From: Roger Gantz [mailto:gantzrp@yahoo.com]
Sent: Saturday, September 15, 2012 12:59 PM
To: Tribal Health Directors & AIHC/NPAIHB Delegates

Colleagues:

Reminder. The AIHC has submitted a formal request to Commissioner Kriedler to have the ACA qualified health plans (QHP) "essential community provider" certification provisions include a requirement that QHPs offer all I/T/U providers a network provider contract in their service area(s). The AIHC has also requested that the contract in the Indian Addendum, which to the best of our understanding is still being formalized by HHS and TTAG. Attached are copies of the communications between the Commissioner's office and AIHC. Sheryl is scheduling a meeting with the Commissioner and members of the AIHC Executive Committee to make this request in-person.

TX

Roger

American Indian Health Commission for Washington State

"Improving Indian Health through Tribal-State Collaboration"

Chair
Marilyn Scott
Upper Skagit Tribe

Vice-Chair
Cheryl Sanders
Lummi Tribe

Treasurer
VACANT
Jamestown S'Klallam Tribe

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Leslie Wosnig
Suquamish Tribe

Member-at-Large
Bonnie Sanchez
Squaxin Island Tribe

Executive Director
Sheryl Lowe

Member Tribes:
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Colville
Cowlitz
Jamestown S'Klallam
Kalispel
Lower Elwha Klallam
Lummi
Makah
Muckleshoot
Nisqually
Nooksack
Port Gamble
S'Klallam
Puyallup
Quileute
Quinault
Samish
Saux-Suiattle
Shoalwater Bay
Skokomish
Snoqualmie
Spokane
Squaxin Island
Stillaguamish
Suquamish
Swinomish
Tulalip
Upper Skagit

Member Organizations:
Seattle Indian Health Board
NATIVE Project of Spokane

September 6, 2012

John F. Hamje
Tribal Liaison & Deputy Insurance Commissioner
Office of the Insurance Commissioner
P.O. Box 40256
Olympia, Washington 98504-0256

Dear Mr. Hamje:

On behalf of Washington's Tribes and the American Indian Health Commission (AIHC), I want to thank Commissioner Krielder and you for the August 9, 2012 letter's response to our July 18, 2012, letter's request to meet with the Commissioner on the forthcoming criteria governing Washington Health Benefits Exchange (WHBE) qualified health plan's (QHP) essential community provider requirements.

Your letter indicated that the Office of the Insurance Commission is not yet able to address our request due to forthcoming guidance from the Department of Health and Human Services (HHS). However, the March 23, 2012, HHS rules governing health benefit exchanges and QHP standards provides sufficient guidance for our request. While the rule (45 CFR 156.235) governing essential community provider requirements adopted a "sufficient number and geographic" standard, the preamble states,

We emphasize that Exchanges have the discretion to set higher, more stringent standards with respect to essential community provider participation, including a standard that QHP issuers offer a contract to any willing essential community provider (Federal Register, Vol.77, No. 59, March 27, 2012 (page 18421))

We have heard that HHS will be promulgating guidance for the federal facilitated exchange (FFE) on network adequacy and essential community provider requirements, including specific provision for Indian Health Services-operated programs (I), 638 tribal contracted and compacted programs (T) and urban Indian health programs (U). We have been told that these requirements will not be directly applied to state operated exchanges.

We understand that the interplay between exchanges and the Indian Health Care Improvement Act (IHCIA) is complex. HHS has affirmed in its rule preamble that the Act's provisions apply to state operated exchanges, as well as Medicare, Medicaid and the Children's Health Insurance Program. In recognition of this complexity, HHS is working with Tribal Technical Assistance Group (TTAG) to design an Indian Addendum template for states that will set forth QHP requirements when they contract with I/T/U providers, as well as exchange requirements. We anticipate that the template will be available by October.

*P.O. Box 226 ** Port Angeles, WA ** 98362 ** Phone: 360-775-5736*
*E-mail: slowe@aihc-wa.com ** Website: www.aihc-wa.com*

Given the very tight timelines for the Commissioner to complete WHBE QHP certification requirements, we are concerned about the opportunity to meet with him to ensure there is sufficient time for input on the essential community provider rules and/or contract requirements. We are therefore going to proceed to request a meeting with the Commissioner as soon as possible.

As a precursor to the meeting, enclosed is a document developed by the Northwest Portland Area Indian Health Board, Affiliated Tribes of Northwest Indians and AIHC to help guide Tribes work with their respective exchanges. The document provides legislative references to our request to require WHBE QHPs to offer network contracts to all I/T/U facilities urban.

I want to again thank the Commissioner for his support to the Tribes on health care access issues. If you have any questions about our recommendations, please contact either Sheryl Lowe, AHIC Executive Director at 360-775-5736 or slowe@aihc-wa.com; or myself at (360) 854-7039 or marilyns@upperskagit.com.

Sincerely,

Marilyn Scott, Chair
American Indian Health Commission

Enclosure

cc:

AIHC Delegates
Mike Krielder
Richard Onizuka
Beth Berendt
Barbara Flye
Molly Voris
Brad Finnegan

American Indian Health Commission for Washington State

"Improving Indian Health through Tribal-State Collaboration"

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Puyallup
Quileute
Quinault
Samish
Saux-Suiattle
Shoalwater Bay
Skokomish
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Spokane
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Stillaguamish
Suquamish
Swinomish
Tulalip
Upper Skagit

Member Organizations:
Seattle Indian Health Board
NATIVE Project of Spokane

July 18, 2012

Margaret Stanley, Chair
Washington Health Benefit Exchange
P.O. Box 657
Olympia, WA 98507

Mike Kriedler, Commissioner
Washington State Office of the Insurance Commissioner
Insurance Building, Capitol Campus,
Olympia, WA 98504

Dear Ms. Stanley and Mr. Kriedler:

On behalf of Washington's Tribes and the American Indian Health Commission (AIHC), I want to thank the Washington Health Benefit Exchange Board (WHBEB) and the Office of the Insurance Commissioner (OIC) for the opportunity to comment on your forthcoming work to develop the criteria for qualified health plans (QHP) to contract with essential community providers.

Washington's Indian health programs consists of Indian Health Services-operated programs (I), 638 tribal contracted and compacted programs (T) and urban Indian health programs (U). They are uniquely qualified to serve as essential community providers. Twenty-seven of our federally recognized tribes currently have medical clinics and our two urban Indian health programs serve American Indian (AI) and Alaska Native (AN) people living in the Seattle and Spokane areas. When a tribe operates its own health program its members nearly exclusively use that program and not a program operated by another tribe or the Indian Health Service. This fact is important to note as it is the basis for our request to require that all QHPs offer contracts to each of the state's Indian health programs.

As you know, the Affordable Care Act (ACA) and its l rules require that each Health Benefit Exchange (HBE) ensure that QHPs "*… must have a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards*." The ACA and enabling network adequacy rule also requires that QHPs are to "*… maintain a network that is sufficient in number and types of providers... to assure that all services will be accessible without unreasonable delay.*"

We have been advised that the OIC will be responsible for determining network adequacy requirements and what constitutes a "sufficient number" of essential community providers that QHPs must contract with to meet the ACA standards. For the reasons outlined below, Washington's Tribes and the AIHC believe that the criteria should require that all QHPs offer network provider contracts with an Indian Addendum to all I/T/U programs in the QHP's service area.

I/T/U programs are best able to provide culturally appropriate primary care and other HBE essential health benefits to AI/AN people. Washington's I/T/U programs are nationally recognized for providing medical homes including care coordination for AI/AN people and other low-income people in their catchment areas. Tribal clinics are also able to provide other essential health benefits including pharmacy and behavioral health services. Washington's I/T/U providers with some 36 clinic locations are uniquely located to provide access to AI/AN people residing on the Washington's Indian reservations and critical locations for AI/AN people living in urban areas.

Washington's I/T/U programs have demonstrated capacity to work with a variety of federal programs and health carriers. All of Washington's tribal health programs have contracts with Washington's Medicaid program. I/T/U programs also contract with the Medicaid Healthy Options and Basic Health managed care programs that are targeted to serve low-income peoples across the state. Some of the I/T/U providers also contract with Medicare and other private insurers.

As a federal program, states' HBEs and QHPs must comport with provisions in the Indian Health Care Improvement Act (IHCIA). Under federal treaty and IHICA requirements, tribal members are to receive services from their tribe's programs, and I/T programs must serve eligible AI/AN s. In recognition of this trust responsibility, the IHCIA gives Indian health programs the authority to obtain reimbursement for services provider to AI/AN people from federal programs, including the ACA, and from health insurers, including QHPs, for whom the AI/AN person is enrolled. This obligation to receive payment for services rendered applies to both tribal programs that are QHP in-network providers or are non-network providers. Federal law also prohibits states from enacting laws that would prohibit or limit this right of recovery.

The IHICA sets forth payment rate obligations for services provided by I/T programs. An I/T program has the right to be paid by a health carrier (as well as by any employee benefit or other third party payer) the reasonable charges billed by the tribal program in providing health services through the program, or, if higher, the highest amount the payer would pay for care and services furnished by other providers (other than governmental entities). This applies for services provided to AI/AN people and non-native people alike.

It is important to note that Washington already recognizes the critical role that I/T/U programs have in serving AI/AN people. Washington's Medicaid program contracts with all federally recognized tribes that have medical clinics, as well as the two urban programs. Both the Healthy Options and Basic Health managed care programs require their participating health plans to reimburse I/T/U programs for services provided to AI/AN enrollees whether or not the I/T/U program is a network or non-network provider in their service areas.

Washington's rules governing health carriers also recognize the critical role that I/T/U providers play in serving AI/AN people. The rule (WAC 284-43-200) governing network adequacy requires health carriers to "… *maintain*

arrangements that insure that American Indians who are covered persons have access to Indian health services and facilities that are part of the Indian health system."

While federal provisions require I/T programs to serve AI/AN members enrolled in the HBE regardless of their network status, the benefits of in-network status are substantial for AI/AN patients and providers alike. In-network status will lead to greater coordination and timeliness of care to AI/ANs patients, and more certainty and timeliness of payment to I/T/U programs. For QHPs as well, including I/T/U programs as in-network providers, offers significant advantages as well, including: meeting network adequacy requirements for serving AI/ANs; reducing avoidable hospital emergency room use; timely inpatient discharge and placement; and, potential reduction in the overall volume of billed services to the QHP. Requiring QHPs to offer I/T/U programs network contracts would not create an undue burden on the QHP as the total number of I/T/U facilities is not large; there are only 36 care delivery sites in Washington.

Based on our experience with the Medicaid and BH programs, as well as private health plans, we understand that the relationship between I/T/U programs and private providers are different. To help exchanges and QHPs to contract with I/T/U programs, the Department of Health and Human Services (HHS) is developing an "Indian Addendum" template that state HBEs can use in their contracts with QHPs. The template could be adapted to include state-specific provisions for I/T/Us. The Indian Addendum is designed to list applicable Indian-specific Federal requirements. These provisions of Federal law apply whether or not the Indian Addendum is used.

Use of an Indian Addendum has proven to simplify and clarify the identification and application of these provisions for contracting health plans. Under Medicare, a similar "I/T/U Addendum" has been successfully adopted by Medicare Prescription Drug Plans when contracting with I/T/U pharmacies. In order to ensure a productive relationship between QHPs and their network I/T/U providers, we are requesting that QHPs' contracts with I/T/U providers be required to include the Indian Addendum.

Part of Washington's recently approved Level 2 Establishment grant includes funding for the AIHC to work with the WHBEB to develop and implement policies and programs to ensure the successful enrollment of AI/AN people into the HBE, a WHBEB tribal consultation policy required in federal and state law, and to work with the WHBEB and OIC to develop QHP essential community provider requirements for I/T/U programs. This will include working with the HHS Tribal Technical Advisory Group (TTAG), and the Northwest Portland Area Indian Health Board (NPAIHB) to explain the benefits of the Indian Addendum template that can be adopted by both Washington and Oregon's exchanges.

I want to again thank you for supporting AIHC's work with the WHBEB and OIC to successfully implement Washington's HBE. If you have any questions about our recommendations, please contact either Sheryl Lowe, AHIC Executive Director at 360-775-5736 or slowe@aihc-wa.com; or myself at (360) 854-7039 or marilyns@upperskagit.com.

Sincerely,

Marilyn Scott, Chair
American Indian Health Commission

cc:
WHBE Board Members
AIHC Delegates
Richard Onizuka
Molly Voris
Brad Finnegan
Michael Arnis
Beth Berendt
Barbara Fly
Joe Finkbonner
Jim Roberts

MIKE KREIDLER
STATE INSURANCE COMMISSIONER

STATE OF WASHINGTON

OFFICE OF
INSURANCE COMMISSIONER

Phone: (360) 725-7000
www.insurance.wa.gov

August 9, 2012

The Honorable Marilyn Scott, Chair
American Indian Health Commission
PO Box 226
Port Angeles WA 98362

Dear Ms. Scott:

Thank you for your letter of July 18, 2012 in which you requested that each qualified health plan (QHP) under the federal Affordable Care Act be required to offer network provider contracts to Indian health programs in the QHP's service area. Commissioner Kreidler asked me to respond on his behalf.

Your quotation of language found in WAC 284-43-200(7) is particularly apt in this context. Ensuring access by American Indians to Indian health services is a critical component of the legislative framework for promoting network adequacy in this state. This office is committed to diligent enforcement of this requirement.

At this time, we are not able to address specifically the substance of your request. We expect that the Center for Consumer Information and Insurance Oversight will provide guidance on this subject in the federal regulations that are pending adoption. These regulations, when adopted, could have an impact on Washington State law and practice. In addition, the interplay between the provisions of the Indian Health Care Improvement Act as applicable to the Health Benefit Exchange and QHPs and state law and practice is not yet fully understood. We will keep you informed of our progress and share the results with the Commission when we have something more definitive on the subject. It may be useful to meet with representatives of the Commission to accelerate this process. Would such a meeting be agreeable to the Commission?

Please do not hesitate to contact me if I can be of assistance.

Sincerely,

John F. Hamje
Tribal Liaison and
Deputy Insurance Commissioner
Consumer Protection Division

cc: Richard Onizuka, Chief Executive Officer, Washington State Health Benefit Exchange

Mailing Address: P.O. Box 40256 * Olympia, WA 98504-0256
Street Address: 5000 Capitol Blvd. * Tumwater, WA 98501

Qualified Health Plans and Indian Health Providers

Prepared by Northwest Tribal-State Exchange Planning Network*

July 31, 2012

The Patient Protection and Affordable Care Act ("ACA")[1] requires the establishment of health benefit exchanges ("Exchanges") to serve each State.[2] Each state has the opportunity to establish the Exchange that will serve its residents, rather than rely on a federally established Exchange, so long as its Exchange complies with applicable law, which includes certain provisions of the Indian Health Care Improvement Act ("IHCIA")[3] relevant to payment for services provided by Indian Health Providers. Indian Health Providers are the Indian Health Service ("IHS"), Tribes and Tribal Organizations carrying out programs of the IHS ("Tribal Health Programs"), and urban Indian organizations receiving funding from the IHS pursuant to Title V of the IHCIA ("UIOs").[4]

To ensure compliance with the Indian-specific provisions of law and simplify administration of qualified health plans ("QHPs"),[5] Tribal Health Programs and UIOs urge that Exchanges adopt the following conditions of participations for QHPs:

(1) Require compliance with IHCIA Sections 206 and 408[6] as a condition of certification and recertification;
(2) Require QHPs to *offer* to contract with all Indian Health Providers in the QHP's service area as in-network providers;
(3) Require QHPs to use the Centers for Medicare and Medicaid Services (CMS)-approved "Indian Addendum" when contracting with Indian Health Providers.

These proposed conditions are allowable under CMS rules. CMS has made it clear in its regulations regarding the establishment of Exchanges that States may direct Exchanges to implement State-specific conditions for QHPs, so long as those conditions are not inconsistent with federal requirements.[7] As discussed below, States have the authority to fulfill each of the recommendations above and the concerns they address are commented on directly in CMS's implementing regulations regarding implementation of Exchanges.[8]

Section 408(a) of the IHCIA, a new provision adopted in the ACA, requires all Federal Health Care Programs[9] to accept Indian Health Providers "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." Section 408 goes on to specify that state and local requirements for entities like the Indian Health Provider are not applicable to such providers so long as they meet the applicable standards for such a license and that health professionals of IHS and Tribal Health Programs need not have a license in the state in which they are practicing so long as they meet the requirements of Section 221[10] to be licensed in some state. This new provision of the IHCIA clarifies issues that have historically plagued relationships between Indian Health Providers and various payers.

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* The Northwest Tribal-State Exchange Planning Network is a partnership between the Northwest Portland Area Indian Health Board, the American Indian Health Commission of Washington State, and Affiliated Tribes of Northwest Indians. Funding has been made available by the Oregon Health Insurance Exchange (ORHIX) and Washington Health Benefit Exchange.

Section 206 of the IHCIA establishes a right of all Indian Health Providers to recover from an insurance company, health maintenance organization, employee benefit plan, third-party tortfeasor, or any other responsible or liable third party (including a political subdivision or local governmental entity of a State).[11] This requirement, which was amended in the ACA, was originally enacted in 1988, to assure that insurers and other responsible third-parties would not benefit unfairly from the fact that American Indians and Alaska Natives ("AI/ANs") have a right to receive services of the IHS without incurring any personal obligation to pay.[12] This right arises from the special trust responsibilities and legal obligations of the United States to AI/ANs.[13] These trust and legal obligations also require IHS and Tribal Health Programs to serve their members and other AI/ANs. Section 206 also prohibits States, other subdivisions of a State, or health plan from enacting laws or contract requirements that limit this right to payment.[14]

CMS has affirmed in rulemaking that IHCIA Section 206 and 408 requirements apply to federal and State operated Exchange by stating:

> The primary purpose of section 408 of IHCIA is to deem Indian health providers as eligible to receive payment from Federal Health Care Programs for health care services provided to Indians if certain standards are met. Eligibility to receive payment under section 408 of IHCIA does not depend on in-network status with a QHP. Section 206 of IHCIA provides that all Indian providers have the right to recover from third party payers, including QHPs, up to the reasonable charges billed for providing health services, or, if higher, the highest amount an insurer would pay to other providers to the extent that the patient or another provider would be eligible for such recoveries.[15]

Given that AI/ANs enrolled in Exchanges are not subject to in-network access limitations to health services of Indian Health Providers and that those Providers must be reimbursed for those services, it is in the best interests of States to require all QHPs to certify that they will comply with IHCIA Sections 206 and 408 and to require them to offer network contracts to all Indian Health Providers in their service area(s).

In-network status will lead to greater coordination and timeliness of care to AI/AN patients, and more certainty and timeliness of payment to Indian Health Providers.[16] For QHPs as well, including Indian Health Providers as in-network providers offers significant advantages, including meeting network adequacy requirements for serving AI/ANs; reducing avoidable emergency department use; timely inpatient discharge and placement; and, potential reduction in the overall volume of billed services to the QHP. Requiring QHPs to offer Indian Health Providers network contracts would not create an undue burden on the QHP as the total number of Indian Health Providers facilities is not large.

To facilitate QHPs offering contracts to Indian Health Providers, CMS has determined that it will develop an Indian Addendum template for use by Exchanges and QHPs. CMS also stated that, at its option, an Exchange may require all QHPs to use the Indian Addendum when contracting with Indian Health Providers. CMS further commented that "we believe that QHP issuers will find it in their interest to adopt such a template when contracting with Indian providers."[17]

An Indian Addendum is designed to list applicable Indian-specific Federal requirements and to conform a health plan's standard contract to the Indian-specific requirements of Federal law. These provisions of

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Federal law apply whether or not the Indian Addendum is used, but use of an Indian Addendum has proven to simplify and clarify the identification and application of these provisions for contracting health plans. Under Medicare, a similar "I/T/U Addendum" is being used successfully by Medicare Prescription Drug Plans when contracting with I/T/U pharmacies. Implementing the CMS Addendum as a State requirement of QHPs will substantially improve understanding and the ease of administration.

These recommendations for State requirements for QHPs are based in Federal law, but also will assist States and their Exchanges to assure quality health services to AI/ANs who suffer from poor health status.[18] Indian Health Providers routinely report on quality measures under the Government Performance and Results Act ("GPRA"). These reveal significant accomplishments despite the persistent underfunding for these programs. Indian Health Providers also must meet quality and accreditation standards for the purposes of participating in the Medicare, Medicaid and CHIP programs. As a measure of their level of compliance, many Indian Health Providers are accredited through such organizations as the Accreditation Association for Ambulatory Care or the Joint Commission on Accreditation of Health Care Organizations.

Implementation of the requirements proposed and discussed in this paper, should be addressed by the States and Exchanges as they fulfill their obligations to engage in consultation. Exchanges must consult on an ongoing basis with a list of stakeholders, including "(f) Federally-recognized Tribes, as defined in the Federally Recognized Indian Tribe List Act of 1994, 25 USC 479a, that are located within such Exchange's geographic area."[19]

The Final Rule referred back to the Proposed Rule for a discussion on how Exchanges are to interact with Tribes–

> Each Exchange that has one or more Federally-recognized tribes, as defined in the Federally Recognized Indian Tribe List Act of 1994, 25 U.S.C. 479a, located within the Exchange's geographic area must engage in regular and meaningful consultation and collaboration with such tribes and their tribal officials on all Exchange policies that have tribal implications. We encourage Exchanges to also seek input from all tribal organizations and urban Indian organizations. While the **Exchanges will be charged with the consultation**, tribal consultation is a government-to-government process, and therefore the State should have a role in the process. We encourage States to develop a tribal consultation policy that is approved by the State, the Exchange, and tribe(s)."[20]

It was noted in the preamble to the Final Rule that "future guidance will be provided to States regarding key milestones, including tribal consultation, for approval of a State-based Exchange."[21] Although there is no Federal requirement for Exchanges to fund technical assistance provided by Tribes and tribal organizations to States, this type of expenditure by an Exchange is a permissible use of Exchange establishment grant funding.[22]

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

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

[2] State-based health insurance exchanges (Exchanges) will be available in each State in time to allow enrollment in new health insurance coverage options beginning January 1, 2014. Exchanges are marketplaces for the offering of health insurance coverage, mechanisms for determining eligibility for various government health insurance programs, and vehicles for securing government assistance, if eligible, with covering all or a portion of the health insurance plan monthly premiums.

[3] Pub. L. 94-437, as amended and permanently reauthorized by Section 10211 of the ACA, which enacted, as amended, the Indian Health Care Improvement Reauthorization and Extension Act of 2009, S. 1790, as reported by the U.S. Senate Committee on Indian Affairs.

[4] Collectively, these entities are often referred to as "I/T/Us". The term "IHS" means the agency of that name within the U.S. Department of Health and Human Services ("HHS") established by IHCIA § 601 (25 USC §1661). The terms "Indian tribe," "tribal organization," and "UIO" have the meaning given those terms in IHCIA § 4 (25 USC §1603).

[5] QHPs are established under § 1301of the ACA. A health plan is considered a QHP if it is certified as meeting the applicable Federal standards, as well any State-specific standards added by a State and/or Exchange, and is offered through an Exchange. *Also see*, 45 C.F.R. § Part 156.

[6] 25 U.S.C. §§ 1621e and 1647a, respectively.

[7] 45 C.F.R. § 156.200(d) ("A QHP issuer certified by an Exchange must adhere to the requirements of this subpart and any provisions imposed by the Exchange, or a State in connection with its Exchange, that are conditions of participation or certification with respect to each of its QHPs"). *Also see*, 77 Fed. Reg. 18406.

[8] *Federal Register*, March 27, 2012, CMS, "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans," (CMS-9989-F), 77 Fed. Reg. 18310 et seq. ("Final Rule").

[9] The term Federal Health Care Program has the meaning given that term under section 1128B(f) of the Social Security Act (42 U.S.C. 1320a–7b(f)), except that, for purposes of this subsection, such term shall include the health insurance program under chapter 89 of title 5, United States Code (i.e., the Federal Employees Health Benefits Program).

[10] 25 U.S.C. § 1621t.

[11] 25 U.S.C. § 1621e(a) (IHS and Tribal Health Programs) and (i) (application of all provisions of § 1621e to UIOs.

[12] IHS is not permitted to impose any charges on AI/ANs, nor may it require any Tribal Health Program to do so. 25 U.S.C. 25 U.S.C. §§ 458aaa-14,1621e(f), 1681, and 1681r(b).

[13] 25 U.S.C. § 1602.

[14] 25 U.S.C. § 1621e(c).

[15] Final Rule, 77 Fed. Reg. 18420.

[16] AI/AN enrollees may have needed health care services delayed or denied if they are required, after being served by an out-of-network Indian Health Care Provider, to meet with an in-network primary care provider in order to receive a referral to an in-network specialist.

[17] Final Rule, 77 Fed. Reg. 18423.

[18] 25 U.S.C. § 1601 ("The Congress finds the following: . . . (5) Despite such services, the unmet health needs of American Indian people is far below that of the general population of the United States.")

[19] Final Rule, § 155.130, 77 Fed. Reg. 18447.

[20] *Federal Register*, July 15, 2011, CMS, "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans," (CMS-9989-P), Vol. 76, No. 136, page 41873 ("Proposed Rule").

[21] Final Rule, 77 Fed. Reg. 18320.

[22] Final Rule, 77 Fed. Reg. 18321.

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