TRIBAL EDUCATION AND OUTREACH CONSORTIUM

ACA Tribal Frequently Asked Questions

"PUTTING IT ALL TOGETHER"

The intended audiences for this series of Frequently Asked Questions (FAQs) are Tribal leaders, health directors, and staff working in IHS, Tribal, and urban Indian health programs. The series of FAQs are not intended to be used for consumer education. Some of the answers are in development due to regulations or administrative guidance currently being developed. Thus, this series will be updated as new information becomes available.

A. General Questions about Indian Participation
B. AI/AN Special Benefits & Protections
C. Medicaid and the ACA: MAGI, Classic vs. Expansion, resource exemptions, etc.
D. ACA Tax Penalties and exemptions
E. Tribal Sponsorship
F. QHP Contracting and Plan Management with the I/T/U
G. Tribes as Employers (DONE)

A. General Questions about Indian Participation

A.1. Are Indians required to have health insurance after 2014?

The Affordable Care Act requires most individuals to have health coverage or pay a penalty to the IRS – this is called the "individual mandate." AI/AN qualify for an exemption from the individual mandate, but they must apply for the exemption and provide documents to show that they are eligible for either 1) an exemption for members of federally recognized tribe; and/or 2) a hardship exemption for people who are eligible to receive services from the Indian Health Service.

A.2. What counts as health coverage for purposes of the individual mandate?

Generally, health coverage includes employer-based insurance, Medicaid, Medicare, CHIP, TRICARE and certain other types of coverage. Health coverage is also referred to as minimum essential coverage (MEC). IHS is not considered MEC; however, IHS beneficiaries have access to a hardship exemption to avoid the tax penalty for not having MEC. VA coverage varies for different individuals, so veterans should check with VA to see if they have MEC.

A.3. Is IHS coverage going away under the Affordable Care Act?

No. The IHS, Tribal and urban Indian health programs will not be going away.

A.4. If Indians sign up for insurance will they lose their IHS access or coverage?

No, a person does not lose eligibility for IHS services if they sign up for Medicaid, Medicare, Marketplace plans or other health coverage.

A.5. Why do Indians need health insurance coverage if Indians get services from the Indian Health Service, a tribal program, or an urban Indian health program?

By enrolling in health coverage through the Marketplace, Medicaid, or CHIP, you have better

access to services. The Indian Health Service, tribal programs, or urban Indian programs (known as I/T/Us) may not have enough money to provide all the health care you need. Your I/T/U clinic can bill the insurance company for the care they provide you, which makes more funding available for health care in your community. You will help your tribe save valuable resources that can be used to provide care to other members of your community that may not be eligible for other forms of coverage.

A.6. How will Indians benefit from having Health Insurance?

Contract Health Services (CHS) does not have enough money to meet all the needs, so there is a priority list and sometimes CHS runs out of money. If you have health insurance, you can get the health services you need -- even if it is not high on the CHS priority list and even if CHS is out of money. Health insurance will pay for things that your Tribal or IHS program does not provide, such as medical specialists, tests, emergency room visits, and hospital care.

A.7. If Indians enroll in a marketplace plan, will they have to get their health care from a clinic far away from where they live?

You can continue to use your Tribal or IHS clinic. Let them know that you have insurance so that they can receive payment for services they provide to you.

A.8. If Tribal members are enrolled in a Marketplace health plan or Medicaid can they continue to receive health services from their IHS, Tribal or urban Indian health clinic?

Yes. People with insurance have a choice: they receive health care from the insurance company's network of providers, or they can use their I/T/U clinic.

A.9. Will there be a cost for Tribal members to enroll in a health insurance plan?

When you use the Health Insurance Marketplace website, you will find out if you qualify for programs that pay all or a portion of the costs of health insurance. Your Tribe may be able to help with any additional costs.

A.10. Isn't it "double dipping" for IHS or my Tribal clinic to receive funding from Congress and also bill my Marketplace insurance?

No. Congress included special benefits and protections in the Affordable Care Act intended to encourage Indian participation in the new Insurance Marketplaces. Congress funds the Indian health system at only about half of the level of need, and expects the I/T/U to bill insurance plans. The funding for Indian health care comes from many sources and is needed to provide services for everyone in Tribal communities.

A.11. What is the difference between the Exchanges and Marketplaces?

Exchanges and Marketplaces are the same thing. The word "Exchange" is used in ACA legislation and regulations. The word "Marketplace" is used by the federal government in marketing and advertising because they think the public is more likely to understand it. State exchanges have their own names, such as "CoverOregon" or "Washington Healthplanfinder," or "Your Health Idaho."

A.12. Do you have to sign up for Medicaid or Exchange coverage to be eligible for IHS direct care or contract health services?

The current IHS eligibility guidelines do not require a person to sign up for Medicaid or enroll in a Marketplace plan in order to be eligible for IHS direct care. The eligibility guidelines for the

Contract Health Service (CHS) program do require individuals to sign up for alternate resources if they are eligible for them before CHS funds can be used. However, CHS does not require people to pay insurance premiums to acquire alternate resources.

A.13. What is included in the term "cost sharing"?

Cost sharing includes deductibles, co-pays and co-insurance. It does not include premiums.

A.14. Do Indians have to pay cost sharing if they sign up for Marketplace insurance? [1]

If a person is a member of a federally-recognized Tribe or a shareholder in an Alaska Native regional or village corporation, then he/she should not have to pay cost sharing for plans purchased in the Marketplace. However, there are two types of plans for AI/AN. The "zero cost sharing plan variation" is for AI/AN who are below 300% of FPL and this does not have any cost sharing when the individual receives essential health benefits (EHB) from a provider in the plan network or from the I/T/U. The "limited cost sharing plan variation" is for AI/AN who are above 300% FPL, or whose income has not been determined. In this case, there is no cost-sharing for EHB services provided by the I/T/U or with a referral from CHS. *(See FAQs "QHP Contracting and Plan Management with the I/T/U")*

A.15. What kind of documents am I going to be required in order to get enrolled in a Marketplace health plan?

Everyone needs documents to show that they are a U.S. citizen (birth certificate, tribal enrollment card, or voter ID). If you want to receive the special benefits and protections for AI/AN, then you will have to have a document issued by your Tribe showing that you are a member (such as a Tribal Enrollment Card, a CDIB/CIB, or a letter from your Tribe) or a certificate that shows you are a shareholder in an Alaska Native Regional or Village Corporation. While you do not have to provide documents, you may want to have some things with you to help answer questions on the application. For example, you will need your Social Security Number (SSN). You will be asked to estimate your income for the year, so you might want to have your pay stub with you when you enroll.

A.16. If an employer offers insurance for spouses of employees, are those spouses required to purchase that employer-sponsored insurance? If not, may a spouse go into the Marketplace to purchase insurance?

The ACA regulations do not treat spouses as dependents. Therefore, employers do not have to offer insurance to spouses. If the employer does offer insurance for spouses, those spouses are not required get health care coverage that way, although they may choose to do so. If a married person is employed and does not have affordable insurance from their own employer, or if they they are unemployed and do not have another source of coverage (such as Medicaid or Medicare), they may purchase insurance on the Marketplace. If health insurance is purchased on the Marketplace, the family may receive a tax credit (if the household income is below 400 percent FPL).

A.17. How is income counted to measure affordability of employer-sponsored insurance?

Employer-sponsored insurance that provides minimum essential coverage (MEC) is considered affordable for the employee if the cost for the employee is less than 9.5 percent of the

[1] Cost-sharing explanation provided here applies only to Marketplace insurance plans. There are no premiums for AI/ANs enrolled in Medicaid.

household income. Income from the spouse (and everyone in the tax filing unit) is included in the household income. If the employee has affordable MEC, then he/she is not eligible for tax credits for premiums in the Marketplace.

A.18. If a tribal employer's health plan is deemed 'affordable', will dependents be potentially eligible for subsidies in the Exchange in the event the employee declines dependent's health care insurance?

Employers must offer health insurance to employees and their dependents. Dependents are defined as children, not spouses. However, employers do not have to contribute to the premiums for dependents. The spouses eligibility for tax credits depends on whether the cost of the employee insurance is determined to be unaffordable.

B. American Indian and Alaska Native Special Benefits & Protections

B.1. What are the special benefits and protections for AI/AN in the Marketplace?

Members of federally-recognized Tribes and shareholders in Alaska Native Regional and Village corporations have the following benefits and protections under ACA:

- They do not have to pay cost sharing for plans purchased in the Marketplace.
- They can apply the tax credits that are based on the second lowest cost silver plan to any plan on the Marketplace, including lower cost bronze plans, without losing their cost sharing protections.
- They can enroll, disenroll or change plans each month.
- They are exempt from the individual mandate, which means they do not have a tax penalty if they do not have insurance coverage.

B.2. Are all AI/AN exempt from the tax penalty for not having insurance?

Members of federally-recognized Tribes and shareholders in Alaska Native Regional and Village Corporation will not have to pay the IRS penalty if they do not have insurance coverage. People who are IHS beneficiaries, or eligible to use IHS services, may receive a "hardship exemption" from the tax penalty by applying through a State or Federal Marketplace. This covers most members of families of Tribal members, including descendants who are not eligible to enroll in a Tribe. However, some people who identify as AI/AN are not exempt, such as people who belong to tribes that are not federally-recognized (including some state-recognized Tribes and Tribes located outside the United States). (*See "FAQs on ACA Tax Penalties and Indians")*

B.3. How do Indians apply for an exemption from the tax penalty?

Members of federally-recognized Tribes may claim their exemption when they file their taxes, or they may apply for an exemption from the tax penalty by completing an application and submitting it to the State or Federal Marketplace. Indian people that have access to IHS, Tribal, or urban Indian health care services may apply for a "hardship exemption" by completing an application and submitting it to the State or Federal Marketplace. The IHS is in the process of developing a form letter that IHS beneficiaries can obtain from their I/T/U clinic to use as documentation when applying for a hardship exemption. (See "FAQs on ACA Tax Penalties and

Indians")

B.4. If Indians sign up for insurance will they lose their IHS access or coverage?

No, a person does not lose eligibility for IHS services if they sign up for Medicaid, Medicare, Marketplace plans or other health coverage.

B.5. If AI/AN sign up for health insurance through the Marketplace, will they have to pay monthly premiums?

The rules for premiums and tax credits in the Marketplace are the same for AI/AN as everyone else. However, unlike other people, AI/AN do not lose their cost-sharing protections when they use their tax credits to pay for bronze plans (which have lower premiums and high cost sharing). In some cases, this will mean that the tax credits are more than enough to pay for the premiums. However, this doesn't really mean that insurance is free, because there may be a nominal charge of $1 or $2 a month to create a contract between the consumer and the insurance company. That fee has to be paid monthly. An automatic payment may be set up on a credit card, or a bank account. In some cases, Tribes may be able to help people with the premium amount that is not covered by tax credits.

B.6. What do AI/AN have to do to avoid cost-sharing after they sign up for Marketplace insurance?

In the enrollment process, the individual will be given an opportunity to establish their Indian status (this requires answering questions and submitting documentation). Once they are determined to meet the requirements for Indian status, when they shop for plans, they will be offered variations of plans that are only for Indians. Each plan offered on the Marketplace will have two Indian plan variations that are based on the individual's:

Zero cost sharing plan variation – for people who are below 300 percent FPL. There is no cost sharing for EHBs provided in I/T/U facilities or through network providers.

Limited cost sharing plan variation – for people who are above 300 percent FPL or who chose not to have their income determined. There is no cost sharing for EHBs provided in I/T/U facilities, but they must get a referral from CHS to avoid cost sharing with any other provider.

Sometimes, it is less expensive to purchase a family plan, as compared to separate plans for each family member. A family can save money purchasing a family plan, if they have more than 3 children under 21 years old, since the additional children are not charged premiums in the family plan. However, if anyone covered by the family plan is not a Tribal member, then all the AI/AN in the family plan lose their cost share benefits.

If a person is receiving a service that is not included in the 10 Essential Health Benefits (EHBs), then they would have to pay cost sharing, unless CHS issues an authorization to pay for those services.

B.7. Why have they decided to not have cost sharing available for pediatric dental?

Stand alone pediatric dental plans offered on the Marketplace should have zero cost sharing variations and limited cost sharing variations for AI/AN.

B.8. What is the Indian monthly enrollment option?

Members of federally-recognized Tribes have special enrollment periods each month. This means they can change plans or begin insurance through the Marketplace any month, not just during the annual open enrollment period. Coverage begins on the 1st day of the month, if they enroll before the 15th day of the previous month. If they enroll after the 15th day of the month, they may have to wait 6 weeks for coverage to begin.

Example 1: John enrolls on December 5th and coverage begins January 1st.

Example 2: John enrolls on December 20th; coverage begins February 1st.

Example 3: John enrolled in a plan during the annual open enrollment period, but he wants to change plans. He submits the information to change plans on March 14 and his plan is changed on April 1.

C. Medicaid and the ACA

C.1. What is MAGI and how is it determined?

MAGI is the acronym for Modified Adjusted Gross Income. Adjusted Gross Income (AGI) is figured as part of filing federal income tax. MAGI adds back some income that is non-taxable, such as interest from tax-free bonds and income from foreign investments. For AI/AN, income that is not taxable and not reportable to the IRS is not included in MAGI. MAGI is used for determining the percentage of the federal poverty level (FPL). FPL is used to determine the amount of tax credits people receive to pay for insurance premiums in the Marketplace, as well as cost sharing limits. MAGI is also used for determining eligibility for Medicaid and CHIP. However, some AI/AN income that is included in MAGI is excluded from Medicaid and CHIP eligibility determinations. When people use the single application on line, IRS provides the MAGI through the federal data hub process. The application asks about certain AI/AN income so that it can be subtracted from the MAGI for Medicaid and CHIP eligibility determinations.

C.2. What is the difference between the new MAGI and classic Medicaid determination process?

Before ACA, Medicaid used both income and assets (like a house or a car) to determine eligibility. Starting January 1, 2014, all states must use MAGI only to determine eligibility for all Medicaid programs, except those for the elderly and people with disabilities (long term care). Before ACA, states could disallow a percentage of income for people to qualify for Medicaid and this varied considerably from state to state. The new approach under ACA requires a 5 percent disregard of income under MAGI, bringing all states under the same eligibility rules.

C.3. Is MAGI used to determine eligibility for dual eligibles (people who qualify for both Medicaid and Medicare) for programs like QMB and SLMB?

The eligibility determination process has not changed for the elderly and people with disabilities.

C.4. How often will Medicaid require an redetermination?

This will vary by state. Federal regulations require that the eligibility of every Medicaid and CHIP recipient be reviewed at least every twelve (12) months. Some states may require redetermination every six months or when the client reports a change that may affect their eligibility.

C.5. How are the Indian cost-sharing exemptions different in Medicaid from plans in the Marketplace?

Both Medicaid and Marketplace plans have cost sharing exemptions for AI/AN. However, they use different definitions of AI/AN. In Marketplace plans, descendants who are not enrolled in Tribes do not qualify as AI/AN, and therefore they have no special Indian status or protections (however, low income could qualify them for reduced cost sharing). In Medicaid and CHIP, descendants of Tribal members qualify as AI/AN and receive the cost-sharing protections.

C.6. Does the ACA change Medicaid estate recovery for Indians?

The American Recovery and Reinvestment Act (ARRA) exempt certain Indian-specific property from Medicaid estate recovery. ARRA § 5006(c) amends section 1917(b)(3) of the Social Security Act to exempt certain Indian income, resources, and property from Medicaid estate recovery. These provisions have been in the State Medicaid Manual since April 1, 2003. The ACA did not change these exemptions.

C.7. What types of documents do I have to provide in order to get an eligibility determination for Medicaid?

C.8. What happens if an elder or any other tribal member refuses or is unwilling to provide proof of income?

A person has a right to refuse to apply for Medicaid. They will still be able to receive health care through the Indian health system. If they need a referral from CHS, they will be subject to the CHS rules about alternate resources.

C.9. What are tribes thinking of doing to assist tribal members who need tax return assistance?

Some Tribes are making arrangements with volunteer tax assistance programs, including local universities with students getting degrees in accounting, to come to the Tribal communities to assist people with tax preparation. The IRS can provide information about volunteer tax assistance programs.

C.10. Many tribal households have multiple persons living in the home. What is the best approach for listing household members in the single application for Medicaid, CHIP and Marketplace plans? What about children living with their grandparent or other caretaker that have no legal authority?

The rules for households in determining eligibility are different for Medicaid/CHIP from tax credits for plans purchased in the Marketplace. Tax credits are based on the unit that files taxes together, and everyone in that unit has the same MAGI and FPL. Medicaid and CHIP consider whether people are providing financial support for one another, even if they don't file taxes together. For Medicaid/CHIP, some people can be considered as members of the household even though they live somewhere else (for example, a parent who is receiving more than 50 percent of their income from a child living in a different place). Also, Medicaid/CHIP can count people in the household who are not related. In the single application, the computer program is expected to figure all this out and tell people whether they qualify for Medicaid, CHIP or tax credits. However, the applicant must put the information into the application in

order for the computer to make the determination. If you feel like the computer made the wrong determination, you can appeal.

C.11. For the first year, what info does a tribal member need to provide for self-attestation and when does the insurance become effective?

C.12 What can be done for adults without children in their household with incomes between 100% and 138% FPL in those States that do not expand Medicaid?

AI/AN will continue to receive health care from their I/T/U; however, they will not be eligible for Medicaid or tax credits to offset the costs of premiums. They will be eligible for a hardship exemption, so they will not have to pay the tax penalty for not having insurance. People under 26 years old may be eligible for insurance under their parents' plans. AI/AN can purchase bronze plans with low premiums (some very low for young adults) and avoid any cost-sharing.

D. ACA Tax Penalties and Exemptions for Indians

D.1. What is the tax penalty and the shared responsibility payment? Are they the same thing?

Yes, the "shared responsibility payment" is another term used for a tax penalty for people who do not have minimum essential coverage (MEC).

D.2. Do Indians have to pay a tax penalty for not having insurance?

Most Indians will not have to pay the tax penalty if they do not have insurance.

- If a person is a member of a federally-recognized Tribe or a shareholder in an Alaska Native Regional or Village corporation, they will qualify for the Indian exemption in ACA. They can claim this exemption when they file their federal income tax.
- If a person is an IHS beneficiary, or eligible to be an IHS beneficiary, they will qualify for a hardship exemption. To obtain the hardship exemption, they must file an application through the Marketplace.

Some people who self-identify as Indians will not be able to qualify for these exemptions. For example, members of state-recognized Tribes (that are not also federally-recognized) and people from Tribes located outside the U.S. These people, as well as those who qualify as Indians under ACA, may qualify for other exemptions from the tax penalty that are available to the general population. For example, there are exemptions for people for whom insurance is unaffordable (including smokers where the tobacco rating increases premiums above 8.5 percent of their income), adults with incomes between 100-138 percent FPL who live in states that did not opt for Medicaid Expansion, people living in disaster areas, and people who are incarcerated.

D.3. How do Indians apply for an exemption from the tax penalty?

Members of federally-recognized Tribes may claim their exemption directly from the IRS when they file their tax returns, or they can apply for an exemption by completing an application and submitting it to the Marketplace. IHS beneficiaries, and people who are eligible to be IHS beneficiaries, may apply for the hardship exemption by completing a paper application, providing documentation, and submitting it to the Marketplace.

D.4. Do I have to apply for an exemption every year?

Once the exemption is granted to an AI/AN it extends throughout their lifetime and they do not have to apply again. However, they must notify the IRS if their status changes (ie, if they disenroll from their Tribe, or no longer qualify for IHS services. (Note: Non-Indians have to apply for exemptions on a month-by-month basis.)

D.5. Are non-Indians who qualify as IHS beneficiaries eligible for the hardship exemption? What about pregnant women?

Yes. Non-Indian women are eligible for IHS services during pregnancy and post-partum care if the father of the child is Indian. During the time they are eligible for IHS services, they are also eligible for the IHS-beneficiary hardship exemption. After the post partum eligibility period, they must notify the Marketplace that their status has changed and the hardship exemption will end. Other non-Indians eligible for the IHS-beneficiary hardship exemption include children, adopted children and foster children living in the household of an Indian.

D.6. What types of documents will I need to provide in order to qualify to an exemption?

Guidance on documents has not yet been provided by CMS or IRS. To qualify for Indian status under ACA, some of the documents that will be accepted are Tribal enrollment cards, CDIB/CIB cards, shareholder certificates for Alaska Native Village and Regional Corporations, and other documents issued by a tribe. To qualify for the IHS-beneficiary hardship exemption, a person can obtain a letter from the I/T/U facility where he/she receives care. If a person has not received care from an I/T/U facility, they can submit the same documentation that they would need to submit to show that they qualify for services if they went to an I/T/U facility.

D.7. What are tribes thinking of doing to assist tribal members who need assistance in applying for the tax penalty exemptions?

Tribes that are providing assistance for people to enroll in Medicaid, CHIP and plans through the Marketplace should also be able to assist people with hardship exemption applications. The first year, there will be paper applications that must be mailed for the exemption. Tribes should have copies of the applications, which can be downloaded from the computer websites. Tribes should also be able to provide documentation to support the applications. IHS is developing a standard letter that can be generated by RPMS to submit as documentation with hardship applications.

E. Tribal Sponsorship

E.1. Can DST pay premiums in the exchange for CHS eligibles?

Yes. Direct Service Tribes can assist people by paying the unsubsidized portion of premiums so that they can enroll in Exchange plans at no cost to the individual. The Tribe can make their own policies about who they will sponsor.

E.2. Can IHS pay the unsubsidized portion of premiums for individuals to purchase insurance plans on the Marketplace?

Apparently, federal contracting rules prohibit IHS from paying the unsubsidized portion of the premiums for individuals to purchase plans on the Marketplace.

E.3. How does the special monthly enrollment period for Indians help with Tribal Sponsorship?

Because AI/AN can enroll in any month, a Tribe can spread their enrollment assistance program out for 12 months. They can use revenues from the people who are enrolled early in the year to pay for premiums for people who enroll later.

E.4. We have decided not to do tribal sponsorship here, but I have gotten a few questions regarding dental... Because CHS has the alternate resource requirement, would someone who has medical coverage, but may not have dental coverage, be required to go through the Exchange because they may qualify for adult dental through Medicaid or an inexpensive pediatric dental plan through the Exchange, to satisfy the alternate resource requirement?

Every CHS program must develop their own rules, and there will be different opportunities for insurance in different states. Pediatric dental coverage is an essential health benefit (EHB) required for all plans, both on and off the Exchange (except for grandfathered plans). Therefore, it is likely that a child with medical coverage would also have dental coverage. However, adult dental care is not an EHB. CHS rules generally do not require a person to purchase insurance. Alternate resources are generally expected to be free to the patient.

E.5. Under tribal sponsorship isn't it a reasonable expectation that the tribe will end up administering both the CHS program as it now exists (for those not designated under sponsorship) AND being a sponsor of a defined group?

Every Tribe has to decide how it will manage programs. Some Tribes are thinking that the number of CHS authorizations and payments will decline if every person who is CHS eligible has insurance, so they have decided to use CHS to do outreach, enrollment assistance, and management of their Tribal Sponsorship program.

E.6. At any time are there any consequences to terminating sponsorship if the tribe concludes the risks outweigh the benefits?

Tribes may choose to start, stop or change their Tribal Sponsorship programs at any time. IHS beneficiaries will continue to be able to get their health services through the I/T/U and CHS. IHS beneficiaries will not have a tax penalty if they do not have health insurance, as long as they file for the Indian exemption or the IHS-beneficiary hardship exemption. If the Tribe decides to end Tribal Sponsorship for an individual or a group, they should notify the people affected so that they will know that when their insurance ends and can take measures to avoid being billed for services. The only real consequences may be in terms of tribal politics.

E.7. What is a good rule of thumb for determining the amount of reserves a program should consider given the potential for tax reconciliation/penalties (should the tribe decide to be responsible for any penalties)?

Since the Affordable Care Act is creating a new (and complex) program, there aren't any data to create an estimate on the tax reconciliation impact. You can reduce the risks by having policies where people report any changes in income or employment to you (it is increased income that will be the problem for tax reconciliation), monitoring this, and making adjustments in the advanced payment of tax credits during the year. After the first year, you will get a better idea of what to expect.

E.8. What is the future risk to Tribal Sponsorship (e.g. higher premiums) if after one year or successive years health care usage is significantly higher than expected?

Each year the insurance companies will set their premiums. Premiums could go up or down depending on their experience in the previous year and the perceived competition in the Marketplace. During the first three years of the Marketplace, there are programs in place to spread the risk of newly insured people across all the plans. If premiums go up for the second lowest cost silver plan, then tax credits will also go up, so the Tribal Sponsorship program may be somewhat insulated from premium increases.

E.9. What are the QHP's rules regarding premium increases?

ACA has rules about rate review if premiums increase by more than 10 percent in a year. However, the Marketplace is depending on competition among QHPs to bring premiums down over time.

E.10. Because ID has the doughnut hole due to non-passage of Medicaid Expansion, on average, what makes the most sense in terms of what group to sponsor?

Now that the Marketplaces have published their rates, you can look at the numbers and see where the cut off is for free insurance, ie where the tax credits based on the second lowest cost silver plan exceed the cost of premiums for the least expensive bronze plan. In those cases, there may be a nominal fee of $1-$2 each month for people to enroll. This is your absolute best deal. If you pay the $1 -$2 per month (for example, set up automatic withdrawals on a debit card or special bank account), you can make sure people do not lose their insurance. In other states, it turns out that the free insurance is most likely available for people over 50 years old, which is exactly the group with the highest utilization of health care that you want to have insured (both to increase your revenues and decrease your CHS expenditures). Be careful about the cost to enroll smokers if there is a tobacco surcharge on the premiums, as this may make the insurance more costly.

E.11. What are the greatest risks to the Tribe for Tribal Sponsorship?

The greatest risks are related to billing and contract management. The Tribe may not get the revenues they project unless the Tribe has good billing practices, including an updated charge master, researching and re-billing denied claims, and analyzing payments to make sure that the Tribe is being paid appropriately. Tribes may be receiving contracts from QHPs and MSPs to join their provider networks. A system must be in place to review and analyze those contracts before signing them. Signing a bad contract could limit the revenues that a Tribe receives and/or obligate a Tribe to expensive obligations.

E.12. How does a Tribe propose to track compliance with a Tribal Sponsorship policy that requires people to use their facility for primary care?

AI/AN whose income is below 300 percent FPL will be enrolled in zero cost sharing plan variations which gives them the most flexibility to go wherever they want to go for health care. People over 300 percent FPL, or whose income has not been determined, will be enrolled in a limited cost sharing plan which requires them to get a referral from CHS to avoid cost sharing if they go outside the I/T/U. This referral process can serve as a gatekeeper on utilization of the Tribal facility for primary care. Even with the zero cost sharing plan, some things will not be

covered by their insurance, such as adult dental services, so they will need to come to the Tribal facility. You could develop reports and do analyses to see what services people are receiving in the Tribal clinic. However, when people have a choice, the Tribal clinic's best approach is to make sure that they are competitive. In general, Tribal clinics offer better location and a socially and culturally comfortable place for people. But, it will be important to do research to find out what people want to see improved and to work hard to earn their loyalty. Also, it may be important to train and reward staff for customer service and making internal referrals to Tribal programs that are billable, such as smoking cessation programs.

F. QHP Contracting and Plan Management with the I/T/U

F.1. What are the general requirements of QHPs to contract with the I/T/U?

It depends on the rules of the specific Exchange. There are no federal requirements for QHPs to contract with the I/T/U.

F.2. Do QHP have to offer the I/T/U a contract?

It depends on the rules of the specific Exchange. There are no federal requirements for QHPs to offer I/T/Us a contract to become a network provider.

F.3. What is meant by essential community provider status?

The I/T/U has essential community provider (ECP) status in ACA. And ACA requires the QHPs to include some ECPs in their networks. However, QHPs can meet the federal standards for ECP participation in networks without contracting with I/T/Us. State Exchanges may create different rules for QHP networks that increase ECP participation in networks.

F.4. What is the reimbursement rate if I contract with a QHP?

When you sign a contract to become a network provider for a QHP, you agree to the reimbursement rate in the contract. Each issuer may have different rates.

F.5. Are QHP required to use the Tribal addendum and what if they do not?

Federal rules recommend using the Tribal addendum in QHP contracts with the I/T/U, but the federal regulations do not require it. If the I/T/U receives a QHP contract without the Indian addendum, they can ask the issuer to include the Indian addendum in the contract.

F.6. Do I have to contract with every QHP or can I contract with one or two and direct our Tribal Sponsor enrollees into those plans?

You do not have to contract with any QHP. You may choose to contract with one or two QHPs and limit your Tribal Sponsorship program to those plans. Before you sign any contracts, you should have them reviewed by your lawyer.

F.7. Where can I find the QHP premium rates?

There is not just one rate for premiums. Premiums vary by geographic location, age of the person being insured, and whether or not the person uses tobacco. In addition, premiums vary

for the metallic level of the plan. Not only do premiums vary for just about every individual, the advanced payment of the tax credit (APTC) also varies by individual. The APTC is calculated based on the second lowest cost silver plan premium, which in turn is based on geographic location and age. In addition, APTC is based on FPL. And FPL for a couple is not the same as the sum of the FPL for the two individuals (FPL assumes that two people can live as cheaply as one person, nearly). To get the tax credit, married couples must file taxes together and their APTC is based on the FPL for a couple. There are so many moving parts, that the only way to figure out the premium rate for an individual is to enter the individual's information into a calculator on the Marketplace website. Some states, like California, have calculators that can be used without having to create an account. For the FFM, you must first create an account before you can see the premium rates. Caution: some organizations have tried to create average premiums, but this can be very misleading.

F.8. What is the difference between CHS referrals and authorizations?

CHS referrals are required under ACA rules so that AI/AN enrolled in limited cost sharing plans do not have cost sharing if they go to a provider other than the I/T/U. This referral should not obligate the CHS program to pay for the services that are provided. Under the ACA rules, the referral does not have to be restricted to people who live in the Contract Health Service Delivery Area (CHSDA), and referrals could be provided to tribal members who live out of state.

CHS authorizations essentially authorize the provider to bill the CHS program as the last payer. For authorizations, CHS rules apply. Typically, CHS authorizations may only be issued to people who live in the CHSDA and may be limited by the CHS budget and priority system for CHS programs.

F.9. Should CHS have separate forms for referrals and authorizations?

It is a good idea for CHS to have two separate forms, one for referrals and a different one for authorizations. CHS may need to develop policies and procedures for issuing referrals. For example, they could have a referral system based on telephone calls and e-mails from tribal members who are enrolled in limited cost sharing plans.

F.10. Are there times CHS would issue an authorization for people with Marketplace insurance?

If CHS is going to help people enrolled in insurance plans avoid cost-sharing, then they may need to issue authorizations for those services that are not Essential Health Benefits (EHBs) and therefore not covered by the cost sharing protections. For example, adult dental is not an EHB in Marketplace insurance plans. The authorization means that CHS would pay any cost sharing that the covered individual would otherwise have to pay.

F. 11. Do plans sold on the Marketplace have to pay I/T/U providers for services to people enrolled in their plans?

The law requires plans to pay I/T/U providers for covered services delivered to people who are enrolled in their plans. However, CMS has allowed HMOs that are considered "closed panel plans" to define their services such that any off-plan services are not covered services; and, therefore, they don't have to pay I/T/U providers. Eventually lawyers will probably challenge this interpretation. Until this changes, it is a good idea to discourage AI/AN from enrolling in closed panel plans or help them change plans as soon as possible during the monthly special

enrollment periods.

F.12. What is a "closed panel plan"?

A closed panel plan is a type of health maintenance organization (HMO) where all the providers in the network are employed by the HMO and do not see patients with other types of insurance, and where patients' benefits are restricted to in-network providers. Typically, closed panel plans are found in Washington, Oregon and California. They include Group Health and Kaiser. It may be more difficult for I/T/U providers to be paid when they deliver services to people who are enrolled in closed panel plans. It is a good idea to discourage AI/AN from enrolling in closed panel plans or help them change plans as soon as possible during the monthly special enrollment periods.

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TRIBAL EDUCATION AND OUTREACH CONSORTIUM

Frequently Asked Questions

"THE ACA AND TRIBES AS EMPLOYERS"

The Patient Protection and Affordable Care Act (ACA) of 2010 began a new era of health reform that places new requirements on both individuals and employers. Many individuals will qualify for certain benefits to purchase insurance, including premium tax credits and cost sharing reductions. Smaller employers may be able to purchase insurance for their employees through the Small Business Health Options Program (SHOP) and may qualify for small business tax credits. However, larger employers could be subject to tax penalties for not offering their full-time employees and their dependents the opportunity to enroll in health insurance coverage that is affordable and that provides minimum value.

This FAQ focuses on ACA provisions applicable to Tribal governments and Tribal entities as employers. This FAQ is for informational purposes only and should not be considered or construed as legal advice.

If you have a question that is not included in this FAQ, please email jroberts@npaihb.org and we will try to include your question in future versions of this FAQ.

General Questions

1. **Are American Indian and Alaska Natives (AI/AN) exempt from the ACA individual responsibility (also known as the individual mandate) requirements?**

   No. AI/AN people are still required to have health coverage however enrolled members of federal tribes are exempt from the individual responsibility payment (also known as the tax penalty). A "hardship exemption" may also be available for individuals that are eligible for IHS services. Individuals may apply for exemptions through a state insurance exchange, the federally-operated exchange, or through the IRS.

2. **Are Tribal governments or tribally-operated enterprises exempt from the ACA employer shared responsibility requirements to provide health insurance?**

   No. See response to question #5.

3. **What is the definition of full-time employee?**

   An employee who is employed on average at least 30 **hours of service** per week (or 130 hours of service monthly) is considered a full-time employee.

4. **I understand that the ACA employer provisions are based on number of employees. What are the thresholds for the employer provisions?**

ACA Employer Provision	*Number of employees*

Small Business Tax Credit	24 or less full-time equivalent employees (a combination of full-time and part-time employees)
Small Business Health Options Program (SHOP)	100 or less employees (a State may limit the SHOP to 50)
Shared Employer Responsibility (Tax Penalties)	50 or more full-time employees (or a combination of full-time and part-time employees that are the equivalent of 50 full-time employees). Click here to find out more about full-time employee calculation.

Employer Shared Responsibility

5. **I have heard that employers may be subject to the Employer Shared Responsibility provisions. What are the Employer Shared Responsibility provisions?**

   The Employer Shared Responsibility provisions subject a large employer to a tax penalty if the large employer does not offer its full-time employees and their dependents the opportunity to enroll in health insurance coverage that is affordable and that provides minimum value. An employer is considered a large employer if it employs 50 or more full-time employees (or a combination of full-time and part-time employees that are the equivalent of 50 full-time employees).

6. **When do the Employer Shared Responsibility provisions go into effect?**

   The Employer Shared Responsibility provision was to go into effect on January 1, 2014. However the IRS has postponed the implementation of this provision for one year.

7. **Is there an exemption for governmental entities from the Employer Shared Responsibility provisions?**

   No. The Employer Shared Responsibility provisions apply to all common law employers, including for profit, nonprofit and governmental entities. Governmental entities includes Federal, State, local and Indian tribal government entities.

8. **Our Tribal business employs seasonal workers that work only during summer months. Do these seasonal workers count towards determining whether our organization is considered a large employer?**

   There is a seasonal worker exemption that applies to determination of whether an employer is considered a large employer. Click here to see the seasonal worker exemption.

9. **What are the ACA requirements to provide health insurance to employees?**

< 50 full-time employees	An employer is not subject to the Employer Shared Responsibility provisions and does not have to offer health insurance to its full-time employees.
≥ 50 full-time employees	An employer is subject to the Employer Shared Responsibility provisions and must provide health insurance coverage that is affordable and that provides minimum value.

10. What is considered affordable coverage?

The law requires that the portion of the premium paid by the employee for "self-only" coverage cannot exceed 9.5% of the employee's household income. Since it would be difficult for an employer to determine an employee's household income, an employer may rely on certain affordability safe harbors to avoid a tax penalty.

11. What are the penalties for a Tribal government or Tribal entity that does not provide health insurance coverage?

The penalty is $2,000 multiplied by the number of full-time employees (less 30 full-time employees) divided by 12 (incurred on a monthly basis). However, the penalty is only triggered if a full-time employee receives a premium tax credit or cost sharing reduction in the Individual Marketplace.

For example, if a Tribal government or Tribal entity employs 70 full-time employees, the penalty would be calculated, as follows: 70 full-time employees – 30 full-time employees = 40 full-time employees x $2,000 = $80,000 ÷12 = $6,666.66. The penalty is $6,666.66 per month for each month at least one employee receives a premium tax credit or cost sharing reduction.

12. If a Tribal government offers health insurance coverage to its employees, then it doesn't have worry about incurring any tax penalties, right?

The health insurance coverage offered to the employee has to be affordable and provide minimum value. If it is not affordable or does not provide minimum value, a full-time employee could be eligible to receive a premium tax credit or cost sharing reduction in the Individual Marketplace which would trigger the penalty. The penalty is $3,000 per employee who receives a premium tax credit or cost sharing reduction divided by 12 (incurred on a monthly basis).

For example, if one full-time employee receives a premium tax credit, then the employer would be subject to a tax penalty of $250.00 per month (i.e., $3,000/12 = $250); if ten full-time employees receive premium tax credits, then the employer would be subject to a tax penalty of $2,500.00 per month ($250.00 per employee).

13. We have heard that employers have to offer health insurance coverage to dependents. Who is considered a dependent? Do we have to pay for dependent coverage?

A dependent includes an employee's child, adopted child, stepchild or eligible foster

child who is under 26 years of age. A spouse is not considered a dependent so an employer does not have to offer coverage to a spouse. Although an employer is required to offer dependent coverage, it is not required to pay for dependent coverage.

Transition Relief: An employer has to take steps during the plan year that begins in 2014 to offer coverage to dependents by 2015.

14. Can the dependents of a full-time employee enroll in health insurance coverage through an Individual Marketplace in 2014?

Dependents of a full-time employee who are not offered coverage by the full-time employee's employer in 2014 could be eligible to receive a premium tax credit or cost sharing reduction in an Individual Marketplace.

15. If our Tribal government offers a self-funded sponsored health plan, may a full-time employee receive a premium tax credit in the Marketplace to purchase insurance? Or is the employee required to enroll in our plan?

If Tribal self-funded sponsored health plan is considered health insurance coverage that is affordable and that provides minimum value, the employee would not qualify for a premium tax credit in the Marketplace.

An employee can decline enrollment in an employer's plan whether or not the employee qualifies for a premium tax credit. However, if an employee does not have minimum essential coverage by January 1, 2014, the employee could be subject to a tax penalty unless the employee qualifies for a tax exemption (e.g., members of federally recognized tribes are exempt from the penalty).

16. If a Tribal government or Tribal entity discontinues its employer-sponsored insurance prior to January 1, 2014, may its employees go into the Marketplace to purchase insurance? If the employees quality for a tax credit may it be used to purchase insurance on the Marketplace? And if so, is there a potential tax penalty on the Tribal government or Tribal entity?

Yes. If a Tribal government or Tribal entity discontinues its employer-sponsored insurance prior to January 1, 2014, the Tribal government's or Tribal entity's employees could go the Marketplace to purchase insurance. Employees who are 400% below the federal poverty level could qualify for a premium tax credit to purchase insurance in the Marketplace.

The Tribal government or Tribal entity employer would be subject to a tax penalty for not offering health insurance coverage to its full-time employees. This penalty could be significant depending on the number of full-time employees of the Tribal government or Tribal entity. See Question No. 9.

Small Business Health Options Program (SHOP)

17. What is a SHOP?

SHOP stands for the Small Business Health Insurance Program (SHOP). Each state will have a SHOP where small businesses with up to 100 employees (may be limited to 50 by a State) can purchase health insurance for employees. An employer will be able to compare health plans based on price, coverage and quality.

18. Can a Tribal government or other Tribal entity purchase health insurance for its employees through a SHOP?

A Tribal government or Tribal entity would be eligible to purchase health insurance for its employees through SHOP if it meets the following criteria:

1. It employed 1 to 100 employees (may be limited to 50 by a State) on business days during the prior calendar year and employs at least one employee on the first day of the plan year.
2. It elects to offer all full-time employees coverage in a qualified health plan (QHP) through a SHOP; and
3. Has its principal place of business in the Marketplace and offers coverage to all full-time employees through that SHOP; or offers coverage to each eligible employee through the SHOP serving that employee's primary worksite.

19. How does a Tribal government or Tribal entity apply for health insurance through the SHOP?

A Tribal government or Tribal entity will be able to apply for health insurance through the SHOP website, a Navigator, an insurance broker, or by phone. The application will be available online and in a paper application form. The employer and the eligible employees will be required to complete separate applications.

Small Business Tax Credits

20. I have heard that tax credits may be available to small businesses if an employer provides health insurance to its employees. Is a Tribal government eligible to apply for these tax credits?

An employer that is an agency or instrumentality of an Indian tribal government is not eligible for the tax credits unless it is a 501(c)(3) organization.

21. What are the eligibility criteria for the Small Business Tax Credits?

The 501(c)(3) may be eligible for the tax credits if it:

1. Employs fewer than 25 full-time equivalent employees (FTEs);
2. Pays an average annual wage of less than $50,000 per year per FTE; and
3. Pays for at least 50% of single coverage for employees.

Beginning in 2014, the tax credits will only be available for health insurance plans purchased on through the SHOP.

Links

Affordability Safe Harbors: An employer may only use a safe harbor if it offers its full-time employees and their dependents the opportunity to enroll in health insurance coverage that provides minimum value with respect to the self-only coverage offered to the employee. An employer's use of the safe harbors is optional; however, an employer's use of the safe harbors for any category of employees has to be on a uniform and consistent basis for all employees in such category.

The safe harbors are, as follows:

Form W-2 Safe Harbor	If the employee only portion of the premium for the employer's lowest cost plan does not exceed 9.5% of the employee's W-2 wages then the coverage is deemed affordable. Application of this safe harbor is determined at the end of the calendar year.
Rate of Pay Safe Harbor	For hourly employees, if the employee only portion of the premium does not exceed 9.5% of an amount equal to 130 hours multiplied by the employee's hourly rate of pay as of the first day of the coverage period it is deemed affordable. For salaried employees, the employer would use the employee's monthly salary rather than 130 hours. An employer may only use this safe harbor if an employee's wages are not reduced during the calendar year.
Federal Poverty Line Safe Harbor	If the employee only portion of the premium does not exceed 9.5% of a monthly amount determined as the Federal poverty line (for the State in which the employee is employed) for a single individual for the applicable calendar year, divided by 12, it is deemed affordable.

These safe harbors do not affect an employee's eligibility for a premium tax credit if the employee only portion of the premium exceeds 9.5% of the employee's household income.

Full-Time Employee Calculation: Follow these steps to steps to determine if you are a large employer subject to the Employer Shared Responsibility provisions:

Step 1: Calculate the total number of full-time employees (including any full-time seasonal workers defined as workers that work during certain seasons or periods of the year for no more than 120 days during the taxable year) for each calendar month in the prior calendar year.

Step 2: Calculate the total number of full-time equivalents (including non full-time seasonal workers) for each calendar month in the preceding calendar year.

To determine full-time equivalents, calculate the total number of hours of service (but not more than 120 hours of service for any employee) for all employees who were part-time employees (averaged less than 30 hours of

service per week) for that month, and divide the total hours of service by 120. This is the number of full-time equivalent employees for the calendar month. Fractions are taken into account in determining the number of full-time employees for each calendar month. For example, if part-time employees worked a total of 1,890 hours in a calendar month, there would be 15.7 full-time equivalent employees for that month (i.e., 1,890 ÷ 120 = 15.7).

Step 3: Add the number of full-time employees and full-time equivalents described in Steps 1 and 2 above for each month of the calendar year.

Step 4: Add up the 12 monthly numbers.

Step 5: Divide the sum by 12. (Note: Fractions are disregarded and the result is rounded down to next lowest whole number, e.g. a result of 55.8 would be rounded down to 55).

If the average is 50 or more, you are considered a large employer. If you employ seasonal workers, you could qualify for the seasonal worker exemption.

Health Insurance Coverage: An employer must provide minimum essential coverage under an eligible employer-sponsored plan. An eligible employer-sponsored plan means a group health plan or group health insurance coverage offered by an employer to the employee which is:

- A governmental plan (within the meaning of section 2791(d)(8) of the Public Health Service Act);
- Any other plan or coverage offered in the small or large group market; or
- A grandfathered plan offered in the group market.

Hours of Service: Hours of Service includes each hour an employee is paid or entitled to payment:

- For performance of duties for the employer; and
- Any period of time during which no duties are performed due to vacation, holiday, illness, incapacity including disability, layoff, jury duty, military duty or leave of absence.

To calculate the hours of service of hourly employees:

Actual Hours	Count the actual hours of service.

To calculate the hours of service of non-hourly employees, these are the employer's options:

Actual Hours	Count the actual hours of service.
Days-worked equivalency	Credit the employee with 8 hours of service for each day the employee would be credited with at least 1 hour of service.

Weeks-worked equivalency	Credit the employee with 40 hours of service for each week.

Different methods may be used for different classifications of non-hourly employees provided that the classifications are reasonable and consistently applied.

Minimum Value: Minimum value means that a plan has to cover at least 60% of the total allowed cost of benefits that are expected to be incurred under the plan. Four different methods for determining whether an eligible employer-sponsored plan are provided in recently proposed rules. An employer may use:

1. The minimum value calculator made available by HHS and the IRS provided at: http://www.cciio.cms.gov/resources/regulations/index.html#pm.
2. One of the safe harbors established by HHS and IRS.
3. Actuarial certification if an eligible employer-sponsored plan has nonstandard features that are not compatible with the minimum value calculator and may materially affect the minimum value percentage.
4. As to plans in the small group market, the plan must conform with the requirements for a level of metal coverage (bronze, silver, gold or platinum) defined at 45 CFR 156.140(b).

Seasonal Worker Exception: Follow the full-time employee calculation before applying this Exception.

An employer may not be considered a large employer if the employer's work force only exceeds 50 full-time employees for 120 days or less during the calendar year, and the employees in excess of 50 were employed during the 120 day period or less were seasonal workers.