

Q. Who will be included the definition of Indian used for the Health Insurance Exchanges? Will this cover only individual Indians, or will it include Indian households?

A. The Affordable Care Act (ACA) includes several different, although similar, definitions of “American Indian;” we don’t know at this time whether CMS will select one definition or, if so, which definition will be chosen.

Under the proposed regulations, different methods for determining eligibility will apply for different programs. Medicaid eligibility is determined for each **person**, using information about themselves and individuals in their household. Unlike Medicaid, eligibility for premium tax subsidies will be determined for a **household**, as it is in MinnesotaCare. Minnesota has elected to apply the premium exemption for Indians in MinnesotaCare to an entire household when at least one member is an Indian; it is not clear whether this will change under the Exchange.

Q. How will American Indians be identified by the Health Insurance Exchange? What type of proof will be required?

A. It will be important that American Indians be identified so they are able to access the special benefits and protections for Indians included in the ACA. To determine eligibility for cost-sharing protections, the ACA allows the Exchange to verify AI/AN status using documentation of citizenship and electronic data sources approved by the Secretary of HHS or documents currently accepted by Medicaid showing tribal membership. Minnesota has suggested that IHS data should be included in the planned “data hub,” that would allow exchanges to access data from a number of federal sources to assist in enrolling people into insurance plans, and also that tribal data sources be considered.

Q. How will tribal health care providers be included in the Health Insurance Exchange? How do they become Qualified Health Providers in the Exchange Plans?

A. The proposed regulation requires health insurance networks to include “a sufficient number” of Essential Community Providers (ECP). Minnesota has advocated with CMS for requiring inclusion of all ECPs in insurers’ networks. Minnesota also raised the topic of requiring that tribes be offered contracts that include a “Tribal Addendum” so that they are appropriate for tribes. CMS seemed positive toward using the addendum.

Although IHS, tribal, and urban Indian health care providers may be ECPs, the designation is not automatic and must be renewed periodically. Because of this, tribes have suggested that insurers be required to offer network provider contracts to I/T/U providers, whether they are designated as ECP or not.

Q. Will Tribes and the IHS be paid at the encounter rate under the Health Insurance Exchange?

A. The Health Insurance Exchange is not intended to change the way the state’s health care programs operate or the ways states pay health care providers. In Minnesota, we expect to

continue to pay IHS and tribal health care providers using the same methods that are currently used.

Q. Most tribal health clinics have Benefits Coordinators; can we utilize these individuals as HIE Navigators?

A. According to proposed Exchange regulations, Indian tribes, tribal organizations, and urban Indian organizations can be navigators, along with state or local human service agencies. Tribal navigators would understand the health needs of their communities and with appropriate training, they would be well-equipped to help tribal members determine their best coverage options, including QHPs through the Exchange or other available programs. The tribe would choose which employees would receive the Navigator training.

Tribes and other Indian health care providers also believe that they should be allowed to have Navigators who serve only American Indians without regard to issues of conflict of interest. This would not preclude other navigators from serving American Indians, but rather acknowledges that tribes and IHS are prohibited from serving non-Indians in their federally-funded programs.

Q. What is a sponsorship? Who can the tribe's cover? Is this federal or state? How can we negotiate this with the state?

The proposed rule implementing the ACA permits Indian tribes, tribal organizations and urban Indian organizations to pay premiums on behalf of individuals who are eligible for insurance coverage through the Exchange. In our response to the proposed regulation, we noted that Minnesota supports this provision.

Q. IHS presented to tribal leaders about the Basic Health Program. IHS stated that this program is a state insurance coverage for people that don't meet Medicaid eligibility and are between 133% and 200% of the Federal Poverty Level. Which program is this? MN Care?

The Basic Health Plan appears to be similar to the MinnesotaCare program in who would be covered and what benefits would be included. However, regulations for Basic Health Plans have not been developed, so we cannot say exactly what the differences will be.

Q. What does "exempt from cost sharing" mean and who is exempt?

Under the ACA, Qualified Health Plans within the Exchange may require the payment of deductibles or co-pays. To increase access to care, American Indians with incomes below 300 percent federal poverty levels, and all Indians who obtain services from or receive a referral from I/T/U providers, will be exempt from cost-sharing requirements.