

Memorandum

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Burns-Paiute Tribe
Chehalis Tribe
Coeur d'Alene Tribe
Colville Tribe
Coos, Suislaw &
Lower Umpqua Tribe
Coquille Tribe
Cow Creek Tribe
Cowlitz Tribe
Grand Ronde Tribe
Hoh Tribe
Jamestown S'Klallam Tribe
Kalispel Tribe
Klamath Tribe
Kootenai Tribe
Lower Elwha Tribe
Lummi Tribe
Makah Tribe
Muckleshoot Tribe
Nez Perce Tribe
Nisqually Tribe
Nooksack Tribe
NW Band of Shoshone Tribe
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
Quinalt Tribe
Samish Indian Nation
Sauk-Suiattle Tribe
Shoalwater Bay Tribe
Shoshone-Bannock Tribe
Siletz Tribe
Skokomish Tribe
Snoqualmie Tribe
Spokane Tribe
Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Umatilla Tribe
Upper Skagit Tribe
Warm Springs Tribe
Yakama Nation

2121 SW Broadway
Suite 300
Portland, OR 97201
(503) 228-4185
(503) 228-8182 FAX
www.npaihb.org

To: TRIBAL LEADERS, HEALTH DIRECTORS, NPAIHB DELEGATES
From: JIM ROBERTS, POLICY ANALYST
Date: 12/7/2012
Re: STATE EXCHANGE LETTERS ON INDIAN DEFINITION

I am providing you with copies of letters from the Executive Directors of the Oregon and Washington insurance exchanges and a letter from Oregon Governor Kitzhaber on the same issue. I've also attached a two page document that as simple as possible attempts to explain the challenge with the varying Indian definitions in the Affordable Care Act and in Medicaid.

The letters request the Administration to weigh in with HHS and fix this issue by issuing operational guidance or a regulation that will allow the State Exchanges to align the ACA definitions with the Medicaid cost sharing regulation definition for Indian. The Medicaid definition is closely aligned to the IHS eligibility for services policy.

This solution will allow state insurance Exchanges to streamline eligibility determination for Indians for the ACA monthly enrollment option and cost sharing exemption and similar exemptions in Medicaid.

If you have any questions concerning these items, please call me at (503) 228-4185 or email at jroberts@npaihb.org.



JOHN A. KITZHABER, MD
Governor

December 3, 2012

Ellen Montz, Health Policy Advisor
Office of the Whitehouse
Domestic Policy Council
1600 Pennsylvania Avenue N.W.
Washington, DC 20500

Dear Ms. Montz:

We are seeking the Administration's help so that State Exchanges may implement the single streamlined application process required under the Affordable Care Act (ACA) when identifying American Indian and Alaska Native (AI/AN) people.

The ACA requires State Exchanges to establish a short and simple application process that uses electronic verification to determine eligibility for the individual Exchanges, Medicaid, and Child Health Insurance Programs. The ACA includes Indian-specific provisions that provide special protections and benefits for Indian people. Because the ACA, Medicaid and CHIP do not uniformly apply a common definition for eligibility they pose operational challenges for State Exchanges. We are concerned that these challenges will be costly and reduce timeliness in determining eligibility for Indians using the consolidated and streamlined Medicaid and Exchange application process. This will result in reduced accuracy in eligibility determinations and the application of cost sharing waivers or charges by health plan providers.

We are aware that the California Rural Indian Health Board and the Northwest Portland Area Indian Health Board have sent a letter (sent on September 21, 2012) to the Administration outlining these issues. The letter includes a recommendation for the HHS Secretary to issue operational guidance to assist the Exchanges to permit a uniform definition across Medicaid, state and federal Exchanges. We agree that this is a problem that can be solved easily by having Exchanges adopt the Medicaid definition of Indian.

For the reasons discussed above, we respectfully request that the Administration issue operational guidance to adopt the Medicaid eligibility regulation, at 42 C.F.R. § 447.50, to assist Exchanges to effectively implement the Indian provisions in the ACA.

Sincerely,

John A. Kitzhaber, M.D.
Governor

MB/smg



December 6, 2012

Ms. Ellen Montz, Health Policy Advisor
Office of the White House
Domestic Policy Council
1600 Pennsylvania Avenue N.W.
Washington, DC 20500

Dear Ms. Montz:

I am writing to support the recommendation recently put forth by the Northwest Portland Area Indian Health Board, the California Rural Indian Health Board and others, that the Administration issue guidance to help state exchanges create a uniform definition for American Indian/Alaska Native (AI/AN).

For the past year, the Washington Health Benefit Exchange, the American Indian Health Commission (AIHC) for Washington State, and local tribal communities have been working together to develop a state-based health insurance exchange that will address the needs of American Indians and Alaska Natives, including the 29 federally recognized Tribes and two urban Indian health programs in Washington.

Our efforts to build an exchange with a single application process that can deliver the special benefits and protections to AI/AN families described in the ACA has been hindered by the lack of a common AI/AN definition in the ACA. Three different definitions are currently being used: two for commercial plans offered in exchanges and one for Medicaid plans. We anticipate that building a system that attempts to cross-walk between these different definitions could compromise the accuracy and timeliness of eligibility determinations, complicate the application of cost sharing waivers or charges by health plan providers, and interrupt coverage for individuals moving between Medicaid and commercial plans.

We are committed to providing better access to plans, programs and support for Washington's tribal community through the exchange. As such, the Washington Health Benefit Exchange respectfully requests that the Administration issue guidance to help state exchanges create a uniform definition for AI/AN. Specifically, we recommend adopting the Medicaid eligibility regulation, at 42 C.F.R. § 447.50.

Thank you for your consideration of this request.

Sincerely,



Richard K. Onizuka, PhD
Chief Executive Officer

cc: Jim Roberts, Northwest Portland Area Indian Health Board (NPAIHB)
Sheryl Lowe, American Indian Health Commission (AIHC) for Washington State
Marilyn Scott, AIHC Chair
Jason McGill, GOV
Deborah Sosa, HCA



December 3, 2012

Ms. Ellen Montz, Health Policy Advisor
Office of the White House
Domestic Policy Council
1600 Pennsylvania Avenue N.W.
Washington, DC 20500

Dear Ms. Montz:

Cover Oregon has been working closely with the tribal community in Oregon in developing our state-based health insurance exchange. For the past year, we have been meeting regularly with the nine federally recognized tribes in Oregon and the Native American Rehabilitation Association (NARA) Urban Indian Clinic. We have developed a strong relationship with the tribes based on mutual respect and a commitment to ensure American Indians and Alaska Natives in Oregon can access the many benefits and protections provided to them in the Affordable Care Act.

However, in working with the tribal community, we have identified a significant challenge in implementing the ACA. As you know, the ACA provides special protections and benefits to Indian people. In order to provide those benefits, state exchanges must determine whether a person is an American Indian or Alaska Native through a single application process. But the ACA does not include a common definition for American Indian/Alaska Native (AI/AN) for state exchanges to use. There currently are three different definitions: two for commercial plans that will be offered in exchanges and one for Medicaid plans. We expect this will be a large obstacle for Cover Oregon and state exchanges across the country in serving the American Indian and Alaska Native population. It likely will result in reduced accuracy and timeliness in eligibility determinations. It will also be burdensome for AI/AN families who “churn” between Medicaid and commercial plan eligibility.

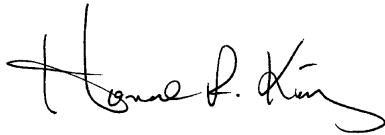
3414 Cherry Avenue NE
Suite 190
Salem, Oregon 97303
Phone: 503-373-9417
Fax: 503-373-9422

coveroregon.com

To alleviate this issue, Cover Oregon respectfully requests that the Administration issue guidance to help state exchanges create a uniform definition for AI/AN. Specifically, we recommend adopting the Medicaid eligibility regulation, at 42 C.F.R. § 447.50. We concur with the Northwest Portland Area Indian Health Board, the California Rural Indian Health Board and others who we understand have made similar recommendations.

Thank you for your consideration of this request. We look forward to providing better access to health coverage not only for Oregon's tribal community but for all Oregonians.

Sincerely,

A handwritten signature in black ink, appearing to read "Howard P. King". The signature is fluid and cursive, with a long horizontal stroke at the end.

Howard "Rocky" King
Cover Oregon Executive Director

CC: Jim Roberts, NPAIHB
Acting Tribal Chairperson, Burns Paiute Tribe
Chairman Bob Garcia, Confederated Tribes of Coos, Lower Umpqua &
Siuslaw Indians
Chairman Reyn Leno, Confederated Tribes of Grand Ronde
Chairwoman Brenda Meade, Coquille Indian Tribe
Chairman Dan Courtney, Cow Creek Band of Umpqua Tribe of Indians
Chairman Gary Frost, Klamath Tribes
Chairwoman Dee Pigsley, Confederated Tribes of Siletz Indians
Chairman Les Minthorn, Confederated Tribes of the Umatilla
Chairman Ron Suppah, Confederated Tribes of the Warm Springs
Ms. Jackie Mercer, NARA NW
Mr. Michael Bonetto, Oregon Health Authority

Need for Uniform Operational Guidance in Determining Eligibility for Indian-specific Benefits and Protections under the Affordable Care Act

ISSUE:

The ACA includes three Indian-specific sections that provide special protections and benefits to AI/ANs. CMS has determined that the two Exchange-related definitions (for Exchange cost-sharing and enrollment protections) “operationally means the same thing.”¹ IRS has said informally that its definition section, which protects against tax penalties being applied to AI/ANs for not maintaining minimum essential coverage, has the same meaning as the definitions used for the Exchange.

CMS has opined that the eligibility standard for the Indian-specific provisions under the ACA are “slightly different” from the AI/AN eligibility standards for IHS services.² In response to requests from States for clarification about who an “Indian” is, CMS adopted Medicaid regulations that simplified the IHS eligibility rules. See, 42 CFR 447.50.

OBJECTIVE:

Uniform operational guidance is needed, consistent with 42 CFR 447.50, regarding eligibility determinations for Indian-specific benefits and protections under Medicaid and the Affordable Care Act through HHS and IRS guidance or regulation.

RECOMMENDED ACTIONS:

1. Issue operational guidance from HHS and Treasury to assist Exchange enrollment staff and others as necessary in determining eligibility for Indian-specific benefits and protections for Exchange and Medicaid coverage;
2. Rely on the CMS regulations, 42 C.F.R. § 447.50, in order to permit a uniform application across Medicaid, state and federal Exchanges and IRS (for the exemption for AI/ANs from the tax penalty for not maintaining minimum essential coverage).

AUTHORITY:

It is well established that (1) the federal government has a trust responsibility to provide health care to Indians, and (2) that laws for the benefit of Indians should be construed liberally in favor Indians.

As established under 45 C.F.R. § 155.315(h) *Flexibility in information collection and verification*, the Secretary of HHS has discretionary authority to approve modifications to the methods used for the collection and verification of information related to eligibility for enrollment through an Exchange and for eligibility for Exchange insurance affordability programs. This authority may be exercised by the Secretary “provided that HHS finds that such modification would reduce the administrative costs and burdens on individuals while maintaining accuracy and minimizing delay, [and] that it would not undermine coordination with Medicaid and CHIP...” As indicated below, these criteria would be met through the issuance and reliance on uniform operational guidance.

TRIBAL SUPPORT FOR USING CMS’ MEDICAID REGULATIONS AS THE UNIFORM OPERATIONAL GUIDANCE

National and regional tribal organizations support the application of uniform operational guidance using the CMS Medicaid regulation at 42 C.F.R. § 447.50 for purposes of implementing the Indian-specific provisions of the Affordable Care Act. Resolutions of support were adopted by the National Congress of American Indians (NCAI), the National Indian Health Board (NIHB), and the Tribal Technical Advisory Group to CMS (TTAG).

¹ Exchange Establishment Final Rule, 77 Fed. Reg. 18346.

² Exchange Establishment Final Rule, 77 Fed. Reg. 18383.

POTENTIAL RAMIFICATIONS FOR FAILING TO ISSUE UNIFORM OPERATIONAL GUIDANCE:

Failure to issue uniform operational guidance will impede Exchange, Medicaid and IRS staff in making accurate and consistent determinations of eligibility as well as delay or completely deny access for some AI/ANs to the Indian-specific benefits and protections established under the Affordable Care Act.

- Delayed eligibility for some AI/AN children: An AI/AN child who is not allowed to enroll as a tribal member until her 18th birthday may not be considered eligible for Exchange-related Indian-specific cost-sharing and enrollment protections, despite being considered an AI/AN for purposes of IHS, Medicaid and CHIP coverage.
- Unwarranted application of tax penalties: If an AI/AN who is eligible and, in fact, is accessing IHS services decides not to secure health insurance coverage, but is not (ultimately) determined to be eligible as an “Indian” for the exemption from the requirement to secure minimum essential coverage, this individual could be subject to significant tax penalties imposed under the ACA by the Internal Revenue Service.
- Reduced timeliness: The consolidated and streamlined Medicaid and Exchange application process is intended to rely, to the greatest extent possible, on electronic verification of application-related information. The lack of uniform operational guidance would complicate (although not prevent) the use of automated databases that may be available for electronic verification, such as using the IHS beneficiary roster, hamper coordination between Medicaid and Exchange eligibility, and likely increase the administrative costs and burden on individuals.
- Reduced accuracy in eligibility determinations: If guidance is not issued by CMS, or if the guidance issued does not provide uniformity across the Indian-specific provisions in Medicaid, Exchange coverage, and pertaining to the exemption from tax penalties, thereby requiring each Exchange to identify any differences in eligibility standards under the various definitions, including understanding the differences, if any, in documentation permitted to satisfy each definition of Indian, error rates for eligibility determinations will increase.
- Blocked access for some Alaska Natives: Some Alaska Native adults and children may not be considered AI/AN by Exchanges until their parents die and they inherit stock in an Alaska Native corporation; likewise, their children would not be considered AI/AN by Exchanges until they die and the stock in an Alaska Native corporation is passed along to children even though the parent and the children would qualify as AI/AN under Medicaid and other governmental services (*e.g.*, IHS and BIA).
- Reduced involvement of AI/AN in insurance options: Even if the instances of an individual being determined to be “Indian” for one Indian-specific provision and not for another represent a relatively small percentage of the total population (which we anticipate), this outcome would likely cast a shadow over AI/ANs involvement with ACA implementation more generally. For example, AI/ANs may be much more reluctant to consider transitioning from the IHS-based coverage model to comprehensive Exchange coverage if there is a risk of ending-up subject to significant cost-sharing requirements under a different, potentially unknown application of a definition of Indian.

For questions please contact Jim Roberts, Policy Analyst, (503) 228-4185 or email at jroberts@npaihb.org.

Chart of Indian-specific Health Care Provisions with Different Citations in Federal Law for Defining "Indian"

a	b	c	d		e
IHS & Medicaid Align		Affordable Care Act-related Provisions			
IHS Eligibility for AI/ANs	Medicaid: Protections and Benefits for AI/ANs	Health Insurance Exchange-related Provisions			Exemption from IRC tax penalties for AI/ANs not having "minimum essential coverage" IRC 45A(c)(6)
		Monthly Enrollment Periods for AI/AN's	Cost-Sharing Protections for AI/AN's Sec. 4(d) ISDEAA		
		Sec. 4 IHCA	No cost-sharing for AI/ANs under 300% FPL (at all providers)	No cost-sharing for AI/ANs served by I/T/U; payment of full amount due to I/T/U (without cost-sharing reductions)	

CMS stated in regulations these definitions "operationally mean the same thing."

IRS stated informally in meetings these definitions are the same.