and protections. This is the same data that is uploaded on a routine basis to the IHS National Data Warehouse. Similarly, the Alaska Medicaid program uses data matching with tribal health programs to verify AI/AN eligibility. If this process can work at the state level it only stands to reason that it can work at the national level.

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<sup>30</sup> A report currently being completed by the Tribal Self-Governance Advisory Committee (TSGAC) on the adequacy and potential use of the IHS data base for verification purposes for submission to IHS, CMS and the IRS will be very helpful in further consideration of this recommendation.

<sup>31</sup> Resource and Patient Management System maintained by the Indian Health Service.

If such an electronic verification mechanism is established for purposes of verifying eligibility for an Indian-specific hardship exemption, as the NIHB is recommending in comments on the companion proposed rule (CMS-9958-P), we concur with the use of the procedures identified in § 155.330(e)(1) and (e)(2) pertaining to updated information.<sup>32</sup>

### **Discussion of Other Process Issues related to AI/AN Exemptions**

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

The NIHB concurs with the option provided under § 155.605(f) for AI/ANs (defined under IRC § 45A(c)(6)) to secure from an Exchange a certificate of exemption from the tax penalty *so long as it is coupled with* the provision in the Proposed Rule which provides an AI/AN the option of claiming their exemption from the tax penalty by including information with their Federal income tax return (if required to file a tax return).<sup>33</sup> The ability to file for the exemption during tax filing process is critical, particularly in the early years of implementation, as many AI/ANs will not learn of their obligation to secure MEC or to file for an exemption until notified after the coverage year ends – during the tax filing process. We recommend that the IRS apply a similar approach – the option to claim an exemption through an Exchange and through the tax filing process – for AI/ANs claiming the exemption from the tax penalty recommended here.

In addition, the NIHB is recommending that, if the request to CMS for the establishment of an Indian-specific hardship exemption is accepted, a parallel option be established for claiming the Indian-specific hardship exemption with an individual's Federal income tax return. We recognize that individuals meeting the existing hardship exemptions are not provided an opportunity to file for the hardship exemption through the tax filing process, and this policy may be carried over to an Indian-specific hardship exemption that might be established. We are concerned, though, that the lack of an ability to file for a hardship exemption after the year's end through the tax filing process will, unnecessarily, reduce the number of eligible persons who file for the exemption. In fact, a key reason the NIHB is advocating for Recommendation #1 – Designating a medical care program of an I/T/U as MEC – in addition to the request to HHS for the establishment of a hardship exemption for AI/AN persons meeting the definition of Indian under 42 C.F.R. § 447.50 is because of the (current) lack of an ability to file for an hardship exemption post year-end through the tax filing process.

#### **Duration of exemption**

The NIHB concurs with the approach taken in the companion proposed rule (CMS-9958-P) on the duration of the exemption from the tax penalty for AI/ANs defined in IRC 45A(c)(6). Under § 155.605(f)(2), the rule proposed by CMS provides that the exemption is provided on a “continuing basis,

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<sup>32</sup> On page 78 Fed Reg 7359, CMS solicited comments as to whether an Exchange should handle changes which are identified through an electronic data matching process that is used for verification of eligibility for exemptions from the tax penalty in a similar manner as that specified in 45 CFR 155.330.

<sup>33</sup> See 78 Fed Reg 7322, February 1, 2013.

until such time that the applicant reports that he or she no longer meets the standards provided in § 155.605(f)(1).”

In the recommendation above whereby “a medical program of an I/T/U” is designated as MEC for purposes of IRC § 5000A (but not IRC § 36B), we request that IRS incorporate a similar duration.<sup>34</sup>

### Cross-populating applications

The NIHB concurs with the CMS proposal in § 155.610(c) wherein “if an individual submits the application in 45 C.F.R. 155.405 (pertaining to the single streamlined application for Exchange-facilitated coverage) and then requests an exemption, the Exchange must use the information collected on the application for coverage and not duplicate any verification processes that share the standards specific in this subpart.”<sup>35</sup>

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

As shown in Attachment B,<sup>36</sup> the information requested on the single streamlined application (as indicated in CMS-10440) corresponds to both the definition of Indian as it is being applied under IRC § 45A(c)(6) and to who is eligible for IHS services and meets the definition under 45 CFR § 155.350. The information gathered on eligibility for I/T/U services could subsequently be used to identify some of the applicants who are eligible for the hardship exemption, and subsequently verify their eligibility against the Indian Verification Data Mart, if such an exemption is established pursuant to these NIHB comments. It would be incumbent, though, on a process being established whereby the IRS is made aware of the individuals who are determined eligible for the exemption through this mechanism.

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

### **OTHER FAMILY MEMBER EXEMPTION**

Even if the issues related to the definition of Indian are resolved, there will still be a need for an additional hardship amendment for certain individuals who are family members of Indians, but who are

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<sup>34</sup> Likewise, the NIHB recommended that a hardship exemption that may be extended by CMS to AI/ANs meeting the definition under 42 CFR § 447.50 would also be on a continuing basis.

<sup>35</sup> 78 Fed Reg 7356.

<sup>36</sup> See Attachment B for a screen shot of the section of the proposed single streamlined application form that pertains to AI/AN eligibility.

themselves not Indian (regardless of the definition used.) Pursuant to § 813(a) and (b) of the Indian Health Care Improvement Act (IHCA)<sup>37</sup> certain members of the family of an AI/AN are entitled to health services of the IHS. These are principally children who include all individuals who are under age 19 years, and are “the natural or adopted child, step-child, foster child, legal ward, or orphan of an eligible Indian,” even if they are not themselves Indian. Such a child

shall be eligible for all health services provided by the [Indian Health] Service on the same basis and subject to the same rules that apply to eligible Indians until such individual attains 19 years of age.<sup>38</sup>

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

We recommend a hardship exemption be allowed for individuals who are eligible for services of IHS pursuant to 25 U.S.C. § 1680c(a) or (b).<sup>39</sup> We make this recommendation out of respect for the importance of families treating each member equally. We are concerned about the unintended consequences that could result if an adopted or step-child who is non-Indian is the cause of an Indian family being charged tax penalties even though this child, like all the Indian children in the family, is able to use Indian health programs to obtain his or her health care. We are confident that the numbers of children in this situation are small and granting a hardship exemption will have little impact on the revenue of the Treasury. However, imposing a penalty on a family would certainly be significant to that family and might be devastating to the way in which each member of the family is treated.

While each of these provisions reference only services provided by the IHS, they are applicable to the tribal health programs that assume programs from the Indian Health Service under the Indian Self-

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<sup>37</sup> Pub. L. 94-437, as amended, codified at 25 U.S.C. § 1680c(a) and (b).

<sup>38</sup> 25 U.S.C. § 1680c(a). And, in fact, entitlement to health services continues past 19 years if the child was “determined to be legally incompetent” before reaching 19 years old, in which case “such remain eligible for such services until 1 year after the date of a determination of competency.” *Id.*

<sup>39</sup> The new hardship exemption would appear as § 155.605.(g)(7). Subsection (b) of 25 U.S.C. § 1680c provides for services to a non-Indian spouse, but only under very limited circumstances that arise rarely in Indian country.

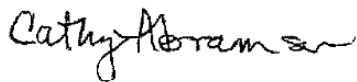
Any spouse of an eligible Indian who is not an Indian, or who is of Indian descent but is not otherwise eligible for the health services provided by the Service, shall be eligible for such health services if all such spouses or spouses who are married to members of each Indian tribe being served are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

Determination and Education Assistance Act (ISDEAA).<sup>40</sup> Although tribes that assume programs of IHS have considerable authority to reallocate and redesign the programs to meet their own tribal needs, there are limits. Under the self-determination provisions of Title I of the ISDEAA, a tribe may not redesign without IHS approval and may only reallocate funds if doing so “would not have an adverse effect on the performance of the contract.”<sup>41</sup> The requirement is even more clearly stated in Title V regarding self-governance where redesign and reallocation are permitted provided they do “not have the effect of denying eligibility of services to population groups otherwise eligible to be served under applicable Federal law.”<sup>42</sup>

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

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

Sincerely,



Cathy Abramson

Chair, NIHB

Cc:

Marilyn Tavenner, Acting Administrator, CMS

Gary Cohen, Director, Center for Consumer Information and Insurance Oversight

Kitty Marx, Director of Tribal Affairs, CMS

Dr. Yvette Roubideaux, Director, IHS

Stacy Bohlen, Executive Director, NIHB

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<sup>40</sup> Pub. L. 93-638, as amended, codified at 25 U.S.C. § 450 *et seq.*

<sup>41</sup> 25 U.S.C. § 450j-1(o).

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



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

Category of Exemption <sup>43</sup>	Method to Claim Exemption		Code Section	Reg Section	Notes:
	Exchange Certification <sup>44</sup>	Tax Filing Process <sup>45</sup>			
Exemptions Identified in ACA					ACA §1501\5000A(d) & (e)
Religious Conscience	✓	No	IRC § 5000A(d)(2)(A)	§ 1.5000A—3(a); § 155.605(c)	
Health Care Sharing Ministry	✓	✓	IRC § 5000A(d)(2)(B)	§ 1.5000A—3(b); § 155.605(d)	
Not Lawfully Present	No	✓	IRC § 5000A(d)(3)	§ 1.5000A—3(c)	IRS PR does not identify a process for claiming this exemption.
Incarcerated	✓	✓	IRC § 5000A(d)(4)	§ 1.5000A—3(d); § 155.605(e)	
Individual with No Affordable Coverage	No	✓	IRC § 5000A(e)(1)	§ 1.5000A—3(e)	Actual income for the year. Special rules for employees' "related individuals". (78 Fed Reg 7320.)
Individual Below Tax Filing Threshold	No	✓	IRC § 5000A(e)(2)	§ 1.5000A—3(f)	Actual income for the year
Indian (IRC 45A)	✓	✓	IRC § 5000A(e)(3)	§ 1.5000A—3(g); §155.605(f)	
Short Coverage Gap	No	✓	IRC § 5000A(e)(4)		

<sup>43</sup> “The term ‘applicable individual’ is used in section 5000A to describe an individual who is subject to the minimum essential coverage provision under section 5000.\*\*\* Although the two categories are distinct in the statute, the consequence for individuals described in either category is the same: individuals in both categories are not subject to the shared responsibility payment for not maintaining minimum essential coverage.” (78 Fed Reg 7318-9.)

<sup>44</sup> 78 Fed Reg 7369 lists the exemption categories and the process (as proposed by CMS) for claiming the exemption.

<sup>45</sup> 78 Fed Reg 7322 lists the exemption categories and the process (as proposed by the IRS) for claiming the exemption.

Category of Exemption <sup>43</sup>	Method to Claim Exemption		Code Section	Reg Section	Notes:
	Exchange Certification <sup>44</sup>	Tax Filing Process <sup>45</sup>			
<i><b>Proposed: Eligible for a medical care program of an I/T/U under 25 U.S.C. § 1680c(a) or (b)</b></i>	✓	✓	IRC §5000A(f)(1)E	<u>Proposed: § 156.602</u>	
Hardship	✓	No	IRC §5000A(e)(5) and ACA §1311(d)(4)(H)	§ 1.5000A—3(h); § 155.605(g)	
Hardship Exemptions Proposed by HHS Secretary (under IRC §5000A(e)(5) and ACA §1311(d)(4)(H))					CMS-9958-P (78 Fed Reg 7368)
Unexpected increased in expenditures	✓	No		§ 155.605(g)(1)	
Unable to afford coverage	✓	No		§ 155.605(g)(2)	Using projected annual household income.
Gross income below the filing threshold	✓	No		§ 155.605(g)(3)	
Not eligible for Medicaid bc State didn't expand Medicaid (§2001(a))	✓	No		§ 155.605(g)(4)	
Unaffordable "affordable" employer coverage	✓	No		§ 155.605(g)(5)	
<i><b>Proposed: Indian, as defined in 42 CFR § 447.50</b></i>	✓	✓		<u>Proposed: § 155.605(g)(6)</u>	

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

**STEP 4**

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

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

Yes. If yes, continue.

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

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

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

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