California Rural Indian Health Board

Northwest Portland Area Indian Health Board

September 21, 2012

Valerie B. Jarrett, Senior Advisor
The White House
1600 Pennsylvania Avenue N.W.
Washington, DC 20500

Jodi Gillette, Senior Policy Advisor
Native American Affairs
1600 Pennsylvania Avenue N.W.
Washington, DC 20500

Dear Ms. Jarrett and Ms. Gillette:

The California Rural Indian Health Board (CRIHB) and the Northwest Portland Area Indian Health Board (NPAIHB) are Tribal organizations organized under the Indian Self-Determination and Education Assistance Act.[1] Our organizations represent health care issues of 63 federally-recognized Tribes in California, Idaho, Oregon, and Washington. We are writing to you about a very important Affordable Care Act matter.

In just three months, States will be applying to the federal government for certification of their Health Insurance Exchanges under the Affordable Care Act. One of the current activities for both State Exchanges and the Federally-Facilitated Exchange is to create a single streamlined application for Medicaid, Child Health Insurance Programs, and the individual Exchanges. The Administration's goal of a short and simple application that uses electronic data bases is at odds with regulatory guidance regarding identifying American Indians and Alaska Natives (AI/AN) for the purposes of cost sharing waivers, special enrollment periods, and other protections in Medicaid, CHIP and the Exchanges. It is imperative that the White House provide guidance on this issue so that AI/AN who were intended to benefit from ACA are not left out.

Here is a short list of potential problems that could occur if the definition of Indian used by Exchanges is different from the one used by Medicaid and CHIP:

- An AI/AN child who is not allowed to enroll as tribal members until her 18th birthday will not be considered as AI/AN by Exchanges, although she would be considered AI/AN by Medicaid and CHIP.

- An Alaska Native adult will not be considered AI/AN by Exchanges until his parent dies and he inherits stock in an Alaska Native corporation. And his children will not be considered AI/AN by Exchanges until he dies and his stock in an Alaska Native corporation is passed along to his children, even though they qualify as AI/AN under Medicaid and CHIP.

[1] As defined in the Indian Self-Determination and Education Assistance Act, P.L. 93-638, 25 U.S.C., Section 450(b) a Tribal organization is a legally established governing body of any Indian tribe(s) that is controlled, sanctioned, or chartered by such Indian Tribe(s) and designated to act on their behalf.

- An American Indian child that may not have enough blood quantum to be enrolled in a Tribe will be considered Indian under Medicaid. But not in Exchanges, because she lacks enough blood quantum to be enrolled in either of her parent's tribe.

- An American Indian cannot enroll in his father's tribe where tribal membership is passed from mother to child in what has been called matrilineal descent, and therefore he would not be considered AI/AN under Exchanges, even though he would qualify as AI/AN in Medicaid.

- An individual who has been determined to be AI/AN by the federal Bureau of Indian Affairs and has a Certificate of Indian Blood issued by that federal agency that is recognized by every other federal agency, is not recognized as Indian by the Federally-facilitated Exchange or state-based exchanges.

- A person enrolled in Medicaid as an AI/AN no longer meets the income criteria and does not purchase health insurance because she gets her care from her Tribal health clinic and assumes that she is exempt from tax penalties because she is AI/AN. However, IRS uses a different definition of AI/AN than Medicaid uses, and she finds out later that she does have to pay a tax penalty.

- The complications of Exchanges to administer and families to understand the varying definition of Indian and the high level of churning that is anticipated for AI/AN families will disenfranchise AI/AN families from participating in opportunities provided under the Affordable Care Act.

In each of these cases, the individuals could be living in a family that is considered AI/AN, in an AI/AN community – perhaps even on a reservation, attending Indian schools funded by the federal government, and receiving their health services at an Indian Health Service clinic or hospital. They could be considered AI/AN for Medicaid, CHIP and every federal Indian program. And, still they would not be qualified for the special protections for AI/AN in Health Insurance Exchanges according to the current interpretation of ACA by the Department of Health and Human Services.

As a result of the differences in how Exchange rules are being written and how Medicaid and CHIP rules are written, it is not possible to have a simple, streamlined application that relies on existing electronic data sources. The application must ask at least three different questions to determine who qualifies as Indian under the different programs. Those three questions take up a lot of space on an application which will be used by a lot of people who are not AI/AN, and they will confuse a lot of people who are AI/AN. If Exchanges use the same definition as Medicaid, CHIP and the Indian Health Service, they could use the electronic registration data base from the IHS as part of the application process. However, the more restrictive definition currently in use by Exchanges may require someone at every Exchange and at every Tribal government site to process paperwork that shows that an individual has a tribal enrollment card. Ironically, the ACA calls for self-attestation for almost every aspect of the application (except citizenship), and yet AI/ANs may be expected to provide documentation instead of using self-attestation to prove that they are a member of a Tribe or Alaska Native regional or village corporation. The Administration should be trying to make it easier for underserved individuals to enroll in health insurance through Exchanges, not more difficult.

Operationally, it is going to be a nightmare to have different definitions of AI/AN for Medicaid, CHIP and Exchanges. Personnel at call centers, navigators, in-person assisters, and individuals working in Indian health clinics will have to explain to people why they are considered an Indian for one federally-funded program, but not for another. Explaining the benefits of this new program will be difficult enough. As health care providers bill Medicaid Plans and Qualified Health Plans, they will need to know whether cost sharing waivers apply for some AI/AN and not for others.

As people have changes in employment, income and family size, they will churn between Medicaid to Exchange coverage assuming that the same rules apply, only to find out later that they have been disenfranchised as AI/AN from Exchanges.

This is a problem that can be solved easily by having Exchanges adopt the Medicaid definition of Indian and use the same types of verification that Medicaid uses. We didn't agree, but understood the view of lawyers and others in HHS immediately after the law passed when they asserted that since there were three different "definitions," these problems couldn't be fixed without a "legislative fix." However, HHS formally, and IRS informally, have agreed that the three statutory definitions have the same meaning. We know it is not likely that Congress will amend the ACA to fix this problem in the next few months while the single, streamlined applications are being designed. It is clearly time for the Administration to reconsider relying on a regulatory correction.

There are many ways to justify aligning how these definitions are implemented to correspond to how the agencies most responsible for administering programs for Indians determine who is Indian. The attached paper discusses these. What is needed now is leadership at the highest levels to require that this problem is solved immediately through the issuance of regulations or similar guidance that applies the Medicaid definition of AI/AN to Exchanges.

We would like to meet with you to discuss this issue and offer assistance to resolve it. For questions, please follow up with Jim Crouch, CRIHB Executive Director, at (916) 929-9761; or Jim Roberts, NPAIHB Policy Analyst, at (503) 347-7664.

Sincerely yours,

Michelle Hayward, Chairperson
California Rural Indian Health Board
Redding Rancheria Tribal Council Member

Andy Joseph, Jr., Chairperson
NW Portland Area Indian Health Board
Colville Tribal Council Member

Attachment: "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"

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[1, 2]

I. Executive Summary

As a component of carrying out the Federal government's special trust responsibility[3] to Indian Tribes and to American Indians and Alaska Natives (AI/ANs), the Patient Protection and Affordable Care Act[4] – inclusive of the expansion and permanent reauthorization of the Indian Health Care Improvement Act – authorized Indian-specific benefits and protections. The two health insurance exchange-related Indian-specific provisions (i.e., monthly enrollment periods and additional cost-sharing protections) are available only to AI/ANs enrolled in the individual market through an Exchange.[5] A third Indian-specific provision in the Affordable Care Act exempts AI/ANs from tax penalties enforced through the Internal Revenue Code (IRC) for not maintaining minimum essential coverage.[6]

In indicating who is eligible for these Indian-specific benefits and protections, the Affordable Care Act relies upon definitions of Indian found in three different, previously-existing federal laws. Each of these definitions specifies that an Indian is "a member of an Indian tribe", but there are slight differences in the wording of what constitutes an "Indian tribe". Given the nearly identical language across the definitions, in the final rule for establishment of Exchanges issued by the Centers for Medicare and Medicaid Services (CMS) the two Exchange-related definitions were determined to "operationally mean the same thing."[7, 8] The Internal Revenue Service has not yet formally opined on the third, IRC-based definition of Indian.[9]

In addition to the ACA-established special benefits and protections for AI/ANs, there are Indian-specific cost-sharing protections under Medicaid that predate the ACA.[10] For purposes of determining eligibility for the Indian-specific Medicaid cost-sharing protections, in 2010 CMS promulgated regulations at 42 C.F.R. § 447.50 that drew from a range of definitions in federal law (as a definition was not provided in the law) to create a comprehensive definition of Indian.[11,]

To ensure AI/ANs are able to access the Medicaid- and Exchange-related special benefits and protections and Exchanges are able to efficiently and consistently make eligibility determinations, and given the apparent agreement that the definitions of Indian applicable within the Exchange are operationally the same, the primary issues remaining to resolve are 1) whether operational guidance will be issued to aid in determining eligibility for Exchange-related Indian-specific benefits and protections and 2) whether any operational guidance that is issued will apply a uniform operational definition of Indian for application across both Medicaid and the Exchange.

We encourage Exchange officials to seek the flexibility that appears to be available from HHS to fashion a uniform operational definition of Indian to be used across the Medicaid and Exchange-related programs.[12, 13] This is particularly important given the complexity of "Indian" determinations and as the Affordable Care Act mandated the creation of a streamlined eligibility determination process for Medicaid and Exchange programs that relies upon a single application form. If it is ultimately determined that applying a uniform operational definition of Indian to each of the Indian-specific benefits and protections is not acceptable to HHS, we recommend that an existing set of guidance materials (namely, the CMS Medicaid eligibility guidance for AI/ANs under 42 C.F.R. § 447.50) be used as the basis for

Indian eligibility determinations, with the identification of specific exceptions to these rules when necessary for any of the Indian-specific protections and benefits.

II. Focus of This Paper

This paper is intended to address two core issues of concern. First, the reliance on three different sections of federal law to define "Indian" under the Affordable Care Act has created confusion as to how an Exchange will implement the definitions for the different ACA protections and benefits that they apply. (Ironically, because the three definitions are actually nearly identical, the definitions themselves do not create this confusion.) Second, the Center for Consumer Information and Insurance Oversight (CMS/CCIIO), an agency within CMS with primary responsibility for ACA implementation, and the Internal Revenue Service (IRS) need to utilize the knowledge and experience of agencies responsible for implementing eligibility for Indian-specific health benefits prior to enactment of the ACA. The CMS Center for Medicaid and State Operations (CMS/CMSO), which is responsible for Medicaid operations including Indian-specific Medicaid protections, have developed regulations and materials to provide the operational guidance to determine who is a "member of an Indian tribe" (which is the core element under each definition of Indian) . An Exchange[14] will ultimately learn – as did CMS/CMSO – that they need detailed guidance materials to assist Federal, Tribal and State officials in determining that a person falls within the statutory definition of Indian.[15]

If implementation guidance is not rooted in the CMS/CMSO's Medicaid experiences, or if no implementation guidance is provided beyond the definition itself, the results for American Indians and Alaska Natives are very likely to be a significant number of AI/ANs not gaining access to the benefits and protections for which they are eligible, as well as disruptions to an otherwise streamlined eligibility determination and enrollment process. For an Exchange, the results would likely be greater costs and longer processing times, as well as a heightened error rate among the Exchange staff and outside assisters. Each of these results would run counter to the expressed goals of the Affordable Care Act.[16]

This paper presents options for avoiding these potentially detrimental results when determining eligibility for Indian-specific benefits and protections through an Exchange. We believe the options presented are within the authority of an Exchange to implement, whether a state-based or Federally-facilitated Exchange.

III. Background

After a great deal of interaction with tribes, in March of 2012 CMS issued guidance that the two definitions of Indian that apply to Exchange-related protections are "operationally the same." [17] This should largely mitigate the confusion generated from having to apply two different sections of federal law to determine who is eligible for the two Indian-specific protections available through an Exchange. Under each definition, the core criterion is that an Indian is "a member of an Indian tribe."

There is general acceptance that all tribes listed by the Bureau of Indian Affairs as Federally-recognized tribes are included in the definition of Indian tribe. But this is not the sole determination of which entities are included under "Indian tribe", as that term is used in each of the statutory provisions cited in the ACA. In fact, the plain language of these definitions includes no reference to Federally-recognized Tribes. Instead, the three ACA-cited definitions include a list of entities – in fact the same list with the exception of the words "pueblo" and "group" not being included in all of the definitions – which includes

"organized groups and communities," including Alaska Native regional and village corporations. Because it is not readily apparent from a simple read of the definitions which entities are included in the description of "Indian tribes," IHS and CMS both previously determined – for purposes of determining eligibility for IHS services and for Indian-specific Medicaid protections, respectively – that detailed guidance was necessary on which entities are included as "Indian tribes", who is considered a "member" of such Indian tribes, and what documentation serves to prove one's status as an "Indian".

It is important to point out that a basic principle of tribal sovereignty is that tribes can decide who their members are. This is very similar to the United States government deciding who can be a U.S. citizen. For the United States as well as for tribes, the definition of a citizen can change over time, [18] and there may be differences between countries (and tribes) as to what qualifies an individual to be a citizen. For some tribes, tribal membership confers at a specified age, such as 18. For other tribes, parents may apply for membership for their children at time of birth. The eligibility guidance issued by IHS and CMS accommodates such differences in tribal membership/citizenship procedures to ensure that all AI/AN persons intended by Congress to be eligible for such Indian-specific benefits and protections are in fact included.

To date, for purposes of implementing the Indian-specific Exchange-related provisions of the ACA, the Department of Health and Human Services, and by extension CMS, has been reluctant to issue detailed guidance on the implementation of these definitions, particularly guidance that applies a uniform operational definition across the Medicaid and Exchange provisions. As expressed by HHS before it determined that the various statutory provisions cited in the ACA were operationally the same, there was concern that the ACA-specific definitions of Indian[19] might result in different benefits being available to different individuals because the definitions might cover different individuals. Thus, HHS concluded that its ability was constrained to apply *in toto* the operational guidance issued by CMS in the past, which included individuals eligible under each of the definitions of who is Indian.

We understand there may be disagreements between the national tribal organizations and HHS on these matters. For example, some of the specific categories used for determining eligibility for Medicaid protections that are included under the CMS operational guidelines may be considered not to be within the narrower ACA-cited definitions. But, we believe that any exclusions of eligibility categories that may be required by HHS are identifiable, would be limited, and would enable the remainder of the CMS guidance to be relied upon for purposes of determining eligibility through an Exchange-facilitated, streamlined eligibility determination process.

Simultaneously, if determined necessary by HHS and the Administration to do so, a legislative fix could be pursued with Congress in order to either solidify the application of a uniform operational definition or to eliminate the need to include specific exceptions to a uniform operational definition.

IV. The ACA References Different Provisions of Federal Law in Defining Persons Eligible for Indian-specific Benefits and Protections

In addition to the health insurance benefits made available to all Americans, including AI/AN, the Affordable Care Act established additional benefits and protections that are specific to American Indians and Alaska Natives. Table A presents (1) the Indian-specific protections and benefits contained in the

ACA, (2) the section of federal law referenced defining eligibility for the provision, and (3) the lead implementing agency for the provision.

Table A: Indian-Specific Provisions of Affordable Care Act

	Exchange-related Provisions		IRS-related
	Special Enrollment Periods for AI/ANs	**Cost-Sharing Protections for AI/ANs**	**Exemption from Penalty for Failing to Maintain Minimum Essential Coverage**
Section of ACA	ACA § 1311(c)(6)(D)	ACA § 1402(d)(1) and (2)	ACA § 1501(b)) creating IRC[20] § 5000A(e)(3)
Section of federal law cited that defines eligibility for Indian-specific provision	**Section 4 of IHCIA:** "(D) special monthly enrollment periods for Indians (as defined in section 4 of the Indian Health Care Improvement Act)."	**Section 4(d) of ISDEAA:**[21] "If an individual enrolled in any qualified health plan in the individual market through an Exchange is an Indian (as defined in section 4(d) of the Indian Self-Determination and Education Assistance Act (25 USC 450b(d)))…"	**Section 45A(c)(6) of the IRC:** "[A]ny applicable individual for any month during which the individual is a member of an Indian tribe (as defined in section 45A(c)(6)"
Lead implementing agency	Exchange (but with option of deferring to HHS for eligibility determinations)	Exchange (but with option of deferring to HHS for eligibility determinations)	Internal Revenue Service

Two of the Indian-specific protections (special monthly enrollment periods[22] and additional cost-sharing protections[23]) are available only to AI/ANs who are enrolled in the individual market through an Exchange. An Exchange, whether operated by a state or state-established entity or by HHS, has the responsibility for determining eligibility for these Exchange-related Indian-specific provisions, although an Exchange may rely upon HHS for determinations of eligibility for the premium tax credits and cost-sharing assistance as provided for under 45 CFR 155.302(c). A third provision (providing an exemption from any penalties for AI/ANs who do not maintain minimum essential coverage) is to be administered by the Internal Revenue Service,[24] We understand there will be coordination between determinations made by HHS and those that IRS must make, however the mechanics of the working relationship are as yet unknown to us.

Eligibility for the special monthly enrollment periods is defined in section 4 of the IHCIA. Eligibility for the cost-sharing protections is defined in section 4(d) of the ISDEAA. Under both provisions, as well as under the Internal Revenue Code-related definition, an "Indian" is defined as a person who is a member of an Indian tribe.

<u>Exchange-related Definitions of Indian (IHCIA and ISDEAA) "Operationally Mean the Same Thing"</u>

Shown below is a combined definition of "Indian tribe" drawn from the definitions in the IHCIA and the ISDEAA that are referenced in the Exchange-related provisions. The definition of Indian tribe from the ISDEAA is shown verbatim, with any additional language from the IHCIA definition added and highlighted in underline.

> Indian tribe means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act, which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status of Indians.[25]

As is evident, the definition of an "Indian tribe" is nearly identical under each definition, with the exception that the IHCIA definition includes the phrase "or group" in addition to the language contained in the ISDEAA definition. This additional phrase creates no functional difference in meaning. It is understood that the "or group" phrase was included in the IHCIA definition in an attempt to include redundancies to assure that the definition is comprehensive and not misunderstood.[26]

The position that these definitions are effectively and operationally the same is held by national tribal organizations and advisory bodies, including the Tribal Technical Advisory Group to CMS (TTAG), the National Congress of American Indians (NCAI), the National Indian Health Board (NIHB), the Tribal Self-Governance Advisory Committee (TSGAC), and the Northwest Portland Area Indian Health Board (NPAIHB), among others.[27] In addition to being the position of these tribal organizations, the opinion that these two definitions "operationally mean the same thing" is held by the United States Government.

CMS included guidance in the Final Rule on the establishment of Exchanges released in March of 2012. In the Final Rule, CMS noted:

> [S]ince both the ISDEAA and IHCIA operationally mean the same thing, there is uniformity among the definition of Indian for purposes of the Exchange-related benefits described in this final rule. We accept that the definitions of ''Indian'' as provided under section 4(d) of ISDEAA (codified at 25 U.S.C. 450 *et seq.*) and section 4 of IHCIA (codified at 25 U.S.C. 1603) operationally mean the same thing: an individual who is a member of an Indian tribe. In their definitions of an ''Indian tribe,'' both of these acts have nearly identical language that refers to a number of Indian entities (tribes, bands, nations, or other organized groups or communities) that are included in this definition on the basis that they are "recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians."[28]

An Exchange would be well within the boundaries of this guidance if the Exchange considered persons who are eligible for the Exchange-related Indian-specific special monthly enrollment periods to be eligible for the Exchange-related Indian-specific cost-sharing protections, and vice versa. As such, a uniform operational definition could be fashioned to guide eligibility determinations for these Exchange-related provisions of the ACA.

IRC-related Definition of Indian: Providing an Exemption from Potential Tax Penalties

The definition of an Indian tribe found in Internal Revenue Code (IRC) § 45A(c)(6) (referenced in the ACA for purposes of eligibility of Indians for the exemption from the penalty for not maintaining minimum essential coverage) is also identical to that in the ISDEAA, with one exception.

> Indian tribe means any Indian tribe, band, nation, pueblo, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act, which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status of Indians.[29]

The IRC § 45A(c)(6) definition includes the word "pueblo", as in "Indian tribe means any Indian tribe, band, nation, pueblo, or other organized group…" (For reference, the phrase "or group" is also shown in the definition above, although this phrase is only found in the IHCIA Sec. 4 definition.) To further support the contention that these definitions are not in fact different, dropping the word pueblo from the definition would not actually exclude pueblos.[30] This again makes the point that the differences among the three definitions of Indian tribe referenced in the ACA are without meaning, especially when one considers that the HHS regulations implementing the ISDEAA definition actually includes pueblos, although they are not expressly referenced in the statutory definition.[31]

The Internal Revenue Service has not yet formally issued an opinion on this issue. In different meetings of the Medicare, Medicaid and Health Reform Policy Committee of the National Indian Health Board, representatives of the IRS offered different approaches that IRS may take in consideration of who is Indian for purposes of waiving the tax penalty. On February 21, 2012, IRS representatives indicated that the IRS likely would accept a determination made by an Exchange as to who is "Indian" (in instances when an individual is certified as being an Indian by an Exchange.)[32] If this position holds, a determination by an Exchange of Indian status could be used to indicate eligibility for an exemption from tax penalties under the ACA, if any. However, it is unrealistic to assume that every AI/AN who files taxes will go to an Exchange to determine their eligibility for waiver of the tax penalty. Operationally, it would be very expensive for Exchanges to provide this information for the 1.5 million AI/ANs who are not expected to enroll in Exchange plans. Furthermore, the Bureau of Indian Affairs and Tribes have been the designated entities to make these determinations long before ACA. The Exchange would only make a determination if the individual provided the Exchange with documentation from either the BIA or a Tribe, and that in turn only adds a layer of bureaucracy and works against the concept of "streamlining." At a later meeting on July 24, 2012, representatives of the IRS said that the IRS would likely use self-attestation of Indian status on the tax forms as the basis for waiving the penalty.

V. Indian-specific Cost-sharing Protections under Medicaid

In 1997, Congress enacted protections for AI/ANs in the Balance Budget Act (BBA).[33] The provision prevents a state from mandating an AI/AN enroll in a managed care entity if that entity is not an Indian-specific entity. Under the BBA provision, an Indian is identified as a person meeting the definition in section 4(c) of the Indian Health Care Improvement Act of 1976 (25 U.S.C. 1603(c)). [34, 35]

In 2008, a second set of Indian-specific cost-sharing protections in the Medicaid program were enacted through the American Recovery and Reinvestment Act of 2009 (ARRA of Recovery Act). [36] These protections block the imposition of cost-sharing for AI/ANs for items or services furnished by Indian health programs, as well prevent a reduction in the amount of payment to an Indian health program as a result of no cost-sharing by AI/AN patients. But in contrast to the BBA and Affordable Care Act examples, other than indicating that the provision is applicable to "Indians", a specific definition of Indian

was not included in the Recovery Act nor was a reference to an existing definition of Indian in another federal statute provided.

In order to provide guidance to states in determining eligibility for the Indian-specific Medicaid cost-sharing protections under ARRA, HHS promulgated regulations at 42 C.F.R. § 447.50 (effective July 1, 2010) that drew from a range of definitions in federal law to create a single operational definition of Indian.[37] This CMS regulatory guidance drew from the statutory definitions of Indian in the IHCIA, the ISDEAA, and in the Snyder Act, which itself has no definition of Indian, but instead is viewed as broad underlying authority for all Indian health programs and other services to AI/ANs.[38] In doing so, "Indian" was defined to mean –

> any individual defined at 25 USC 1603(c)[IHCIA Sec. 4(13)], 1603(f) [IHCIA Sec. 4(28) , or 1679(b) [IHCIA Sec. 809(a)], or who has been determined eligible as an Indian, pursuant to Sec. 136.12 of this part. This means the individual:
> (i) Is a member of a Federally-recognized Indian tribe;
> (ii) Resides in an urban center and meets one or more of the following four criteria:
> (A) Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;
> (B) Is an Eskimo or Aleut or other Alaska Native;
> (C) Is considered by the Secretary of the Interior to be an Indian for any purpose; or
> (D) Is determined to be an Indian under regulations promulgated by the Secretary;
> (iii) Is considered by the Secretary of the Interior to be an Indian for any purpose; or
> (iv) Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

To further facilitate the eligibility determination process, CMS issued guidance on the documentation that may be provided to substantiate meeting the definition of Indian under 42 C.F.R. § 447.50.

> Documentation that an individual is an Indian could include Tribal enrollment and membership cards, a certificate of degree of Indian blood issued by the Bureau of Indian Affairs, a Tribal census document, or a document issued by a Tribe indicating an individual's affiliation with the Tribe. The Indian health care programs and urban Indian health programs are responsible for determining who is eligible to receive an item or service furnished by their programs and so a medical record card or similar documentation that specifies an individual is an Indian as defined above could suffice as appropriate documentation. These documents are examples of documents that may be used, but do not constitute an all-inclusive list of such documents.[39]

In issuing this guidance, CMS commented, "We agree that administrative simplicity is very important. Therefore, we have defined the term 'Indian' for purposes of the exemption from premiums and cost sharing in broad terms that indicate the kinds of documentation that could support the application of the exception."[40]

Although CMS did not issue a directive to states to apply § 447.50 uniformly for all Indian-specific Medicaid protections, including the BBA protections, in practice it appears that states and their eligibility workers may be applying a single definition of Indian for both sets of protections.[41] Given the more extensive operational guidance issued by CMS and a definition that would not result in the exclusion of persons for whom eligibility was intended, the definition of Indian promulgated by HHS under 42 C.F.R. § 447.50 appears to be the uniform definition relied upon for Medicaid purposes, including Medicaid managed care.

VI. Multiple Definitions of Indian May Impede Health Reform Goals

Given the apparent agreement that the definitions of Indian applicable within the Exchange are operationally the same, the primary issues to resolve are 1) whether operational guidance will be issued to facilitate implementation of the Exchange-related Indian-specific benefits and protections and 2) whether the definitions of Indian under Medicaid and the Exchange will be applied in a uniform manner or with certain populations excluded under some definitions.

First, what might be the problems created by applying the definitions of Indian differently? In short, applying the definitions of Indian differently may impede the central goals of health reform.

A central goal of the Affordable Care Act is the streamlining of eligibility determinations for federal health insurance programs.[42] The creation of an Exchange serving each state[43] and the requirement that "the Exchange must use a single streamlined application to determine eligibility and to collect information necessary for: (1) enrollment… (3) cost-sharing reductions; and (4) Medicaid…"[44] are two primary means for achieving the streamlining of eligibility determinations.[45] But if an Exchange were required to apply different definitions of Indian when making eligibility determinations for Medicaid and Exchange-related programs – even if those definitions had very little difference in practice – the efforts at streamlining eligibility determinations could be significantly frustrated. Results of this would be likely to include –

- Increased inaccuracies in eligibility determinations: Enrollment staff, as well as AI/ANs themselves, could become confused – and ultimately frustrated – if they are required to understand obscure differences between the definitions. Without a thorough understanding of any differences in the application of the definitions, instances of inaccurate eligibility determinations being made are likely to increase.[46]

- Unwarranted application of tax penalties: If an AI/AN were determined to be eligible for IHS services as an "Indian" (and therefor chose not to secure health insurance coverage), but was not determined to be eligible as an "Indian" for the exemption from the requirement to secure minimum essential coverage, this individual and his or her family could be subject to significant tax penalties.

- Interruption of streamlined process: Applying definitions differently will lead to individuals needing to interact with Exchange/Medicaid eligibility staff and tribal offices on multiple

occasions as they navigate understanding the differences in the definitions and the different documents that might satisfy one definition but not another.

- Increased training necessary: If enforcement of multiple definitions of Indian were required to be carried out by an Exchange, enrollment staff of an Exchange and individuals and organizations involved in outreach to AI/AN[47] would need to be educated in the nuances under each definition of Indian, including understanding the differences, if any, in documentation permitted to satisfy each definition of Indian.

- Increased and uncertain cost-sharing liabilities: AI/ANs determined to be "Indian" for purposes of Medicaid will be afforded comprehensive Indian-specific cost-sharing protections under Medicaid. However, if the same individuals' income increases and the individuals are then eligible for Exchange coverage and not Medicaid, they are likely to assume they are eligible for the comprehensive Indian-specific cost-sharing protections through the Exchange. If the Exchange determines that such individuals are not eligible for cost-sharing waivers on the basis of AI/AN status, this will become very confusing to both the individuals and the QHP. Uncertainty in the applicability of cost-sharing protections could result in significant liabilities to the affected individuals without their having the slightest awareness of this discrepancy.

- Uncertain application of cost-sharing protections within families by providers: Providers that serve AI/ANs, and do not collect cost-sharing for the AI/ANs because of their status of being an Indian for purposes of the Medicaid program, would need to understand that patients' status as an Indian – or the status of just some of the members of an AI/AN household – might have changed when they secured health insurance coverage through an Exchange. The provider would then need to collect cost-sharing from some or all members of a previously "Indian" household.

- Reduced timeliness: The streamlined application process is being designed to rely, to the extent possible, on electronic verification of application-related information. The lack of a single operational definition would complicate (although not prevent) the use of automated databases that may be available for verification purpose, such as using the IHS beneficiary roster.

- Reduced involvement of AI/AN in insurance options: Even if the instances of an individual being determined to be "Indian" for one Exchange-related provision and not for another were rare (which we anticipate), this outcome would likely cast a shadow over AI/ANs involvement with ACA implementation more generally. For instance, AI/ANs may be much more reluctant to transition from the IHS-based coverage model to comprehensive Exchange coverage if they could end-up subject to significant cost-sharing requirements under a different, potentially unknown application of a definition of Indian.

Individually and collectively, these results would run directly counter to the central goal of the ACA to expand access to affordable health insurance coverage for all Americans. And, these results could seriously impede the specific policy declarations of the United States Congress contained in ACA § 10221(a)[48] for AI/ANs that:

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

> (1) to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy;
> …
> (3) to ensure maximum Indian participation in the direction of health care services so as to render the persons administering such services and the services themselves more responsive to the needs and desires of Indian communities;
> …

VII. Addressing the Problem: Why a Uniform Operational Definition of Indian is Needed and Potentially Permitted

To ensure AI/ANs are able to access the Medicaid and Exchange-related special benefits and protections that they are statutorily entitled to, and Exchanges are able to efficiently and consistently make accurate eligibility determinations, it is critical that – to the greatest extent possible – a uniform operational definition of "Indian" be employed.

For purposes of determining eligibility for ARRA-enacted Indian-specific Medicaid cost-sharing provisions, HHS fashioned a single operational definition of Indian that was inclusive of the existing definitions of Indian contained in federal law. In the same manner, fashioning such an operational definition for purposes of the Medicaid and Exchange-related eligibility determinations would enable an Exchange to carry-out the requirements established for an Exchange (e.g., to conduct a streamlined eligibility determination process using a single application form) in an efficient and accurate manner. More specifically, extending the 42 C.F.R. § 447.50 guidance that was developed for Indian-specific Medicaid eligibility determinations as the uniform operational definition for both Medicaid and Exchange-related eligibility determinations would provide such uniformity of definition.

In the Final Rule on the establishment of Exchanges which was promulgated on March 27, 2012, HHS may have offered states the flexibility to apply such a uniform operational definition of Indian.[49]

States Offered Flexibility in the Application and Verification of Definitions of Indian

In response to comments submitted to HHS regarding the definition of Indian and verification of an individual's status as an Indian, the following guidance was included in the preamble to the Final Rule:

> We are maintaining the verification process described under § 155.350 in this final rule. This verification is tied to a full exemption from cost-sharing, which could involve a substantial expenditure for the Federal government; consequently, we are specifying a more stringent process for verification though we note that § 155.315(h) allows the Exchange flexibility to modify this and other verification processes with HHS approval. In addition, we note that the documentation process described under § 155.350(c)(3) is similar to the documentation process utilized by the IHS when determining eligibility for American Indians/Alaska Natives who seek services at IHS facilities.[50] (*Underline added.)*

In this response, HHS indicated that verification of Indian status would be required (and a simple attestation would not suffice), but the Exchange is afforded discretion in how it conducts the eligibility verification.

The Final Rule response continued with the following, indicating that CMS recognizes that even the definitions of Indian with the potentially greatest variance are still only "slightly different."

> The [Indian eligibility] standard for Exchanges is slightly different from the [Indian eligibility] standard for such [IHS] services, however, which means that the registration database for Indian Tribe, Tribal Organization, or Urban Indian Organization programs may not be a one-to-one match. With that in mind, we are working closely with the IHS and intend to work with States and tribes to determine whether and how electronic data can support this process.[51]

As referenced above, the definition used to determine eligibility for IHS services (which most closely resembles the CMS § 447.50 Medicaid eligibility guidance) has the most inclusive definition of Indian, and the Exchange-related definitions may be considered the most restrictive.[52] But still, these definitions are considered only "slightly different".

The language of 45 C.F.R. § 155.315(h) cited above which provides flexibility to Exchanges in implementation of eligibility determination processes, reads as follows:

> § 155.315 (h) *Flexibility in information collection and verification.* HHS may approve an Exchange Blueprint in accordance with § 155.105(d) or a significant change to the Exchange Blueprint in accordance with § 155.105(e) to modify the methods to be used for collection of information and verification of information as set forth in this subpart, as well as the specific information required to be collected, provided that HHS finds that such modification would reduce the administrative costs and burdens on individuals while maintaining accuracy and minimizing delay, that it would not undermine coordination with Medicaid and CHIP, and that applicable requirements under § 155.260, § 155.270, paragraph (i) of this section, and section 6103 of the Code with respect to the confidentiality, disclosure, maintenance, or use of such information will be met.[53] (*Underline added.*)

As indicated, central to HHS approving a request by an Exchange for flexibility authorized under 45 C.F.R. § 155.315(h) is a determination that "HHS finds that such modification would reduce the administrative costs and burdens on individuals while maintaining accuracy and minimizing delay, that it would not undermine coordination with Medicaid and CHIP…" Given the number of definitions of "Indian" involved and the nuanced differences across the definitions, the threshold requirements for applying the § 155.315(h) authority would seem to be readily satisfied if an Exchange were to rely upon a uniform operational definition of Indian, such as using the § 447.50 guidance from CMS, when determining eligibility for the Medicaid and Exchange-related Indian-specific provisions.

A uniform operational definition would seem likely to result in –

- Administrative costs on state Exchanges being lessened;
- Paperwork burdens on individual AI/ANs being reduced;
- The overall accuracy and consistency of eligibility determinations across Medicaid and ACA-related provisions being increased;

- Delays in accessing the special benefits and protections afforded AI/ANs through the Affordable Care Act being reduced;
- The seamless coordination between Medicaid and Exchange-related programs being furthered;
- Participation by AI/ANs in the Exchange-related programs being heightened; and
- Clarity across providers and QHPs in the application of Indian-specific benefits and protections would be enhanced.

If it is ultimately determined that full uniformity across the application of the definitions of Indian to each Indian-specific provision cannot be achieved, we strongly recommend that Exchanges use the CMS guidance on eligibility and documentation provided under § 447.50 as the base for Indian-specific eligibility determinations and identify specific exceptions (i.e., exclusions) from eligibility, as needed, for any particular Indian-specific provision.

VIII. Conclusion

We encourage Exchange officials – whether operated by a state or HHS – to seek the flexibility that appears to be available under the Affordable Care Act and its implementing regulations to fashion a uniform operational definition of Indian to be used across the Medicaid and Exchange-related programs in order to be able to carry-out a streamlined eligibility determination process using a single application form, with the result being eligibility determinations conducted more efficiency and more accurately. Previous eligibility guidance issued by CMS could be relied upon to implement the uniform operational definition.

If it is determined that applying a single operational definition of Indian to each of the Indian-specific benefits and protections is not agreed to by HHS, we recommend that an existing set of guidance materials (namely the CMS Medicaid eligibility guidance for AI/ANs under 42 C.F.R. § 447.50) be used as the basis for Indian eligibility determinations with specific exceptions to these rules identified where necessary.

As stated previously, national and regional tribal organizations support the application of a uniform operational definition of Indian for purposes of implementing the provisions of the Affordable Care Act. These include NCAI, NIHB, TTAG, TSGAC and NPAIHB.[54] These organizations believe that providing a uniform definition will ultimately lead to advances in the health status of AI/ANs by more effectively matching available resources to the needs of *eligible* AI/AN individuals. We stand ready to continue to work with state and federal Exchange officials to make the determination of Indian status an efficient and effective process.

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[1] For a more detailed exposition of the issue of the definition of an Indian, see "Tribal Technical Advisory Group to CMS, Analysis of and Comment on Definition of 'Indian' in Proposed Rules to Implement Provisions of the Patient Protection and Affordable Care Act," October 31, 2011, submitted to CMS and the IRS. ("TTAG Analysis")

[2] A separate paper will be prepared by Northwest Portland Area Indian Health Board ("NPAIHB") discussing verification materials for documenting Indian status.

[3] The Indian Health Care Improvement Act ("IHCIA"), Pub. L. 94-347, was permanently reauthorized and amended March 23, 2010, by § 10221(a) of the ACA. IHCIA § 103 reads, in part:

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

> (1) to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy;
>
> (2) to raise the health status of Indians and urban Indians to at least the levels set forth in the goals contained within the Healthy People 2010 initiative or successor objectives;
>
> (3) to ensure maximum Indian participation in the direction of health care services so as to render the persons administering such services and the services themselves more responsive to the needs and desires of Indian communities;
>
> (4) to increase the proportion of all degrees in the health professions awarded to Indians so that the proportion of Indian health professionals in each Service area is raised to at least the level of that of the general population;
>
> (5) to require that all actions under this Act shall be carried out with active and meaningful consultation with Indian tribes and tribal organizations, and conference with urban Indian organizations, to implement this Act and the national policy of Indian self-determination;
>
> (6) to ensure that the United States and Indian tribes work in a government-to-government relationship to ensure quality health care for all tribal members; and
>
> (7) to provide funding for programs and facilities operated by Indian tribes and tribal organizations in amounts that are not less than the amounts provided to programs and facilities operated directly by the Service.

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

[5] Health insurance exchanges ("Exchanges") are to be available by October 1, 2013 in each State in order to allow enrollment in new health insurance coverage options effective 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.

[6] ACA § 1501(b) / IRC § 5000A(e)(3).

[7] *See Federal Register*, March 27, 2012, CMS, "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans," (CMS-9989-F), Vol. 77, No. 59, page 18346. ("Final Rule") The Department of Health and Human Services (HHS) and CMS did not opine on the definition of Indian pertaining to the exemption from tax penalties afforded AI/ANs under ACA § 1501(b) as it falls within the Internal Revenue Code. (*See* IRC § 5000A(e)(3).) CMS did determine that the two Exchange-related definitions (contained in the IHCIA and the Indian Self-Determination and Education Assistance Act) "operationally mean the same thing."

[8] The position that these definitions are effectively and operationally the same is also held by numerous tribes and tribal organizations, including the National Congress of American Indians ("NCAI"), the National Indian Health Board ("NIHB"), the Tribal Technical Advisory Group to CMS ("TTAG"), the Tribal Self-Governance Advisory Committee ("TSGAC"), and the Northwest Portland Area Indian Health Board (NPAIHB"), among others.

[9] In a meeting of the Medicare, Medicaid and Health Reform Policy Committee of the National Indian Health Board on February 21, 2012, IRS representatives indicated that the IRS likely would defer to the uniform determination made by an Exchange as to who is "Indian" and as such qualifies for an exemption from tax penalties under the ACA.

[10] These cost-sharing protections for AI/ANs include those established under § 5006 of the American Reinvestment and Recovery Act of 2009, Pub. L. 111-5 and those enacted as part of the Balanced Budget Act of 1997 (Social Security Act § 1932(a)(2)(C).)

[11] *See* 42 C.F.R. § 447.50, promulgated May 28, 2010. In particular, these regulations drew from the definitions of Indian in the Snyder Act, the IHCIA, and the Indian Self-Determination and Education Assistance Act ("ISDEAA"). A second set of Indian-specific Medicaid protections was enacted in the Balanced Budget Act of

1997. The provision amended section 1932(a)(2)(C) of the Social Security Act and is codified at 42 U.S.C. 1396u-2(a)(2)(C), with regulations issued at 42 C.F.R. § 438.50(d)(2).

[12] *See* discussion in the Final Rule at 77 Fed. Reg. 18383; and *see* 45 C.F.R. § 155.315(h) "Flexibility in information collection and verification" at Final Rule, 77 Fed. Reg. 18455.

[13] Again, the range of Indian-specific eligibility determinations include the cost-sharing and monthly enrollment protections in the individual market through an Exchange, eligibility for Medicaid cost-sharing and managed care protections, and the exemption from penalties for AI/AN not securing minimum essential coverage.

[14] This issue is of concern under state-based Exchanges as well as the Federally-facilitated Exchange (FFE).

[15] While these regulations and other materials demonstrate that the statutory definitions can be reconciled, mere restatement of the statutory language is not sufficient to facilitate accurate eligibility determinations.

[16] See Federal Register, Vol. 75, No. 148, August 3, 2010, Request for Comments, "Planning and Establishment of State-Level Exchanges," Section G. Enrollment and eligibility, Office of Consumer Information and Insurance Oversight, HHS, page 45588, which includes "additional requirements to assist Exchanges by… simplifying and coordinating enrollment in the Exchanges, Medicaid and the Children's Health Insurance Program (CHIP)."

[17] 77 *Federal Register* 18346.

[18] For example, on October 30, 2000, President Clinton signed into law H.R. 2883, the Child Citizenship Act of 2000. The new law, Public Law 106-395, amends the Immigration and Nationality Act (INA) to permit foreign-born children — including adopted children — to acquire citizenship automatically and immediately if they meet certain requirements, rather than having citizenship conferred only after an application process is completed. This law became effective on February 27, 2001.

[19] ACA § 1311(c)(6)(D) referring to section 4 of the IHCIA and codified at 25 U.S.C. 1603; ACA § 1402(d)(1) and (2) referring to section 4(d) of the ISDEAA and codified at 25 U.S.C. 450 *et seq.*; and ACA § 1501(b)) creating IRC § 5000A(e)(3) which refers to section 45A(c)(6) of the Internal Revenue Code.

[20] The Internal Revenue Code.

[21] The ISDEAA, Pub. L. 93-638.

[22] The special monthly enrollment periods are described in 45 C.F.R. § 155.420(d)(8). An AI/AN may enroll in a health plan or change from one health plan to another one time per month.

[23] *See* ACA § 1402(d)(1) and (2). The additional cost-sharing protections are described in 45 C.F.R. § 155.300(a) and (b)). Under ACA § 1402(d)(1), the cost-sharing protections encompass a waiver of all cost-sharing for an AI/AN individual whose household income is not more than 300 percent of the Federal poverty level. Under ACA § 1402(d)(2), there is no cost-sharing for an AI/AN individual of any income level when furnished an item or service directly or through referral by an Indian Health Care Provider. "Indian Health Care Providers" are comprised of the Indian Health Service, Tribes and tribal organizations, and urban Indian organizations. Collectively, these entities are also sometimes referred to as "I/T/U". The Indian Health Service 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). The issuer of a health plan shall not reduce the payment to an Indian Health Care Provider by the amount of any cost-sharing that would be due from an AI/AN but for this provision. The Secretary of HHS is to pay to the health plan the amount necessary to reflect the increase in actuarial value of the plan required by reason of this provision.

[24] The determination of eligibility for this exemption is not within the functions of an Exchange. The IRS has responsibility for implementing this Indian-specific protection, which is found in IRC § 5000A(e)(3) and waives the penalties for AI/ANs who do not maintain minimum essential coverage, although the IRS may rely upon an Exchange's determination of who is Indian for those individuals who have been determined to be "Indian" for purposes of Exchange-related provisions.

[25] Wording contained in IHCIA Sec. 4(14) and ISDEAA Sec. 4(d), except that the double underlined words ("or group") are only contained in IHCIA Sec. 4(14).

[26] *See* TTAG Analysis, page 6.

[27] TTAG October 2010; NCAI Res. # ABQ-10-080, November 2010, NIHB Res. 10-01, October 2010; TSGAC February 2011; and NPAIHB, October 21, 2010.

[28] Final Rule, 77 Fed. Reg. 18346.

[29] Wording contained in IHCIA § 4(14), ISDEAA § 4(d), and IRC § 45A(c)(6), except that the underlined word ("pueblo") is only contained in IRC § 45A(c)(6) and the double underlined words ("or group") are only contained in IHCIA Sec. 4(14).

[30] This is the result because pueblos are also considered to be Indian Tribes, nations, organized groups, and communities recognized as eligible for the special programs and services provided by the United States to Indians because of their status of Indians.

[31] 25 C.F.R. § 900.6 (HHS and Department of the Interior (―DOI‖) Title I), 25 C.F.R. § 1000.2 (DOI Title IV), 42 C.F.R. § 137.10 (Title V). These regulatory definitions also include ―rancherias and colonies.

[32] A significant percentage of American Indians and Alaska Natives that seek an exemption from the tax penalties may not engage an Exchange as the AI/AN individuals may have determined not to pursue health insurance coverage. For these individuals, it is assumed attestations would be made and/or documentation would be provided directly to the IRS.

[33] Public Law 105-33. The primary protection established is "A State may not require… the enrollment in a managed care entity of an individual who is an Indian (as defined in section 4(c) of the Indian Health Care Improvement Act of 1977 of 1976 (25 U.S.C. 1603(c)) unless the entity is one of the following [Indian organizations] (and only if such entity is participating under the plan)… "

[34] For purposes implementing the protections afforded AI/AN in the Balanced Budget Act of 1997, *see* 42 C.F.R. § 438.50(d)(2).

[35] In referencing subsection (c) of section 4 of the IHCIA, this definition of Indian is more restrictive than the reference to "Indian" under the IHCIA for purposes of the special monthly enrollment period for AI/ANs enrolled in the individual market through an Exchange (authorized under ACA § 1311(c)(6)(D)).

[36] These cost-sharing protections for AI/ANs were established under § 5006 of the American Reinvestment and Recovery Act of 2009, Pub. L. 111-5.

[37] *See* 42 C.F.R. § 447.50, promulgated May 28, 2010.

[38] The Snyder Act is the primary statute authorizing the Federal government to provide health care to Indians and implementing the unique Federal obligations to Indians. It directs and authorizes HHS to "direct, supervise, and expend such moneys as Congress may from time to time appropriate, for the benefit, care, and assistance of the Indians throughout the United States" for the "relief of distress and conservation of health." 25 U.S.C. § 13.

[39] Medicaid Program; Premiums and Cost Sharing, 75 Fed. Reg., No. 103, pp. 30, 244, 30,248 (May 28, 2010).

[40] Medicaid Program; Premiums and Cost Sharing, 75 Fed. Reg., No. 103, p. 30247.

[41] For example, in a recent Section 1115 waiver application from the State of Kansas, a single operational definition of Indian was applied to both sets of Indian-specific Medicaid protections.

[42] Federal Register, Vol. 75, No. 148, August 3, 2010, Request for Comments, "Planning and Establishment of State-Level Exchanges," Section G. Enrollment and eligibility, Office of Consumer Information and Insurance Oversight, HHS, page 45588.

[43] ACA § 1311 and 45 C.F.R. § 155.100.

[44] ACA § 1413(b) and 45 C.F.R. § 155.405(a). "CHIP" refers to the Children's Health Insurance Program under title XXI of the Social Security Act.

[45] An additional approach to streamlining eligibility across federal programs is the implementation of a common methodology ("modified adjusted gross income") for determining household income, as authorized by ACA § 1401 / IRC § 36B(d)(2)(B).

[46] Conversely, as it appears to occur today under Medicaid, to simplify implementation a state or a subset of Exchange/Medicaid eligibility staff in a state might default to applying one definition for all Indian-specific purposes in a state. AI/ANs applying on one occasion or in one state may be found to be eligible whereas the same AI/ANs would be found to be ineligible on another occasion or in another state, or vice versus.

[47] Such as grantees under the Navigator program authorized under ACA § 1311(i) or "in-person assisters". *See* 45 C.F.R. § 155.210.

[48] Enacted through the passage of the ACA, Congress made the declarations of national Indian health policy in IHCIA § 103.

[49] *See* discussion in the Final Rule at 77 Fed. Reg. 18383; and *see* 45 C.F.R. § 155.315(h) "Flexibility in information collection and verification" at Final Rule, 77 Fed. Reg. 18455.

[50] Final Rule, 77 Fed. Reg. 18383.

[51] Final Rule, 77 Fed. Reg. 18383.

[52] An additional definition is used for purposes of determining eligibility for services through the Indian Health Service, although this generally aligns with the guidance under 42 C.F.R. § 447.50.

[53] Final Rule, 77 Fed. Reg. 18455.

[54] NCAI Res. # ABQ-10-080, November 2010, NIHB Res. 10-01, October 2010; TTAG October 2010; TSGAC February 2011; and NPAIHB, October 21, 2010.