IHS TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE

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Sent via email: Mark.Chambers@Treasury.gov

October 23, 2015

Dr. Elaine Buckberg
Deputy Assistant Secretary for Policy
Office of Economic Policy
Department of Treasury
1500 Pennsylvania Avenue NW
Washington, DC 20220

RE: Request for Extension of Transition Relief from the Employer Mandate

Dear Dr. Buckberg:

On behalf of the Tribal Self-Governance Advisory Committee to IHS (TSGAC), I would like to thank you again for your and your staff's participation at the recent TSGAC quarterly meeting in Washington, D.C. We appreciate the opportunity to engage in a discussion on implementation of the Patient Protection and Affordable Care Act (Affordable Care Act or ACA).

On behalf of TSGAC, please accept this letter as a formal request for an extension of transition relief in the application of the employer shared responsibility mandate ("employer mandate") under the Affordable Care Act on Indian Tribes, Tribal Organizations as defined by Section 4(L) of the Indian Self-Determination and Education Assistance Act, and Tribally Owned Entities (collectively referred to as "Tribes").

Further, as we discussed at the recent TSGAC meeting held on October 7, 2015, the TSGAC will be submitting shortly for the Treasury Department's consideration options and recommendations on potential approaches for other forms of permanent administrative relief in the implementation of the employer mandate on Tribes as these requirements pertain to a Tribe's Tribal member employees. [1]

As we discussed with you, many Tribes with large governmental commercial operations have always offered their employees health coverage and will continue to do so. But many others, in particular Tribes who employ large numbers of Tribal member employees, have not done so as those employees have a right to access Indian Health Service (IHS) services at no cost to the Tribal employees. Those Tribes are particularly vulnerable to the employer mandate, which will force them to either purchase insurance for Tribal member employees otherwise exempt from the individual mandate, or pay significant penalties to the United States.

Specifically, we are requesting an extension of transition relief in implementation of the following requirements under the employer mandate from January 1, 2015 until at least January 1, 2016 and preferably to January 1, 2017:

[1] For purposes of the transition relief for the employer mandate, we are defining "Tribal members" as persons eligible for an exemption from the penalty for not securing health insurance coverage under Internal Revenue Code (IRC) § 5000A(e)(3) as a member of an Indian Tribe and persons eligible for an exemption from the penalty for not securing health insurance coverage under IRC § 5000A(e)(5) and ACA § 1501, under which ACA § 155.605(g)(6) was established, granting an exemption for American Indians and Alaska Natives who are eligible for services through an Indian health care provider.

- Employer coverage requirements, including any associated mandate to make shared responsibility payments under Internal Revenue Code (Code) section 4980H;
- Employer reporting requirements under Code section 6056; and
- Application of the extension of transition relief to all employees of Tribes.

We are requesting this transition relief for two primary reasons:

1) To provide Tribes additional time to seek a permanent remedy to these requirements; and
2) To allow Tribes that have not historically provided health insurance coverage to their employees and that currently lack the capacity to offer coverage and/or meet the reporting requirements additional time to get technical assistance and determine how to manage the reduction in funding and services to Tribal members that will be caused by the employer mandate.

For those Tribes that have not historically provided formal health insurance coverage to their employees, as we discussed at the October 7th TSGAC meeting and as was presented in previous correspondence in a joint letter dated June 29, 2015 (attached), the imposition of the employer mandate requirements under the ACA is creating a significant hardship. Specifically, if required to offer comprehensive coverage or make "employer shared responsibility payments" to the federal government, many Tribes will have to reduce current service levels to Tribal members due to the costs of either purchasing coverage or making payments to the Treasury.

Further, for all Tribes, whether they have provided comprehensive health insurance coverage to their employees as a standard business practice or not, having Tribes make payments to the federal government for the health care needs of Tribal members is in direct conflict with the federal government's trust responsibility to meeting the health care needs of Tribes and their citizens.

Providing Tribes with additional transition relief in implementing the ACA's employer mandate would build on previous Treasury Department actions pertaining to all or a subset of employers. There are eight forms of transition relief for 2014 and / or 2015 already provided. For example, a one-year delay was provided to all employers with regard to all their employees (from January 1, 2014, to January 1, 2015). An additional one-year extension was provided to mid-size employers with regard to all their employees (from January 1, 2015, to January 1, 2016), eliminating the requirements during the current 2015 coverage year.

We believe that providing the extension of relief requested in this letter will not disadvantage employees of Tribes. Coverage decisions have already been made by Tribes for the 2015 coverage year. Implementation of an extension of transition relief until January 1, 2016 will not impact the actions of Tribal employers for this current coverage year. In addition, an extension of relief to Tribes for an additional one-year period through January 1, 2017, if provided, would enable Tribes to have sufficient time to prepare to implement the current employer mandate or modified requirements that might be established for Tribes.

We are also formally requesting to engage, pursuant to the Department of the Treasury Tribal Consultation Policy, in Tribal consultation on the matters presented in this letter.[2]

[2] The Department of the Treasury Tribal consultation policy became effective on September 23, 2015 and replaced the Department's interim consultation policy.

We look forward to your continued engagement with us on this matter. And, we appreciate your recognition of the importance of this issue to Tribes and their citizens. If you have any questions, you can reach me at (860) 862-6192; or via email: lmalerba@moheganmail.com. Thank you.

Sincerely,

Lynn Malerba

Chief Lynn Malerba, Mohegan Tribe
Chairwoman, TSGAC

cc: Mr. Robert McSwain, Deputy Director, IHS
P. Benjamin Smith, Director, OTSG, IHS
TSGAC and Technical Workgroup

Enclosure: Joint Tribal Organization letter to The White House dated June 29, 2015.

National Indian Health Board

National Congress of American Indians

Submitted via e-mail: Tracy_L_Goodluck@who.eop.gov
Raina_D_Thiele@who.eop.gov

June 29, 2015

Raina D. Thiele
Associate Director of Intergovernmental Affairs and Public Engagement
The White House
1600 Pennsylvania Avenue NW
Washington, DC 20500

Tracy L. Goodluck
Policy Advisor for Native American Affairs, White House Domestic Policy Council
The White House
1600 Pennsylvania Avenue NW
Washington, DC 20500

Re: Request for Tribal Relief from the Affordable Care Act Employer Mandate.

Dear Ms. Thiele and Ms. Goodluck:

On behalf of the National Indian Health Board (NIHB), the National Congress of American Indians (NCAI), the Tribal Self-Governance Advisory Committee (TSGAC), the Direct Service Tribal Advisory Committee (DSTAC), the United South and Eastern Tribes, Inc. (USET), and the Rocky Mountain Tribal Leaders Council (RMTLC), we write to you to again request a meeting to discuss the need for relief for Tribes from the Patient Protection and Affordable Care Act's (ACA) employer shared responsibility rule (the "employer mandate"). We continue to await response to our original letter submitted to the White House on February 2, 2015.

The Internal Revenue Service's (IRS) Final Rule implementing the employer mandate is inconsistent with the federal trust responsibility to Tribes, denies many Tribal members the opportunity to take advantage of the benefits and protections designed for them in the Marketplace, and chills Marketplace enrollment for American Indians and Alaska Natives (AI/AN). It is cost-prohibitive for many Tribes and will result in a diminution of Tribal services

for Indian people. If fully implemented in Indian Country, Tribes will be faced with one of two undesirable options: either providing expensive employee coverage, which will result in a reduction of governmental services and the disqualification of Tribal member employees from AI/AN-specific benefits and protections in the marketplace, or using scarce (and in all likelihood, federal) resources to pay the IRS substantial employer mandate penalties. Neither outcome represents good federal policy.

As discussed below, the ACA contains several provisions designed to encourage AI/AN enrollment in the ACA Marketplaces, and the Center for Consumer Information and Insurance Oversight (CCIIO) has been actively encouraging Tribes to encourage their members take advantage of these provisions by enrolling in the Marketplaces, and Tribes have expended considerable resources to take CCIIO up on that challenge.

But the IRS's application of the employer mandate to Tribal governments works at cross purposes to encouraging Marketplace enrollment. Tribal workforces include a significant number of Tribal member employees. The offer of employer-sponsored health coverage to a Tribal member employee disqualifies that employee from the premium subsidies that are critical to facilitating Marketplace enrollment. With the employer mandate in place, Tribes are placed in the untenable position of either having to offer insurance at full price to their Tribal member employees, who will then be unable to take advantage of Marketplace premium subsidies even if they do not accept the employer-based coverage, or to forego offering coverage (or offer insufficient coverage) to their Tribal member employees and pay substantial penalties to the IRS.[1]

These twin policies from IRS and CCIIO are inconsistent, and have combined to discourage AI/AN Marketplace participation and significantly increase costs to Tribal governments. Together, they create a federal policy that is inconsistent with the right of AI/ANs to obtain federally-funded, trust-obligated health care without charge to the individual at I/T/U facilities, and which further forces many Tribal employers to purchase coverage for workforces largely comprised of Tribal members who are (1) exempt from the ACA's individual mandate to obtain coverage and (2) eligible to obtain health care through the I/T/U system. And application of the employer mandate will be simply unaffordable to many Tribes and Tribal organizations and act as a barrier to the provision of critical governmental services.

Finally, neither the ACA nor its implementing regulations should be interpreted as applying to Tribes in the first instance. The employer mandate is set out in Section 4980H of the Tax Code, as added by Section 1513 of the ACA (as amended).[2] Section 4980H of the Code does not specifically include Tribal governments within the definition of a covered employer, and Section 54.4980H-2(b)(4) of the employer shared responsibility regulations reserves application of special rules for government entities.

[1] We illustrate these various scenarios in the examples below.

[2] *See* 26 U.S.C. § 4980h; 26 C.F.R. § 54.4980H–1 - .4980H-5.

With the employer mandate in effect as of January 1, 2015, we request consultation on the need for Tribal relief from the rule as soon as possible. In addition, IRS Information Reporting deadlines for employers subject to the mandate for the 2015 tax year are fast approaching (i.e., employers must issue 1095-C statements to full-time employees by January 31, 2016 and must file 1094-C and 1095-C forms by February 29, 2016, or March 31, 2016, if filing electronically).

I. Background.

Congress has recognized both that "[f]ederal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people"[3] and that it is a "major national goal . . . to provide the resources, processes, and structure that will enable Indian tribes and tribal members to obtain the quantity and quality of health care services and opportunities that will eradicate the health disparities between Indians and the general population of the United States."[4] The federal trust responsibility and laws enacted pursuant thereto provide ample authority for the federal agencies of the Executive Department to design, implement and tailor federal programs in a manner that recognizes and supports the unique government to government relationship between sovereign Tribal governments and the United States.[5] One manner in which the federal government partially fulfills its trust responsibility is by making AI/ANs eligible to receive care through the Indian Health Service (IHS) system without charge to the individual patient.[6]

In light of the federal government's trust responsibility, many Tribal employers have not historically offered health coverage to their employees. Not only are the majority of many Tribal workforces eligible for IHS services, but the remote location of many I/T/U facilities creates additional difficulties in locating plans that treat Tribal facilities as in-network or otherwise preferred providers. This often leaves the I/T/U as the only viable health service option for the employee population, regardless of coverage status. In addition, insurance plans in these remote areas are frequently expensive, have high cost-sharing amounts, or are less comprehensive than plans available in urban settings.[7] Federal responsibility for the provision of health services

[3] 25 U.S.C. § 1601(1).

[4] 25 U.S.C. § 1601(2).

[5] Additional background on the authority of federal agencies to tailor their programs to meet the unique needs of federally-recognized tribes and American Indians and Alaska Natives is provided in Appendix B to the CMS TTAG Strategic Plan, "Appendix B: Legal Basis for Special CMS Provisions for American Indians and Alaska Natives." A copy of Appendix B is appended to this letter.

[6] 42 C.F.R. §§ 136.11 and 136.12.

[7] *See, e.g.*, Letter from Monica J. Linden, Commissioner, Montana Department of Securities and Insurance, to Kathleen Sebelius, Secretary, U.S. Department of Health and Human Services (Mar. 10, 2014) (recognizing practical difficulties for Tribal employers in finding and offering adequate coverage and seeking Tribal exemption from employer mandate).

allows Tribal governments to expend scarce resources elsewhere rather than obtaining high cost, low quality employee insurance.[8]

II. Discussion.

With these unique circumstances in mind, the application of the employer mandate to Tribal employers presents three primary problems: (1) it undercuts the federal government's trust responsibility by forcing AI/ANs to "pay" for health coverage (whether directly or by proxy through their Tribal employer); (2) it undercuts multiple ACA provisions designed to encourage AI/AN enrollment in the Marketplaces; and (3) compliance with the mandate requires a significant diminution in Tribal governmental services. We discuss each issue in turn.

1. The Employer Mandate Runs Counter to the Federal Government's Trust Responsibility by Requiring Tribes to Either Pay the Federal Government Penalties or Subsidize Private Insurance Companies.

As noted above, the federal government owes a trust responsibility towards AI/ANs, through which they are eligible to receive health care through the IHS system without cost to the individual. However, IHS is chronically underfunded, and AI/ANs continue to suffer the highest health disparities of any ethnic group in the United States and are disproportionately likely to be uninsured.[9] The employer mandate forces Tribes to divert funding necessary to sustain Tribal health programs, which by right should come from the federal government, and redirect it to the purchase of employee health insurance from private companies.

This contradicts the trust responsibility by resulting in a redundant payment cycle in which (1) Tribal employers use their own funding (most likely a combination of federal funding and outside revenue) to purchase employee insurance; (2) many employees visit the local IHS health program for services; and (3) the employee's insurer then reimburses IHS. In the alternative, the Tribal employer does not purchase insurance and instead simply pays penalties to the IRS, another federal agency.

In these circumstances, the employer mandate essentially results in Tribes funding the federal government: either they take their limited Tribal funding (some or all of which might be federal funding anyway) and pay it to the IRS in the form of a tax penalty, or they purchase insurance from private companies, which then pay IHS after keeping between 15-20% of the premium payments off the top.[10] Tribal subsidization of the United States does not respect either the trust

[8] We note that the federal government's budgeting and expenditures do not come close to meeting the requirements of the trust responsibility: IHS is only funded at approximately 56% of need, and the most recent contract support cost shortfall was estimated at $90 million. NATIONAL TRIBAL BUDGET FORMULATION WORKGROUP'S RECOMMENDATIONS ON THE INDIAN HEALTH SERVICE FISCAL YEAR 2015 BUDGET 3, 6 (2013).

[9] *See generally* SAMANTHA ARTIGA ET AL., HENRY J. KAISER FAMILY FOUNDATION, HEALTH COVERAGE AND CARE FOR AMERICAN INDIANS AND ALASKA NATIVES (2013), *available at* http://kff.org/disparities-policy/issue-brief/health-coverage-and-care-for-american-indians-and-alaska-natives/ (last visited July 18, 2014).

[10] *See* 45 C.F.R. § 158.210 (establishing acceptable insurance medical-loss ratios in the large group, and individual health markets).

responsibility or the government-to-government relationship between Tribes and the United States. It is also inefficient, as federal funds will be used to circuitously pay for the cost of insurance premiums or for tax penalties rather than directly funding health care through the IHS system, while also allowing insurance companies to step in and keep a percentage of the funding for themselves. The trust responsibility neither envisions Tribes as middlemen for transactions between private insurers and IHS nor Tribal "funding" of federal agencies through the payment of penalties.

2. The Employer Mandate Undercuts the ACA's Indian-Specific Protections.

Applying the employer mandate to Tribal employers directly undercuts the ACA's Indian-specific protections in three ways. First, it punishes Tribes for assisting AI/AN enrollment in the Marketplaces, despite the multiple ACA provisions designed specifically to encourage such activities. Second, it can disqualify AI/ANs from eligibility for premium tax credits in Marketplace plans, thus leaving them unaffordable. Third, it ignores the fact that AI/ANs are exempt from the individual mandate and forces Tribal employers to pay for AI/AN insurance plans as a proxy for the individual. None of these outcomes benefit Tribal employers, individual AI/ANs, or the federal government.

The ACA contains several provisions designed to maximize AI/AN participation in Marketplace plans: for example, Indian-specific cost-sharing protections that help defray the cost of health coverage,[11] special AI/AN enrollment periods,[12] and the ability for Tribes sponsor Marketplace plan premium payments for Tribal members.[13] Many Tribes and Tribal organizations have aggressively sought to facilitate AI/AN enrollment in Marketplace plans in order to take advantage of these protections. However, the employer mandate actively discourages AI/AN Marketplace participation, in direct contradiction to the provisions described above.

First, Tribes may find it more affordable to offer Marketplace premium assistance to Tribal member employees than it is to pay for employee-sponsored coverage. However, it is our understanding that the IRS has opined that Tribal premium sponsorship for member employees does not satisfy the employer mandate. Tribes will therefore be forced to either continue offering premium assistance and pay the employer mandate penalty (thus diminishing the funding available for premium assistance and AI/AN Marketplace enrollment) or else purchase employer coverage and discontinue premium assistance (which may not be financially viable and which forecloses Tribes from obtaining a benefit that Congress deliberately included in the ACA).

Second, even if a Tribe does offer employer coverage, AI/AN employees will almost certainly be personally responsible for paying premium costs and (depending on the type of plan and location

[11] 42 U.S.C. § 18071(d).

[12] 42 U.S.C. § 18031(c)(6)(D).

[13] 25 U.S.C. §§ 1642, 1644.

of services) for deductibles, co-payments, and co-insurance. Recognizing that eligibility for IHS services acts as a natural disincentive for AI/AN enrollment in any insurance plan (employer-sponsored or otherwise) that requires such expenditures, Congress further incentivized AI/AN Marketplace participating through the availability of premium tax credits: various types of Indian-specific income is excluded when calculating AI/AN eligibility for the tax credits, thus leaving it comparatively easier for AI/ANs to qualify[14] and making many individual Marketplace plans significantly more affordable or comprehensive to AI/ANs than employer-sponsored coverage. However, employees are automatically disqualified from tax credit eligibility upon receiving a qualifying offer of coverage from their employer.[15] So, even if a Tribe provides employer-based insurance that is less affordable or comprehensive than a plan available through the individual Marketplace, the mere offer of coverage eliminates the ability of AI/ANs to obtain the tax credits that make the individual plan affordable in the first instance.

Finally, Congress exempted AI/ANs from the ACA's individual mandate out of recognition that AI/ANs are entitled to federal health care benefits and therefore should not be forced to pay for non-IHS coverage. Requiring Tribal employers to provide AI/ANs with such coverage anyway, and penalizing them if they do not, functionally invalidates the AI/AN exemption from the individual mandate by shifting the penalty from the individual to the Tribe itself. This also leaves AI/AN employees with two choices: either accept the coverage and be personally responsible for any applicable employee share of premiums or cost-sharing (again invalidating the individual mandate) or else reject the coverage and lose eligibility for Marketplace tax credits. Under either scenario, the individual AI/AN is "paying" for health coverage.

The following examples illustrate the various ways in which the employer mandate uniquely disadvantages Tribal employers and AI/ANs:

1. **The Tribal employer complies with the employer mandate and offers minimum essential coverage to all employees.**
    a. Tribal employer offers minimum essential coverage to all of its employees, the majority of which are Tribal members.
    b. Due to extremely limited and zero sum nature of Tribal budgets, the Tribe is forced to diminish basic governmental services to make up for the cost of coverage.
    c. In partnership with CCIIO, the Tribe is actively encouraging Tribal members to enroll in the Marketplaces. Tribal members who are employees are disqualified from Marketplace tax credits due to the offer of coverage.
    d. By providing coverage to Tribal member employees, the Tribe is required by proxy to comply with the individual mandate "on behalf" of AI/AN employees, thus nullifying the AI/AN individual mandate exemption.

[14] *See* 26 U.S.C. § 36B(d) (tying tax credit eligibility to modified adjusted gross income); *see also* 43 U.S.C. § 1620; 25 U.S.C. § 1407; 25 U.S.C. § 171b(a) (exempting various AI/AN-specific income from modified adjusted gross income calculation).

[15] 26 U.S.C. § 36B(2)(B); 26 U.S.C. § 5000A(f)(1)(B), (f)(2).

2. **The Tribal employer does not offer health insurance to any employees, and instead pays the "first" employer mandate penalty of $2,000 per employee per year.**[16]
    a. The Tribe does not offer coverage to its employees.
    b. The Tribe must pay $2,000 per employee per year in penalties to the IRS. The Tribe is forced to reduce government services in order to make up for the penalty costs.
    c. Tribal member employees do not have an offer of coverage and can take advantage of premium assistance and AI/AN cost-sharing exemption on the Marketplaces, but the Tribe must "pay" the IRS a penalty in order for those AI/AN employees to qualify for those statutory rights.
    d. Due to the zero sum funding of Tribal governments, the Tribe will be receiving federal funding to provide services to their members and then paying it back to the IRS in the form of an employer mandate penalty.

3. **The Tribal employer offers employees a "low end" plan (high deductible, few covered services, etc.) that satisfies the first employer mandate penalty but not the "second" employer mandate penalty.**[17]
    a. The Tribe purposefully designs its coverage options to result in significantly expensive plans for their employees. The Tribe is liable for payment of the "second" employer mandate penalty if employees go onto the Marketplace and obtain a premium tax credit or cost-sharing reduction.
    b. Tribal member employees are not likely to accept that coverage, as it results in high personal costs and they have a right to care through the IHS system.
    c. Tribal member employees are also not likely to obtain coverage through the Marketplaces, as they have a right to care through the IHS system, thus foregoing their statutory benefits under the ACA.
    d. In order to encourage members to take advantage of Marketplace premium assistance and AI/AN cost-sharing exemptions, the Tribe will have to pay the IRS a penalty of up to $3,000 per Tribal member employee that receives a tax credit or cost-sharing reduction in order to ensure that those members qualify for their statutory benefits.

[16] This penalty applies when (1) an employer offers health coverage to less than 95% of its full-time employees and their dependents in a calendar month, and (2) at least one of the full-time employees then enrolls in a QHP through a Marketplace and receives an advance premium tax credit or cost sharing reduction. 26 U.S.C. § 4980H(a); 26 C.F.R. § 54.4980H–4(a). In such cases, the penalty amount for each applicable month is equal to the number of the employer's full-time employees for the month (subtracted by thirty), multiplied by 1/12 of $2,000. 26 U.S.C. § 4980H(c)(2)(D); 26 C.F.R. § 54.4980H–1(a)(41).

[17] This penalty applies when an employer does offer health coverage to at least 95% of its full-time employees and their dependents, but (1) at least one full-time employee receives a premium tax credit or cost sharing reduction to help pay for coverage in a Marketplace because the coverage was either unaffordable or failed to provide minimum essential coverage. 26 U.S.C. § 4980H(b)(1); 26 C.F.R. §§ 54.4980H–5(e)(1). In such cases, the penalty amount is calculated by taking the number of full-time employees who receive a premium tax credit in a given month and multiplying that amount by 1/12 of $3,000. 26 U.S.C. § 4980H(b)(1); 26 C.F.R. § 54.4980H–1(a)(41).

e. Due to the zero sum funding of Tribal governments, the Tribe will be receiving federal funding to provide services to their members and then paying it back to the IRS in the form of an employer mandate penalty.
f. The Tribe is still responsible for paying for coverage for employees (AI/AN or otherwise) who do enroll in the employer-sponsored plan.

These scenarios underscore the employer mandate's inherent incompatibility with both the unique nature of the Tribal health system and the AI/AN-specific provisions of the ACA.

Applying the mandate in any circumstances results in either a significant diminution in Tribal governmental services, a functional elimination of the AI/AN exemption from the individual mandate, or the disqualification of AI/ANs from their statutorily-established Marketplace benefits and protections. The end result is that the Tribe must either bear the burden of paying for expensive and/or low-quality coverage or else subject itself to significant employer mandate penalties, while the AI/AN employee must choose between accepting whatever coverage is offered and losing tax credit eligibility, remaining uninsured, or having their Tribe "pay" the IRS before they can qualify for the benefits and protections in the Marketplace to which they are legally entitled. This fundamentally undercuts congressional intent in crafting the ACA and requires a Tribal exemption from the mandate.

3. The Employer Mandate Will Be Unaffordable for Tribal Governments.

Compliance with the employer mandate forces Tribes to either absorb the cost of employee health insurance or else pay non-compliance penalties of up to $2,000 per year per full-time employee.[18] Not only is this potentially devastating for Tribes that are already faced with significant financial hardships, but it fails to recognize the fundamental distinction between Tribal employers and private businesses.

It is our understanding that the IRS views the application of the mandate to Tribal employers similarly to that of non-governmental businesses: essentially as a revenue-driven cost-benefit analysis. This is simply not the case in the Tribal context. Tribes are sovereign, governmental entities that are directly responsible for the health and welfare of their people, and are often the only major employers in Tribal territories. Forcing Tribes to pay millions of dollars in penalties – or, alternatively, to purchase costly insurance for Tribal member employees who are otherwise exempt from the individual mandate and eligible for IHS services – will not just affect Tribal business decisions concerning hiring or expansion, but will directly limit their ability to provide basic social, health, safety, and other governmental services on which their members and other reservation residents rely. Tribes cannot "pass on" the costs of compliance by raising prices on goods or services. Tribal governmental funding is a zero sum game, and any funding used to either comply with the mandate or pay the penalties will necessarily come from coffers used to provide what may be the only constituent services for hundreds of miles.

[18] *See generally* 26 C.F.R. §§ 54.4980H–4, H-5.

While it is true that all employers must account for insurance costs when making decisions concerning expansion or hiring, the stakes are comparatively much higher when a Tribe might have to choose between complying with the mandate and funding an adequate reservation police force or other Tribal entity. If applied to Tribal governments, the mandate has the potential to critically undercut Tribal governmental functions.

4. The Internal Revenue Service Should Issue a Regulatory Exemption from the Employer Mandate.

The IRS has previously recognized the burden that the ACA's employer-specific provisions place on Tribal employers: for example, the IRS explicitly excludes "federally recognized Indian tribal governments or . . . any tribally chartered corporation wholly owned by a federally recognized Indian tribal government" from an otherwise-applicable requirement that employers report the cost of coverage under an employer-sponsored group health plan on their employees' W-2 forms.[19] For the reasons discussed above, the IRS should similarly exempt Tribes and Tribal organizations from the employer mandate.

The IRS has the legal authority to issue such an exemption. The ACA's definition of the "applicable large employers" subject to the mandate does not explicitly include Indian Tribes.[20] Statutes of general applicability that interfere with exclusive issues of self-governance, such as the relationship between Tribal employees and on-reservation businesses, generally require "a clear and plain congressional intent" that they apply to Tribes before they will be so interpreted.[21] Although Congress repeatedly referenced Indian Tribes within the ACA,[22] it did not include any such reference in the employer mandate, therefore indicating that the mandate does not apply of its own force to Tribal employers.[23] Because the sole explicit application of

[19] *See* Internal Revenue Service, "Employer-Provided Health Coverage Informational Reporting Requirements: Questions and Answers," *available at* http://www.irs.gov/uac/Employer-Provided-Health-Coverage-Informational-Reporting-Requirements:-Questions-and-Answers (Dec. 19, 2013).

[20] *See* 26 U.S.C. § 4980H(c)(2)(A) (defining the term as "with respect to a calendar year, an employer who employed an average of at least 50 full-time employees on business days during the preceding calendar year").

[21] *E.E.O.C. v. Fond du Lac Heavy Equip. & Const. Co., Inc.*, 986 F.2d 246, 249 (8th Cir. 1993) (Age Discrimination in Employment Act did not apply to employment discrimination action involving member of Indian Tribe, Tribe as employer, and reservation employment); *accord Snyder v. Navajo Nation*, 382 F.3d 892, 896 (9th Cir. 2004) (Fair Labor Standards Act did not apply to dispute between Navajo and non-Navajo Tribal police officers and Navajo Nation over "work [done] on the reservation to serve the interests of the tribe and reservation governance").

[22] *See, e.g.*, Section 1402(d)(2) (referring to health services provided by an Indian Tribe); Section 2901(b) (referring to health programs operated by Indian Tribes); Section 2951(h)(2) (referring to Tribes carrying out early childhood home visitation programs); Section 2953(c)(2)(A) (discussing Tribal eligibility to operate personal responsibility education programs); Section 3503 (discussing Tribal eligibility for quality improvement and technical assistance grant awards).

[23] *See, e.g., Dean v. United States*, 556 U.S. 568, 573 (2009) ("[W]here Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposeful in the disparate inclusion or exclusion.").

the employer mandate to Tribes is found in IRS regulations,[24] the IRS may accordingly promulgate the following standalone exemption in 26 C.F.R. § 54.4980H–2:

> **26 C.F.R. § 54.4980H–2 Applicable large employer and applicable large employer member.**
> **(a) In general.** Section 4980H applies to an applicable large employer and to all of the applicable large employer members that comprise that applicable large employer.
>
> **(b) Determining applicable large employer status—**
>
> . . . .
>
> **(5) Indian Tribes and Tribal Entities.** For the purposes of any penalty or assessment under 26 U.S.C. § 4980H or 26 C.F.R. § 54.4980H, the term "applicable large employer" shall not include any Indian tribe, tribal health program, tribal organization, or urban Indian organization (as defined in 25 U.S.C. § 1603).

III. Conclusion.

We request a meeting to further discuss this issue and ask that the IRS exercise its legal authority to provide categorical relief for Indian Tribes, Tribal organizations, and Urban Indian Organizations from the employer mandate. The ACA employer mandate creates an impossible choice for Tribal governments, forcing them to either pay for the cost of insurance for Tribal member employees who are otherwise exempt from having to obtain coverage, or pay a tax penalty in order to ensure that Tribal member employees qualify for the benefits and protections to which they are entitled by law. The mandate discourages Tribes from facilitating AI/AN Marketplace enrollment, requires Tribes to pay an individual mandate penalty by proxy on behalf of its AI/AN employees, and precludes AI/AN eligibility for tax credits. The mandate also acts as a federal directive that many AI/ANs pay for their health care in circumvention of the trust responsibility. Finally, the mandate is unaffordable for many Tribes, as Tribes will pay for both the penalties and the insurance payments with already-scarce resources that would be far better allocated towards funding direct Tribal services and programs.

Thank you for the opportunity to engage with us on this matter. We stand ready to work with you on any necessary follow up issues and look forward to a continued open dialogue on the employer mandate. NIHB Director of Federal Relations, Devin Delrow (ddelrow@nihb.org), will follow up by phone to secure a mutually acceptable meeting date and time.

Sincerely,

[24] Internal Revenue Service, Shared Responsibility for Employers Regarding Health Coverage; Final Rule, 79 Fed. Reg. 8,544 (Feb. 12, 2014); 26 C.F.R. § 54.4980H–1(a)(23).

Lester Secatero, Chairman,
The National Indian Health Board

Brian Patterson, President
United South and Eastern Tribes, Inc.

Marilynn (Lynn) Malerba
Chief, Mohegan Tribe
Chairwoman, TSGAC

W. Ron Allen, Chairman
Chief, Jamestown S'Kallam Tribe
Chairman, SGCETC

Brian Cladoosby, Chairman
Swinomish Indian Tribal Community
President, NCAI

Sandra Ortega, Councilwoman,
Tohono O'odham Nation
Chair, DSTAC

Attachments:
1. TTAG Strategic Plan, Appendix B [See footnote 5]
2. Rocky Mountain Tribal Leaders Council Resolution and Letter to White House, May 18, 2015
3. NIHB and USET Letter to White House Requesting Relief from Employer Mandate, February 2, 2015

Appendix B: Legal Basis for Special CMS Provisions for American Indians and Alaska Natives

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November 2012

I. Introduction

There is a special relationship between the United States and Indian Tribes that creates a trust responsibility toward Indian people regarding health care. The existence of this truly unique obligation supplies the legal justification and moral foundation for health policy making specific to American Indians and Alaska Natives (AI/ANs) – with the objectives of enhancing their access to health care and overcoming the chronic health status disparities of this segment of the American population.

It is beyond question that the obligation to carry out the trust responsibility to Indians applies to all agencies of the federal government – including the Centers for Medicare & Medicaid Services (CMS) – as evidenced by Presidential Executive Orders and Special Memoranda.[6] Furthermore, with regard to health care for AI/ANs, federal law assigns comprehensive duties to the Secretary of the Department of Health and Human Services (HHS) in order to achieve the goals and objectives established by Congress for Indian health. The trust responsibility, and laws enacted pursuant thereto, provides ample authority for the Secretary – whether acting through the Indian Health Service (IHS), CMS, or other agency of HHS – to take pro-active efforts to achieve the Indian health objectives Congress has articulated.

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[5] The initial version of this Appendix D appeared in the first Strategic Plan submitted to CMS in 2005 by the CMS Tribal Technical Advisory Group. In that submission, the author acknowledged the Northwest Portland Area Indian Health Board (NPAIHB) and its member tribes for their generous support of the author's earlier work which provided foundation for that paper. That earlier paper, titled "The Federal Trust Responsibility: Justification for Indian-Specific Health Policy," was presented at the National Roundtable on the Indian Health System and Medicaid Reform sponsored by the NPAIHB at the Urban Institute on August 31, 2005. This Appendix D has been updated to reflect significant Indian-specific health policy legislative and administrative actions that have occurred since it was originally drafted. The authors would like to thank the United South and Eastern Tribes, Inc. for its generous support in updating this Appendix D.

[6] *See, e.g.,* Exec. Order No. 13175, 65 Fed. Reg. 67249 (Nov. 6, 2000) *reprinted in* 2000 U.S.C.C.A.N. at B77; White House Memorandum for Heads of Executive Departments and Agencies, Nov. 5, 2009; Dep't of Health and Human Services Tribal Consultation Policy (Dec. 14, 2010); Centers for Medicare and Medicaid Services Tribal Consultation Policy (Nov. 17, 2011); *Cramer v. United States,* 261 U.S. 219 (1923).

HHS and CMS both recognize this authority in their tribal consultation policy:

> Since the formation of the Union, the United States (U.S.) has recognized Indian Tribes as sovereign nations. A unique government-to-government relationship exists between Indian Tribes and the Federal Government and this relationship is grounded in the U.S. Constitution, numerous treaties, statutes, Federal case law, regulations, and executive orders that establish and define a trust relationship with Indian Tribes. This relationship is derived from the political and legal relationship that Indian Tribes have with the Federal Government and is not based upon race. This special relationship is affirmed in statutes and various Presidential Executive Orders …[7]

While CMS often looks to the Social Security Act for authority, the historic and complex body of federal Indian law and case law applies throughout the federal government to all agencies, including CMS. The intent of this paper is to provide a brief summary of federal Indian law that is most relevant to current and future regulations and guidance regarding participation of Indians and the Indian health system in Medicare, Medicaid, Child Health Insurance Programs, and health insurance exchanges.

II. The United States has a Trust Responsibility to Indians

A. Origins of the trust responsibility to Indians

The federal trust responsibility to Indians, and the related power to exercise control over Indian affairs in aid of that responsibility, is rooted in the United States Constitution – most significantly the Indian Commerce Clause, the Treaty Clause, and the exercise of the Supremacy Clause.[8] The Constitution contains no explicit language that defines the trust relationship. Rather, the parameters of the trust responsibility have evolved over time through judicial pronouncements, treaties, Acts of Congress, Executive Orders, regulations, and the ongoing course of dealings between the federal government and Indian tribal governments.

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[7] Dep't of Health and Human Services Tribal Consultation Policy (Dec. 14, 2010), at 1; Centers for Medicare and Medicaid Services Tribal Consultation Policy (Nov. 17, 2011), at 1.

[8] *Morton v. Mancari,* 417 U.S. 535, 551-552 (1974) ("The plenary power of Congress to deal with the special problems of Indians is drawn both explicitly and implicitly from the Constitution itself."); *McClanahan v. Arizona State Tax Comm'n,* 411 U.S. 164, 172, n.7 (1973); *see also* TASK FORCE No. 9, VOL. 1, AMERICAN INDIAN POLICY REVIEW COMM'N 31 (1976) (explaining the origins of Constitutional power to regulate Indian affairs as flowing from Congress's treaty making powers, powers to regulate commerce with Indian tribes, and its authority to withhold appropriations); FELIX S. COHEN, HANDBOOK OF FEDERAL INDIAN LAW 418-423 (2005); Reid Payton Chambers, *Judicial Enforcement of the Federal Trust Responsibility to Indians,* 27 STAN. L. REV. 1213, 1215-1220 (1975).

The earliest formal dealings between the federal government and Indian Tribes were undertaken through treaty-making. From the United States' perspective, treaty objectives were essentially two-fold: cessation of hostilities to achieve and maintain public peace, and acquisition of land occupied by tribal members. Tribes doubtless had a peace-making motive as well, but in return for the vast tracts of land they relinquished to the more powerful federal government, Tribes also obtained the promise – expressed or implied – of support for the social, educational, and welfare needs of their people, including health care. These treaties/promises were the first expression of the federal government's obligation to Indian tribes.

The initial express recognition that a trust responsibility existed came from the courts. In the landmark case of *Cherokee Nation v. Georgia,* 30 U.S, 1 (1831), Chief Justice John Marshall established the legal foundation for the trust responsibility by describing Indian Tribes as "domestic dependent nations" whose relationship with the United States "resembles that of a ward to his guardian." *Id.* At 17. That theme – and the duty of the federal sovereign to Indian Tribes – carried forward some 50 years later when, in *United States v. Kagama,* 118 U.S. 375, 384 (1886), the Supreme Court acknowledged that Tribes are under the protection and care of the United States:

> From their very weakness and helplessness, so largely due to the course of dealing of the federal government with them, and the treaties in which it has been promised, there arises the duty of protection, and with it the power [of protection].[9]

Through nearly two centuries of case law, the courts have extensively examined the parameters of the trust responsibility to Indians, frequently in the context of whether the federal government has the authority to perform an action and whether there are limitations on the exercise of Congressional power over Indian affairs. While Congress has plenary authority over Indian matters through the Constitution, the "guardian-ward" relationship articulated by Chief Justice Marshall requires that federal actions be beneficial, or at least not harmful, to Indian welfare. This is not to say, however, that the United States has always acted honorably toward Indians throughout its history.[10] Nonetheless, the fact that our government has failed in some instances to act in an honorable manner

[9] *See also Board of County Commissioners of Creek County v. Seber,* 318 U.S. 705, 715 (1943) ("Of necessity the United States assumed the duty of furnishing . . . protection [to Indian tribes] and with it the authority to do all that was required to perform that obligation . . . .").

[10] An example is unilateral abrogation of Indian treaties by Congress. *See, e.g., Lone Wolf v. Hitchcock,* 187 U.S. 553 (1903).

toward Indians does not and should not absolve the more powerful sovereign from its responsibility to carry out its obligations honorably.

B. "Indian" as a *political* rather than a *racial* classification: Indian-specific lawmaking and the "rationally related" standard of review

In pursuit of its authority under the Constitution and the trust responsibility, Congress has enacted Indian-specific laws on a wide variety of topics[11] as well as included Indian-specific provisions in general laws to address Indian participation in federal programs.[12] In the landmark case of *Morton v. Mancari,* 417 U.S. 535 (1974), the Supreme Court set out the standard of review for such laws – the "rational basis" test. In *Mancari*, the Court reviewed an assertion by non-Indians that the application of Indian preference in employment at the Bureau of Indian Affairs (as ordered in the Indian Reorganization Act[13]) was racially discriminatory under the then-recently amended civil rights law which prohibited racial discrimination in most areas of federal employment.

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[11] *See, e.g.,* Indian Health Care Improvement Act, 25 U.S.C. § 1601, *et seq*.; Indian Self-Determination and Education Assistance Act, 25 U.S.C. §450, *et seq.;* Indian Education Act, 20 U.S.C. §7401, *et seq.;* Tribally Controlled Schools Act, 25 U.S.C. §2501, *et seq.;* Tribally Controlled College or University Assistance Act, 25 U.S.C. §1801, *et seq.;* Native American Housing Assistance and Self-Determination Act, 25 U.S.C. §4101, *et seq.;* Indian Child Welfare Act, 25 U.S.C. §1901, *et seq.;* Indian Child Protection and Family Violence Prevention Act, 25 U.S.C. §3201, *et seq.;* Indian Employment, Training, and Related Services Demonstration Act, 25 U.S.C. §3401, *et seq.*

[12] *See, e.g.,* 42 U.S.C. §1395qq (eligibility of IHS/tribal facilities for Medicare payments); 42 U.S.C. §1396j (eligibility of IHS/tribal facilities for Medicaid payments); 42 U.S.C. §1397bb(b)(3)(D) (assurance of CHIP services to eligible low-income Indian children); Elementary and Secondary Education Act, as amended, 20 U.S.C. §6301, *et seq.* (funding set-asides throughout this law for the benefit of children enrolled in the Bureau of Indian Affairs school system); Impact Aid Program, 20 U.S.C. §7701, *et seq.* (federal aid to public school districts for Indian children living on Indian lands); Carl D. Perkins Vocational and Applied Technology Education Act, 20 U.S.C. §§2326 and 2327 (funding set-aside for Indian vocational education programs and tribal vocational Institutions); Higher Education Act, 20 U.S.C. §1059c (funding for tribally-controlled higher education institutions); Individuals with Disabilities Education Act, 20 U.S.C. §1411(c) (funding set-aside for Bureau of Indian Affairs schools); Head Start Act, 42 U.S.C. §9801, *et seq.* (includes funding allocation for Indian tribal programs and special criteria for program eligibility); Federal Highway Act, 23 U.S.C. §101, *et seq.* (1998, 2005, 2008 and 2012 amendments include funding set-asides for Indian reservation roads programs and direct development of regulations through Negotiated Rulemaking with tribes); American Recovery and Reinvestment Act of 2009, P.L. 111-5 (Feb. 17, 2009) (§5006 making amendments to the Social Security Act to provide various protections for Indians under Medicaid and CHIP, discussed below); Patient Protection and Affordable Care Act, P.L. 111-148 (Mar. 23, 2010) (various Indian specific provisions, discussed below).

[13] 25 U.S.C. §461, *et seq.* The Indian hiring preference appears at 25 U.S.C. §472.

While the Supreme Court's civil rights jurisprudence has generally applied strict scrutiny when reviewing classifications based on race, color, or national origin,[14] in *Mancari* the Court determined that this test was not appropriate when reviewing an Indian employment preference law. Indeed, the Court declared that the practice under review was not even a "racial" preference. Rather, in view of the unique historic and political relationship between the United States and Indian Tribes, the Court characterized the preference law as *political* rather than *racial,* and said that "[a]s long as the special treatment [for Indians] can be tied rationally to the fulfillment of Congress' unique obligation toward the Indians, such legislative judgments will not be disturbed." *Id.* At 555. The Court found that hiring preferences in the federal government's Indian service were intended *"to further the Government's trust obligation toward the Indian tribes,"* to provide greater participation in their own self-government, and "to reduce the negative effect of having non-Indians administer matters that affect Indian tribal life" in agencies, such as the BIA, which administer federal programs for Indians. *Id.* At 541-542 (emphasis added).[15]

Once the link between special treatment for Indians as a political class and the federal government's unique obligation to Indians is established, "ordinary rational basis scrutiny applies to Indian classifications just as it does to other non-suspect classifications under equal protection analysis." *Narragansett Indian Tribe v. National Indian Gaming Comm'n.,* 158 F.3d 1335, 1340 (D.C. Cir. 1998).

The Indian hiring preference sanctioned by the Court in *Mancari* is only one of the many activities the Court has held are rationally related to the United States' unique obligation toward Indians. The Court

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[14] The Supreme Court has interpreted Title VI to allow racial and ethnic classifications only if those classifications are permissible under the Equal Protection Clause. *Regents of Univ. of Cal. v. Bakke,* 438 U.S. 265, 287 (1978). In this regard, the Court has also stated that "all racial classifications, imposed by whatever federal, state, or local governmental actor, must be analyzed by a reviewing court under strict scrutiny. In other words, such classifications are constitutional only if they are narrowly tailored measures that further compelling governmental Interests." *Adarand Constructors, Inc. v. Pena,* 515 U.S. 200, 227 (1995).

[15] Indian Preference provisions are not limited to the BIA, and have been applied in a variety of federal programs for the benefit of Indians. Section 7 of the Indian Self Determination Act, for example, establishes a broad federal policy of providing hiring, training, and contracting preferences for Indians in contracts or grants with Indian organizations across all federal agencies. 25 U.S.C. § 450e(b). Indian preference provisions are also found in other statutes. *See, e.g.,* 42 U.S.C. § 9839(h) (establishing an Indian hiring preference at American Indian Programs Branch of Head Start Bureau); 20 U.S.C. § 3423c(c) (establishing an Indian employment preference in the Office of Indian Education in the Department of Education). *See also Preston v. Heckler,* 734 F.2d 1359 (9th Cir. 1984) (Indian Preference Act requires Secretary of HHS to adopt standards for evaluating qualifications of Indians for employment in the Indian Health Service that are separate and independent from general civil service standards).

has upheld a number of other activities singling out Indians for special or preferential treatment, *e.g.,* the right of for-profit Indian businesses to be exempt from state taxation, *Moe v. Confederated Salish & Kootenai Tribes,* 425 U.S. 463, 479-80 (1976); fishing rights, *Washington v. Washington State Commercial Passenger Fishing Vessel Ass'n,* 443 U.S. 658, 673 n.20 (1979); and the authority to apply federal law instead of state law to Indians charged with on-reservation crimes, *United States v. Antelope,* 430 U.S. 641, 645-47 (1977). The Court in *Antelope* explained its decisions in the following way:

> The decisions of this Court leave no doubt that federal legislation with respect to Indian tribes, although relating to Indians as such, *is not based upon impermissible racial classifications.* Quite the contrary, classifications singling out Indian tribes as subjects of legislation are expressly provided for in the Constitution and supported by the ensuing history of the Federal Government's relations with Indians.

Antelope, 430 U.S. at 645 (emphasis added).

The courts continue to acknowledge the special political status of Indians and to uphold legislation singling out Indians on that basis. *See, e.g.*, *Am. Fed'n of Gov't Employees, AFL-CIO v. United States*, 330 F.3d 513, 522-23 (D.C. Cir. 2003) (finding outsourcing preference for Indian-owned firms was rationally related to the legitimate legislative purpose of promoting the economic development of federally recognized Tribes and their members); *United States v. Wilgus*, 638 F.3d 1274, 1287-88 (10th Cir. 2011) (upholding exception to the Bald Eagle Protection Act for Indian tribal members to possess eagle feathers).

III. Congress's Recognition of the Federal Trust Responsibility in Health Laws

Since the early part of the 20th century, Congress has enacted a number of laws that authorize, direct, and fund the provision of health care services to Indian people.[16] Here we focus on the most significant legislative enactments intended to ensure access of Indian people to federally-assisted health care programs and to enhance the viability of Indian Health Service and tribal programs that serve the Indian population.

A. The Indian Health Care Improvement Act

[16] *See, e.g.,* Snyder Act, 25 U.S.C. § 13; Johnson-O'Malley Act, 25 U.S.C. § 452; Transfer Act, 42 U.S.C. § 2001, *et seq.* (transferred responsibility for Indian health to Public Health Service); annual appropriations to the Indian Health Service included in the Interior and Related Agencies Appropriations Acts.

The Indian Health Care Improvement Act (IHCIA)[17] was originally enacted in 1976 as Public Law 94-437. It brought statutory order and direction to the delivery of federal health services to Indian people. Its legislative history catalogued the deplorable conditions of Indian health that demanded legislative attention: inadequate and under-staffed health facilities; improper or non-existent sanitation facilities; prevalence of disease; poor health status; inadequate funding;[18] low enrollment of Indians in Medicare, Medicaid, and Social Security; serious shortage of health professionals, including Indian health professionals; and the need for health care for Indian people who had moved from reservations to urban areas. The legislation addressed each of these deficiencies through focused titles: Manpower; Health Services; Health Facilities (including sanitation facilities); Access to Medicare and Medicaid; Urban Indian Health; and a feasibility study for establishing an American Indian School of Medicine.[19]

The IHCIA has been periodically reauthorized and amended since 1976. In 2010, the law was comprehensively amended and authorized as a permanent law of the United States.[20] Throughout its history, the IHCIA has contained an unequivocal recognition of the United States' responsibility to improve the health of Indian people, to provide federal health services to this population, and to foster maximum Indian participation in health care program management. The 2010 amendments reiterated and reinforced these federal commitments through the following provisions:

> **Congressional Findings**
> The Congress finds the following:
> (1) Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people.
> (2) A major national goal of the United States is to provide the resources, processes, and structure that will enable Indian tribes and tribal members to obtain the quantity and quality of health care services and

[17] 25 U.S.C. §1601*, et seq.* The Indian Health Care Improvement Act was amended and permanently reauthorized by Section 10221 of the Patient Protection and Affordable Care Act, P.L. 111-148 (Mar. 23, 2010).

[18] The House Interior and Insular Affairs Committee noted that per capita spending on Indian health in 1976 was 25 percent less than the average American per capita amount. H.R. REP. No. 94-1026, pt. I, at 16 (1976), *reprinted in* 1976 U.S.C.C.A.N. 2652, 2655. According to the U.S. Commission on Civil Rights, IHS per capita spending for Indian medical care in 2003 was 62 percent lower than the U.S. per capita amount. U.S. Commission on Civil Rights, *Broken Promises: Evaluating the Native American Health Care System* (Sept. 2004), at 98.

[19] The IHCIA was later amended to include formal establishment of the Indian Health Service as an agency of DHHS. Pub. L. No. 100-713 (1988). The IHS establishment is codified at 25 U.S.C. § 1661.

[20] Sec. 10221 of the Patient Protection and Affordable Care Act, P.L. 111-148 (Mar. 23, 2010).

opportunities that will eradicate the health disparities between Indians and the general population of the United States.

(3) A major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level and to encourage the maximum participation of Indians in the planning and management of those services.

(4) Federal health services to Indians have resulted in a reduction in the prevalence and incidence of preventable illnesses among, and unnecessary and premature deaths of, Indians.

(5) Despite such services, the unmet health needs of American Indian people are severe and the health status of the Indians is far below that of the general population of the United States.[21]

Declaration of National Indian Health Policy

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 and allied and associated health professions awarded to Indians so that the proportion of Indian health professions in each Service are is raised to at least the level of that of the general population;

(5) to require that all actions under this chapter shall be carried out with active and meaningful consultation with Indian tribes and tribal organizations, and conference with urban Indian organizations, to implement this chapter 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.[22]

It is important to note that these expressions of policy, obligation, and objectives apply to the federal government as a whole. The Act reposes responsibility for their implementation in the Secretary of Health and Human Services. While the Indian Health Service has first-line responsibility for administering the Indian health system, the Secretary of HHS remains the official with ultimate responsibility to see that programs are performed as directed and the objectives established by Congress are achieved. Thus, the obligation to exercise the trust responsibility for Indian health, to implement the expressed policies, and to achieve the stated goals extend to the Centers for Medicare & Medicaid Services, as an agency of HHS.

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[21] 25 U.S.C. §1601.

[22] 25 U.S.C. §1602.

B. Statutory Authority for Participation in Medicare and Medicaid

In the 1976 IHCIA, Congress amended the Social Security Act to extend to Indian health facilities the authority to collect Medicare and Medicaid reimbursements. Prior to these amendments, the IHS, as a federal agency, was not permitted to claim reimbursements from Medicare and Medicaid.

- Sec. 1880[23] made IHS hospitals (including those operated by Indian Tribes[24]) eligible to collect Medicare reimbursement.
- Sec. 1911[25] made IHS and tribal facilities eligible to collect reimbursements from Medicaid
- An amendment to Sec. 1905(b)[26] applied a 100 percent federal medical assistance percentage (FMAP) to Medicaid services provided to an Indian by an IHS or tribally-operated facility.

Sections 1880 and 1911 were intended to bring additional revenue into the Indian health system in order to address the deplorable condition of Indian health facilities, many of which were in such a poor state they were unable to achieve accreditation. The application of a 100 percent FMAP to the Medicaid-covered services provided by these facilities was made in express recognition of the federal government's treaty obligations for Indian health. The Committee of jurisdiction observed that since the United States already had an obligation to pay for health services to Indians as *IHS beneficiaries*, it was appropriate for the U.S. to pay the full cost of their care as *Medicaid beneficiaries*.[27] This action is consistent with the status of AI/ANs as a *political* designation.

Through amendments to Sec. 1880 made in 2000, 2003 and 2010, IHS and tribal hospitals and clinics are authorized to collect reimbursements for all Medicare Part A and Part B services. As health care

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[23] 42 U.S.C. §1395qq.

[24] Tribes and tribal organizations are authorized to operate IHS-funded hospitals and clinics through contracts and compacts issued pursuant to the Indian Self-Determination and Education Assistance Act, 25 U.S.C. § 450, *et seq.*

[25] 42 U.S.C. §1396j.

[26] 42 U.S.C. §1396d(b).

[27] H.R. REP. No. 94-1026, pt. III, at 21 (1976), as reprinted in 1976 U.S.C.C.A.N. 2782, 2796.

providers, IHS and tribal health programs are authorized to collect reimbursements under Medicare Parts C and D, as well.[28]

C. Statutory Authority for Participation in CHIP

IHS and tribal health providers are authorized to collect payments when providing services to individuals enrolled in the Children's Health Insurance Program (CHIP).[29] To assure that low-income Indian children who are CHIP-eligible are not overlooked, Congress, when creating the program in 1997, expressly required States to describe in their State plans the procedures they will use to assure access for these children.[30]

D. Indian-Specific Provisions Designed to Ensure Indian Access to Medicaid, Medicare and CHIP

Since early 2009, Congress has added several significant provisions to Titles XIX and XXI of the Social Security Act that give voice to the federal government's unique responsibility to Indian people and the need to remove barriers to their participation in Medicaid and CHIP, especially when AI/ANs eligible for those programs receive services from Indian health providers. We highlight these actions below.

- *Proof of Citizenship for Medicaid Enrollment.* In the Deficit Reduction Act of 2005 (DRA), Congress directed that on and after July 1, 2006, persons who apply to enroll or renew enrollment in Medicaid must provide documentary proof of identity and U.S. citizenship, and identified the types of documents that would be acceptable proof. Indian health advocates feared – correctly, as it turns out – that many AI/ANs would not possess sanctioned documentation of their status as U.S. citizens. Recognizing the barrier this presented for Indian access to Medicaid and CHIP, in 2009 Congress amended these requirements to designate documents issued by a federally-recognized Indian Tribe evidencing an individual's membership, enrollment in, or affiliation with such Tribe as satisfactory evidence of U.S.

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[28] In fact, Congress expressly authorized the Secretary of HHS to issue standards to assure access by pharmacies operated by the IHS, tribes and urban Indian organizations to the Medicare Part D prescription drug benefit (42 U.S.C. §1395w-104(b)(1)(C)(iv)), and required the Secretary to establish procedures (including authority to waive requirements) to assure participation by these pharmacies in the transitional assistance feature of the temporary discount drug program. 42 U.S.C. §1395w-141(g)(5)(B). Congress added language in the Affordable Care Act to allow Indian patients to qualify for the catastrophic coverage phase of the Part D program. 42 U.S.C. §1395w–102(b)(4)(C).

[29] 42 U.S.C. §2105(c)(6)(B); *see also* 25 U.S.C. §1647a.

[30] 42 U.S.C. §2103(a)(3)(D).

citizenship.[31] Significantly, Congress gave tribal documentation "tier I" status – the same as a U.S. passport. Individuals presenting tribal affiliation documentation would not be required to present any additional identity documentation.

This legislative action recognizes not only the historic reality that Indian people were the original occupants of the North American continent, it also implements in the clearest possible way the policy of maintaining a government-to-government relationship with Indian Tribes. It also demonstrates respect for the sovereignty of Tribes both to determine tribal membership and to issue legal documents. As a practical matter, amending the law to order acceptance of tribal documentation underscores Congress's recognition of its continued responsibility to enact Indian-specific legislation when needed to assure full access to federal programs.

- *Medicaid Premium and Cost-Sharing Protections*. Pursuant to an amendment to Medicaid made in 2009, States are prohibited from imposing any premium or cost-sharing on an Indian for a covered service provided by the IHS, a health program operated by an Indian Tribe, Tribal Organization or urban Indian organization, or through referral under contract health services.[32]

- *Disregard of Certain Indian Property from Resources for Medicaid and CHIP Eligibility.* In 2009, Congress amended the Medicaid and CHIP laws to exempt from the resources calculation certain enumerated types of Indian property. Primarily, the excluded property is of a type that flows to an individual Indian by virtue of his/her membership in a Tribe.[33]

- *Medicaid Estate Recovery Protections*. In an express endorsement of a provision in the CMS State Medicaid Manual, in 2009 Congress statutorily exempted certain Indian-related income, resources and property held by a deceased Indian from the Medicaid estate recovery

[31] 42 U.S.C. §1396b(x)(3)(B), as added by Sec. 211 of the Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3) (Feb. 4, 2009).

[32] 42 U.S.C. §§1396o(j) and 1396o-1(b)(3)(vii), as added by Sec. 5006(a) of the American Recovery and Reinvestment Act of 2009 (P.L. 111-5) (Feb. 17, 2009). In recognition of the trust responsibility, Indian children have been exempt from cost-sharing in the CHIP program pursuant to regulation at 42 C.F.R. §457.535.

[33] 42 U.S.C. §§1396a(ff) and 1397gg(e)(1)(H), as added by Sec. 5006(b) of the American Recovery and Reinvestment Act of 2009 (P.L. 111-5) (Feb. 17, 2009).

requirement.[34] The objective of the Manual and statutory protection was to remove a disincentive to enrollment for Indian people eligible for Medicaid.

- *Special Indian-specific Rules for Medicaid Managed Care*. In 2009, Congress removed several barriers to full and fair participation of Indian people and Indian health providers in Medicaid programs operated through managed care entities. This gave an Indian Medicaid enrollee the option to select an Indian health program as his/her primary care provider, and directed that Indian health providers (IHS, tribal, and urban Indian organization programs) be paid at a rate not less than that of the managed care entity's network provider.[35] These changes were needed to overcome the reluctance of managed care entities to admit Indian health providers to their networks and to reimburse them for services provided to Indian Medicaid enrollees.

- *Authority for Tribal Medicaid Administrative Match*. Federal funds may not be used to meet State matching requirements, except as authorized by Federal law. In 2005, CMS issued a State Medicaid Director letter that permits Indian Tribes and Tribal Organizations to certify funds received under the Indian Self-Determination and Education Assistance Act as public expenditures to be used as the non-Federal share of expenditures to fulfill State matching requirements for administrative claiming activities under the Medicaid program. These activities include, among other things, outreach and application assistance for Medicaid enrollment and activities that ensure appropriate utilization of Medicaid services by Medicaid beneficiaries.

E. Solicitation of Input from Indian Health Programs.

In recognition of the need to assure that impacts on the unique Indian health system by proposed changes in Medicare, Medicaid, and CHIP are fully evaluated, Congress placed in the Social Security Act a requirement for prior notice to and solicitation of input from IHS, tribal health programs, and urban

[34] 42 U.S.C. §1396p(b)(3)(B), as added by Sec. 5006(c) of the American Recovery and Reinvestment Act of 2009 (P.L. 111-5) (Feb. 17, 2009).

[35] 42 U.S.C. §1396u-2(h), as added by Sec. 5006(d) of the American Recovery and Reinvestment Act (P.L. 111-5) (Feb. 17, 2009).

Indian organizations. On the federal level, this requirement is to be carried out by CMS through maintenance of the Tribal Technical Advisory Group originally chartered by the agency in 2003.[36]

States are required to solicit advice from IHS and tribal health programs and urban Indian organizations within their borders prior to submission of any state plan amendments, waiver requests, and demonstration projects to CMS.[37]

F. Cap on Rates Charged for Contract Health Services.

Modeling on the Medicare Provider Agreement provision that caps the amount a hospital can charge for services purchased by the Department of Veterans Affairs, in 2003 Congress enacted a similar limitation on the amount a Medicare participating hospital may charge for services purchased by Indian health programs operated by the IHS, Tribes, and Tribal Organizations, and urban Indian organizations (I/T/Us). As a condition for participation in Medicare, such hospitals must accept patients referred by I/T/Us in accordance with the admission practices, payment methodology, and payment rates set forth in Secretarial regulations, and may accept no more than the payment rates set by the Secretary.[38] This statutory rate cap is often referred to by the shorthand "Medicare-like rates."

In regulations issued by IHS and CMS in 2007, the maximum amount a Medicare hospital is permitted to accept for a service purchased by an I/T/U is the applicable Medicare rate.[39]

These statutory and regulatory actions are intended to enable I/T/Us to achieve greater economies for the services they must purchase for their Indian patients with funds appropriated for contract health services.

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[36] 42 U.S.C. §1320b-24, as added by Sec. 5006(e)(1) of the American Recovery and Reinvestment Act (P.L. 111-5) (Feb. 17, 2009). The maintenance of the Tribal Technical Advisory Group does not substitute for government-to-government consultation with tribes.

[37] 42 U.S.C. §§1396a(a)(73) and 1397gg(e)(1)(C), as added by Sec. 5006(e)(2) of the American Recovery and Reinvestment Act (P.L. 111-5) (Feb. 17, 2009).

[38] 42 U.S.C. §1395cc(a)(1)(U), as added by the Medicare Modernization Act of 2003 (P.L. 108-173).

[39] 72 Fed. Reg. 30706 (June 4, 2007), adding Subpt. D to 42 C.F.R. Part 136, and adding §489.29 to 42 C.F.R. Part 489. These regulations became effective on July 5, 2007.

G. Indian-Specific Provisions Designed to Ensure Indian Access to the Health Insurance Exchanges

The Patient Protection and Affordable Care Act (ACA) was enacted by Congress in 2010 in order to reform the health insurance market and make health insurance more accessible and affordable for all Americans. It imposes a responsibility on most Americans to acquire or maintain health insurance coverage, and contains a number of provisions intended to strengthen health insurance consumer protections and enhance the health care workforce. Congress included a number of provisions designed to ensure that Indians could take advantage of the new reforms. We highlight several of these below.

- *Exemption from Penalty for Failure to Comply with the Individual Mandate*. Although Congress designed the law to make nearly all Americans responsible for acquiring or maintaining acceptable levels of health insurance coverage, Congress specifically exempted members of Indian Tribes from the tax penalty for failure to obtain acceptable coverage.[40] This provision is based on the theory that the United States is responsible for providing health care to Indians, but it has failed to supply an acceptable package of benefits through the Indian Health Service. Having failed in that responsibility, it would violate the trust responsibility to require Indians to pay for non-IHS coverage or be assessed a tax penalty for failing to do so.

- *Cost-Sharing Protections for Indians Enrolled in a Health Insurance Exchange Plan*. The Affordable Care Act prohibits assessment of any cost-sharing for any service provided by an Indian health provider to an AI/AN enrolled in an Exchange plan. Furthermore, no cost sharing may be assessed by non-Indian health providers to an AI/AN enrolled in such a plan if the individual receives services through an Indian health provider or through contract health services. Indians with income below 300 percent of the Federal Poverty Level do not have cost sharing in the private sector even if they do not have a referral from an Indian health provider. The Secretary of HHS is responsible for paying the Exchange plan the additional actuarial cost that results from these cost-sharing protections.[41]

- *Special enrollment periods for AI/AN*. The ACA provides special enrollment periods for AI/ANs for health insurance exchanges. This is another measure to provide access to this important source of funding for the I/T/U.

[40] 26 U.S.C. §5000A(e)(3).

[41] 42 U.S.C. §18071(d).

These provisions are designed to reduce the costs for AI/ANs to access the Exchange plans and to provide incentives for them to do so, as well as to increase the likelihood that I/T/Us will receive payments from health insurance exchange plans for services they provide to AI/Ans.

IV. Executive Branch Recognition of the Federal Trust Responsibility in Administering Federal Health Programs

A. Executive Branch Administration of the Trust Responsibility

The Executive Branch is responsible for carrying out the federal trust responsibility to provide health care to Indians. The federal government's general trust duty to provide social services and its duty as a trustee to protect and manage Indian trust property are different types of duties and thus are treated differently by the courts.[42] Courts have generally been reluctant to impose liability for the federal government's failure to provide social services under the general trust relationship.[43] One notable exception is the case of *Morton v. Ruiz*[44] where the Supreme Court said the Bureau of Indian Affairs erred in refusing to provide welfare benefits to unemployed Indians who lived off, but near, their reservation. The Court reiterated that the "overriding duty of our Federal Government [is] to deal fairly with Indians wherever located", and that BIA's failure to publish eligibility criteria through Administrative Procedure Act regulations was not consistent with the "distinctive obligation of trust incumbent upon the Government in its dealings" with Indians.[45]

The IHCIA policy statements quoted above expressly recognize a trust responsibility to maintain and improve the health of Indians, and establish a national policy to assure the highest possible health status to Indians, as well as to provide all resources necessary to effect that policy. While currently there may be no available mechanism to enforce these policies judicially, this does not make them meaningless. They establish the goals, which the Executive Branch – particularly the Department of Health and Human Services – must strive to achieve as it implements federal law. In fact, they justify – indeed, require – the Executive Branch to be proactive and use its resources "to assure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect

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[42] *Seminole Nation v. United States*, 316 U.S. 286, 297 (1942).

[43] *See, e.g., Gila River Pima-Maricopa Indian Community v. U.S.,* 427 F.2d 1194 (Ct.Cl. 1970), *cert. denied.* 400 U.S. 819 (1970).

[44] 415 U.S. 199 (1974).

[45] *Id.* at 236. *See also* Chambers, note 2, *supra,* at 1245-46 (arguing that courts should apply the trust responsibility as a "fairness doctrine" in suits against the United States for breach of a duty to provide social services).

that policy." 25 U.S.C. §1602(1). The Executive Branch has a dual duty – to carry out the policy established by Congress in federal law, and to perform the United States' trust responsibility to Indians in accord with the Congressionally-established standard.

Indian people take the United States at its word when reading the policy statement in the IHCIA, and have a right to expect its trustee to achieve the goal of assuring them the highest possible health status. As stated by Justice Black in his lament over the U.S. breaking faith with Indians, "Great nations, like great men, should keep their word."[46]

B. CMS Administration of the Trust Responsibility

As part of DHHS, and as an agency required to implement statutory provisions intended to benefit Indian health, CMS should affirmatively advance policy objectives as set out by Congress in the IHCIA when making Indian-related decisions in the Medicare and Medicaid programs. The trust responsibility and the federal laws enacted to carry it out not only permit CMS to treat AI/ANs served by the Indian health system as unique Medicare and Medicaid consumers entitled to special treatment, they require it.

CMS shares the responsibility to carry out the policy goals established by Congress in the IHCIA. Both the HHS and CMS tribal consultation policies recognize "the unique government to government" relationship between the United States and Tribes, as well as the trust responsibility "defined and established" by "the U.S. Constitution, numerous treaties, statutes, Federal case law, regulations, and executive orders."[47] One manifestation of this trust responsibility is CMS's recognition that "CMS and Indian Tribes share the goals of eliminating health disparities for American Indians and Alaska Natives (AI/AN) and of ensuring that access to Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and Exchanges is maximized."[48] Through its consultation policy, CMS has committed to consulting with Indian Tribes when developing policy that may affect Indians.

CMS has exercised its authority to administer federal health care programs and interpret the statutes within its jurisdiction in a manner that assures access by Indian people and participation by the unique Indian health delivery system. In recent decades, CMS (previously HCFA) has taken steps to carry out

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[46] *Federal Power Comm'n v. Tuscarora Indian Nation,* 362 U.S. 99, 142 (1960) (Black, J., dissenting),

[47] Centers for Medicare & Medicaid Services Tribal Consultation Policy (Nov. 17, 2011), at 1; U.S. Dep't of Health and Human Services Tribal Consultation Policy (Dec. 14, 2010), at 1.

[48] Centers for Medicare & Medicaid Services Tribal Consultation Policy (Nov. 17, 2011), at 2.

the trust responsibility to Indians in its administration of the Medicare, Medicaid, and CHIP programs. Each was a rational exercise of the agency's authority and fully justified by the United States' special obligations to Indian Tribes.

A summary of these actions follows:

- *Authority for Tribal Facilities to Bill Medicaid at the Same Rate as IHS Facilities*. In 1996, through a Memorandum of Agreement with IHS, HCFA re-interpreted the term "facility of the Indian Health Service" in Section 1911 (Medicaid) to allow a tribally-owned facility operated under an ISDEAA agreement to elect designation as a "facility of the Indian Health Service." Previously, HCFA had interpreted the term "facility of the Indian Health Service" to include only facilities actually owned or leased by IHS. The MOA enabled these tribally-owned facilities to bill Medicaid at the annually-established Medicaid billing rates for IHS facilities and applied the 100 percent FMAP to Medicaid services provided by such facilities.

- *Exemption of IHS and Tribal Clinics from the Outpatient Prospective Payment System*. In 2002, the Director of the Center for Medicare agreed to continue the exemption of IHS and tribal clinics from the Outpatient Prospective Payment System.

- *CMS has Broadly Defined the Hospital Services that are Subject to the Medicare-like Rates Cap*. In 2007, CMS issued regulations implementing Section 506 of the Medicare Modernization Act to require all Medicare-participating hospitals to accept Medicare-like rates when providing services to I/T/U beneficiaries. The final regulations broadly defined hospital and critical access hospital services subject to the rule to include inpatient, outpatient, skilled nursing facilities, and any other service or component of a hospital. 42 C.F.R. §136.30; 42 C.F.R. §489.29.

- *IHS and Tribal Facility Participation in Medicaid*. The 1996 IHS/HCFA MOA incorporated the regulatory policy that states must accept as Medicaid providers IHS facilities that meet state requirements, but these facilities are not required to obtain a state license. 42 C.F.R. §431.110. Thus, it applied this regulatory policy to tribally-owned facilities. Congress converted this policy into law for all federally-funded health programs serving AI/AN in the 2010 amendments to the Indian Health Care Improvement Act.[49]

[49] 25 U.S.C. §1647a.

- *Cost-Sharing Protections for Indian Children in CHIP*. In 1999, HCFA issued guidance, followed by a proposed rule, that prohibits states from imposing any cost-sharing on AI/AN children under CHIP, citing the unique federal relationship with Indian Tribes. This rule was subsequently promulgated in final form. 42 C.F.R. §457.535. This HCFA regulation reflects the agency's interpretation of how best to carry out the statutory provision requiring states to demonstrate how they will assure CHIP access for eligible Indian children. 42 U.S.C. §1397bb(b)(3)(D). In 2000, HCFA announced that the policy prohibiting cost sharing for Indian children under CHIP would be extended to Section 1115 Medicaid demonstration projects and stated the agency would no longer approve Section 1115 projects that impose such cost-sharing. 66 Fed. Reg. 2490, 2526 (Jan. 11, 2001).

- *State-Tribal Consultation on Medicaid Programs*. In 2001, CMS issued a policy statement that requires states to consult with Tribes within their borders on Medicaid waiver proposals and waiver renewals before submitting them to CMS.[50] Congress subsequently made this consultation requirement statutory, adding State Plan Amendments and demonstration projects as requisite subjects of tribal consultation.[51] CMS informed the States of this consultation requirement on several occasions and codified the 2001 policy statement.[52] In May of 2012, CMS announced that it would not accept the waiver applications submitted by New Mexico and Kansas until they met the tribal consultation requirements.

- *CMS Tribal Technical Advisory Group*. In 2003, CMS chartered a Tribal Technical Advisory Group comprised of tribal officials and tribal employees to advise the agency on Medicare, Medicaid, and CHIP issues that impact Indian health programs. CMS's foresight was met with approval by Congress, which granted the TTAG explicit statutory status in 2009 and added representatives of the IHS and urban Indian organizations to the TTAG's membership. 42 U.S.C. §1320b-24.

- *Indian Health Addendum Required for Medicare Part D Pharmacy Contracts.* When implementing the Medicare Part D drug benefit, CMS recognized that special terms and conditions in pharmacy contracts would be needed to assure that IHS, tribal, and urban Indian

[50] Letter from Health Care Fin. Admin. To State Medicaid Directors (July 17, 2001) http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd071701.pdf.

[51] 42 U.S.C. §§1396a(a)(73) and 1397gg(e)(1)(C), as added by Sec. 5006(e)(2) of the American Recovery and Reinvestment Act (P.L. 111-5) (Feb. 17, 2009).

[52] CMS SMD #09-003 (June 17, 2009); CMS SMDL #10-001 (Jan. 22, 2010); 77 Fed. Reg. 11678 (Feb. 27, 2012).

organization pharmacies would be able to participate in the Part D program. The agency requires Part D plans to include the CMS-approved text of an Indian Health addendum in contracts offered to those pharmacies. 42 C.F.R. §423.120(a)(6). The addendum addresses several aspects of federal law and regulations applicable to those pharmacies, such as Federal Tort Claims Act coverage (obviating the need for privately-purchased professional liability insurance).[53]

- *Approval of Indian-specific State Medicaid Plan Provision*. In April of 2012, CMS approved an Arizona Medicaid waiver request through which several optional Medicaid services can continue to be covered at IHS and tribal facilities, although they are otherwise discontinued from coverage in the State's plan. When these services are provided to Indian patients at IHS and tribal facilities, the 100 percent FMAP continues to apply. This action is a significant acknowledgement by CMS that it has the authority and the obligation to carry out its trust responsibility for Indian health.

Carrying out the trust responsibility to Indians in these and other ways coincides with and compliments CMS's stated program objectives.

V. The Unique Nature of the Indian Health System

The IHS-funded system for providing health services to AI/ANs is one-of-a kind; it is unlike any other mainstream health delivery system. In fact, the federal government created and designed the system in use today for the specific purpose of serving Indian people in the communities in which they live. Overall, the Indian health programs have a community-based approach and seek to provide culturally-appropriate services. As demonstrated in this Plan, the IHS system was created for Indian people as a political class, not as a racial group. These circumstances require unique rules and policies from CMS to enable IHS-funded programs to fully access Medicare, Medicaid, and CHIP and to achieve the agency's health disparities elimination objective.

We outline below some of the unique circumstances of this health system and of Indian Tribes that have been established or recognized by federal law and regulations:

- *Limited service population.* The IHS health care system is not open to the public. It is established to serve AI/AN beneficiaries who fall within the eligibility criteria established by the

[53] The text of the Addendum is included in the Medicare program's solicitation for applications for new cost plan sponsors. *See, e.g.*, "Medicare Prescription Drug Benefit, Solicitation for Applications for New Cost Plan Sponsors, 2012 Contract Year," at 131.

IHS. *See* 42 C.F.R. §136.12.[54] The IHS estimates the service population served by IHS and tribally-operated programs in more than 30 states is approximately 2.1 million AI/Ans.

- *No cost assessed to patients*. IHS serves AI/AN beneficiaries without cost. For several years, Congress reinforced this policy with language in the annual IHS appropriations act that prohibited the agency to charge for services without Congressional consent.[55] IHS services at no cost to the Indian patient remains IHS policy today. Some members of Congress have described the IHS as a pre-paid health plan – pre-paid with land ceded by Tribes to the U.S. government.

- *Indian preference in employment*. Indian preference in hiring applies to the Indian Health Service. 42 C.F.R. §136.41-.43.[56] Such preference also applies to tribally-operated programs through the requirement that, to the greatest extent feasible, preference for training and employment must be given to Indians in connection with administration of any contract or grant authorized by any federal law to Indian organizations or for the benefit of Indians. 25 U.S.C. §450e(b).

- *Only Tribes have rights under ISDEAA*. Indian Tribes (and Tribal Organizations sanctioned by one/more Tribes) – and only those entities – can elect to directly operate an IHS-funded program through a contract or compact from the Indian Health Service issued pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA). 25 U.S.C. §450 *et seq.* The tribal operator receives the program funds the IHS would have used and additional funding for administrative costs. A tribal operator directly hires its staff and has the authority to re-design the program(s) it offers.

- *Federal Tort Claims Act coverage*. Pursuant to federal law, tribal health programs and their employees are covered by the Federal Tort Claims Act (FTCA). 25 U.S.C. §450f, note. For this

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[54] Under certain circumstances non-Indians connected with an Indian beneficiary (such as minor children and spouses) can receive services as beneficiaries. Other non-Indians may receive services in carefully defined circumstances, but are liable for payment. *See* 25 U.S.C. §1680c.

[55] *See, e.g.,* Pub. L. No. 104-134, 110 Stat. 1321-190 (April 26, 1996).

[56] *See also Preston v. Heckler*, 734 F.2d 1359 (9th Cir. 1984) (upholding the Indian Health Service's Indian employment preference).

reason, it is often unnecessary for Tribes to purchase liability insurance for the health services they operate with federal funding.

- *Use of HHS personnel*. To help staff their programs, Tribes and Tribal Organizations are authorized by law to utilize employees of HHS under Intergovernmental Personnel Act assignments and commissioned officers of HHS under Memoranda of Agreement. 25 U.S.C, §450i.

- *Creation of specific health care providers*. Federal law has created health care delivery providers found only in the Indian health care system. *See* Community Health Representative Program, 25 U.S.C. §1616; Community Health Aide Program (CHAP) for Alaska, 25 U.S.C. §1616*l*. The Alaska Medicaid Plan reimburses Indian health programs for covered services provided by CHAPs in Alaska. Through a 2010 amendment to the IHCIA, the Secretary is authorized to implement a CHAP program for Tribes in the lower 48 states.

- *IHS as payer of last resort.* A longstanding IHS regulation makes IHS programs the payer of last resort for eligible Indian beneficiaries, notwithstanding any state or local law to the contrary. 42 C.F.R. §136.61. Congress has made this payer of last resort status a statutory requirement for IHS, tribal, and urban Indian organization programs.[57]

- *IHS-specific Medicare and Medicaid reimbursement rates.* On an annual basis, the IHS (in consultation with CMS) establishes the rates at which Medicare outpatient and Medicaid inpatient and outpatient services provided to eligible Indians shall be reimbursed to IHS facilities. *See, e.g.,*77 Fed. Reg. 33470 (June 6, 2012). This is an all-inclusive encounter rate which is unique to Indian health care. Tribal clinics may instead elect to bill for services as a Federally Qualified Health Center (FQHC).

- *100 Percent Federal Medical Assistance Percentage*. The cost of Medicaid covered services provided to AI/ANs in IHS and tribal facilities are reimbursed to the States at 100 percent FMAP in recognition that the responsibility for Indian health care is a federal obligation. Sec. 1905(b) of SSA; 42 U.S.C. §1396d(b).

[57] 25 U.S.C. §1623(b), as added by Sec. 2901(b) of the Affordable Care Act (P.L. 111-148) (Mar. 23, 2010).

- *No U.S. right of recovery from Tribes*. If an Indian Tribe (or a Tribal Organization sanctioned by one/more Tribes) has a self-insured health plan for its employees, the United States is prohibited by law from recovering from that plan the cost of services provided unless the sponsoring Tribe/Tribal Organization expressly authorizes such recovery. 25 U.S.C. §1621e(f).

- *Indian Tribes are governments*. Upon achieving federal recognition, an Indian Tribe is acknowledged to be and is treated as a *government* by the United States. The U.S. deals with Indian Tribes on a government-to-government basis that is recognized in Executive Orders and consultation policies adopted by federal agencies.[58] Indian Tribes determine their own governmental structure. They are not required to follow the U.S. model of separate legislative, executive, and judicial branches.

- *State law does not apply*. By virtue of the Supremacy Clause, state laws generally do not apply to the IHS system.[59] The Supreme Court has recognized that Indian tribal governments are not subject to state laws, including tax laws, unless those laws are made expressly applicable by federal law. *See, e.g.*, *McClanahan v. Arizona State Tax Comm'n*, 411 U.S. 1641 (1973). Indian tribal governments are not political subdivisions of states. Tribal facilities and their employees may not be required to have state licensure to perform their duties.

- *Federal trust responsibility*. The United States has a trust responsibility to Indian Tribes (described above).

- *Tribal sovereign immunity*. Indian tribal governments enjoy sovereign immunity except vis-à-vis the United States government, the superior sovereign. *See, e.g., United States v. United States Fidelity & Guaranty Co.,* 309 U.S. 506 (1940).

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[58] *See, e.g.,* Exec. Order No. 13175, "Consultation and Coordination with Indian Tribal Governments (Nov. 9, 2000) (issued by President Clinton and subsequently endorsed by Presidents George W. Bush and Barack Obama); White House Memorandum for Heads of Executive Departments and Agencies, Nov. 5, 2009 (President Obama endorsement); Dep't of Health and Human Services Tribal Consultation Policy (Dec. 14, 2010); Centers for Medicare and Medicaid Services Tribal Consultation Policy (Nov. 17, 2011).

[59] For example, Section 408 of the IHCIA provides that an entity operated by IHS, an Indian tribe, tribal organization or urban Indian organization that meets state requirements for licensure must be accepted as a provider but is not required to obtain a state license. 25 U.S.C. §1647a.

In sum, an Indian Tribe that has elected to directly operate its health care program can simultaneously serve in several capacities: as a sovereign government; as beneficiary of IHS-funded health care; as a direct provider of health care (including the right of recovery from third party payers); as administrator of a health program with responsibilities for advising its patients about eligibility for Medicare, Medicaid, and CHIP; and as a sponsor of a health insurance plan for its employees (and the payor under such a plan if it is a self-insured plan). CMS must take these multiple roles into account and fashion special policies to effectively implement Medicare, Medicaid, and CHIP in Indian communities in ways that assure full access by Indian beneficiaries and IHS/tribal providers.

Rocky Mountain Tribal Leaders Council
711 Central Avenue, Suite 220+, Billings, MT 59102 Phone (406) 252-2550 Fax (406) 254-6355
Website http://www.mtwytlc.org

May 18, 2015

President Barak Obama
The White House
1600 Pennsylvania Avenue NW
Washington, D.C. 20500

Dear President Obama:

"Awe Koodabilaxpak Kuuxshish"
"One Who Helps People Throughout the Land"

On behalf of the Rocky Mountain Tribal Leaders Council, which is comprised of elected Tribal Leaders from the eleven member Tribes in this region, I would like to bring the enclosed Resolution to your attention.

We request your serious consideration for the attached documents as they are of critical significance to Tribes and Reservation Communities in Montana and Wyoming, as well as the Shoshone/Bannock of Idaho, and all American Indian citizens.

If you would like to arrange a meeting or a conference call to clarify or expand on the rationale behind any part of the Resolution as it pertains to the Affordable Care Act and Tribes as employers or American Indians in general, please do call us (406-252-2550) to arrange a time for further discussion or contact us via email at wsnell@mtwytlc.com .

Thank you for your willingness to collaborate on these vital concerns. For more information on the Tribal Leaders Council and the Tribes here please visit the website: www.mtwytlc.org

Sincerely,

William Snell, Jr.
Executive Director
Rocky Mountain Tribal Leaders Council

Cc: Tribal Chairs, Presidents & Councils

Enclosures: (2)

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RMTLC-Resolution # 10April2015-06

RESOLUTION OF SUPPORT FOR EXEMPTING TRIBES FROM EMPLOYER MANDATE UNDER THE AFFORDABLE CARE ACT OF 2010 AND TO AMEND THE INTERNAL REVENUE CODE OF 1986 TO PROVIDE AN EXCEPTION TO THE EMPLOYER HEALTH INSURANCE MANDATE WITH RESPECT TO MEMBERS OF INDIAN TRIBES INCLUDING THOSE EMPLOYED BY INDIAN TRIBAL GOVERNMENTS OR TRIBALLY OWNED BUSINESSES.

WHEREAS, duly elected Tribal Chairs, Presidents and Council Members of the Tribal Governments serve as delegates to, and comprise the membership of, the governing body or Board of Directors of the Rocky Mountain Tribal Leaders Council and as such these elected Tribal Leaders are fully authorized to represent their respective Tribes and to conduct all official business on behalf of this Inter-Tribal organization including the approval of all and any official documents; and

WHEREAS, the Rocky Mountain Tribal Leaders Council (Tribal Leaders Council) has been created for the purpose of providing a unified voice for Tribal governments and a collective organization to address issues of concern to member Tribes and their peoples; and

WHEREAS, by acting in unison to direct the formation of national, regional and local policy, elected Tribal Leaders succeed in carrying out their sworn duty to provide leadership on all issues that may affect the Tribes and reservation communities; and

WHEREAS, the Tribal Leaders Council strives to advance and to safeguard the sovereign authority and cultural integrity of each member Tribe; and

WHEREAS, the employer shared responsibility rule (also known as the employer mandate) will impose a significant financial hardship for Tribal employers, and nullify various AI/AN-specific protections in the ACA, and

WHEREAS many Tribal workforces are largely comprised of Tribal members who are otherwise exempt from the ACA's individual mandate to obtain coverage, and who are eligible to obtain care free of charge through the IHS system, and

WHEREAS requiring Tribes to either incur the cost of purchasing insurance for their member employees (who already have a right to no-cost sharing care) or pay a penalty will impose a significant economic burden on Tribal governments, and

WHEREAS, Tribes hold unique political and sovereign status that is recognized in all forums where the rule of law prevails, and

WHEREAS imposing such an economic burden, as well as being contrary to the federal trust responsibility, is fundamentally inconsistent with Treaties that secured millions of acres of land and resources to the United States, and

NOW THEREFORE BE IT RESOLVED, the Rocky Mountain Tribal Leaders Council hereby urges the Administration and Congress to recognize, affirm and uphold the unique Treaty and Trust obligations, and fiduciary responsibilities of the federal government that are due to the Tribes and to each Tribal citizen by according an exception to employer health insurance mandate for American Indians employed by Indian Tribal governments and Tribal organizations operating within the exterior boundaries of Indian reservations, and

BE IT FURTHER RESOLVED that the Rocky Mountain Tribal Leaders Council does endorse and support the attached letter from the National Indian Health Board and other Tribal organizations which asks that IRS categorically exempt Indian Tribes, Tribal organizations[1], and Urban Indian Organizations from the "employer mandate" and

BE IT FURTHER RESOLVED that, in honor and recognition of the federal trust obligations to the Tribes, Tribal governments and Tribal organizations be accorded feasible options for sponsorship of premiums for health insurance through the federal exchange or marketplace (www.healthcare.gov) on behalf of their Tribal employees or enrolled Tribal members, and

NOW BE IT FINALLY RESOLVED, that this resolution shall be the policy of Tribal Leaders Council until it is withdrawn or modified by subsequent resolution.

CERTIFICATION

We, the undersigned, as the Chair and the Secretary of the Rocky Mountain Tribal Leaders Council, do hereby certify that the foregoing Resolution was duly presented and approved, at the duly convened Quarterly Board Meeting of the Rocky Mountain Tribal Leaders Council, which was held on the 9th and 10th of April, 2015 in Fort Hall, Idaho with a full quorum present.

Chairman Ivan Posey
Rocky Mountain Tribal Leaders Council

Secretary Gerald Gray
Rocky Mountain Tribal Leaders Council

[1] Link to the letter that was sent jointly by the National Indian Health Board and the United South and Eastern Tribes (USET) to the Obama Administration.
http://www.usetinc.org/wp-content/uploads/UzMaterbs/ACA%20Employer%20Mandate/Letter%20to%20White%20House%20Requesting%20Tribal%20Relief%20from%20Employer%20Mandate.pdf

National Indian Health Board

Submitted via e-mail: Jodi_A_Gillette@who.eop.gov
Raina_D_Thiele@who.eop.gov

February 2, 2015

Jodi A. Gillette
Senior Policy Advisor for Native American Affairs
The White House
1600 Pennsylvania Avenue NW
Washington, DC 20500

Raina D. Thiele
Associate Director of Intergovernmental Affairs and Public Engagement
The White House
1600 Pennsylvania Avenue NW
Washington, DC 20500

Re: Request for Tribal Relief from the Affordable Care Act Employer Mandate.

Dear Jodi Gillette and Raina Thiele:

On behalf of the National Indian Health Board (NIHB) and the United South and Eastern Tribes, Inc. (USET), we write to request a meeting with you to discuss the need for relief for Tribes from the Affordable Care Act's employer shared responsibility rule (the "employer mandate").

The Internal Revenue Service's (IRS) employer shared responsibility rule is inconsistent with the federal trust responsibility, denies many Tribal members the opportunity to take advantage of the benefits and protections designed for them in the Marketplace, and chills Marketplace enrollment for American Indians and Alaska Natives (AI/AN). It is cost-prohibitive for many Tribes and will result in a diminution of Tribal services for Indian people. If fully implemented in Indian Country, Tribes will be faced with having to choose between providing coverage, which will result in reducing governmental services and disqualifying their Tribal member employees from the benefits and protections for AI/AN in the marketplace, or using scarce federal resources to pay the IRS substantial penalties if they do not comply. Neither outcome represents good federal policy.

The employer shared responsibility rule is mandated by Section 4980H of the Tax Code, as added by Section 1513 of the Patient Protection and Affordable Care Act (ACA) (as amended).[1]

[1] *See* 26 U.S.C. § 4980h; 26 C.F.R. § 54.4980H–1 - .4980H-5.

Section 4980H of the Code does not specifically apply to Tribal governments, and Section 54.4980H-2(b)(4) of the employer shared responsibility regulations reserves application of special rules for government entities.

As discussed below, Tribal workforces include a significant number of Tribal member employees, who are otherwise exempt from the individual mandate. The ACA contains several provisions designed to encourage AI/AN enrollment in the ACA Marketplaces, including special cost-sharing exemptions for AI/ANs. The Center for Consumer Information and Insurance Oversight (CCIIO) has been actively encouraging Tribes to encourage their members take advantage of these provisions by enrolling in the Marketplaces, and Tribes have expended considerable resources to take CCIIO up on that challenge.

But the IRS's application of the employer mandate to Tribal governments works at cross purposes to encouraging Marketplace enrollment, as an offer of coverage to a Tribal member employee disqualifies that employee from the premium subsidies that are critical to facilitating Marketplace enrollment. With the employer mandate in place, Tribes are placed in the untenable position of either having to offer insurance at full price to their Tribal member employees, who will then be unable to take advantage of Marketplace premium subsidies even if they do not accept the employer-based coverage, or to forego offering coverage (or offer insufficient coverage) to their Tribal member employees and pay substantial penalties to the IRS.[2]

These twin policies from IRS and CCIIO are inconsistent, and have combined to discourage AI/AN Marketplace participation and significantly increase costs to Tribal governments. Together, they create a federal policy that is both inconsistent with the right of AI/ANs to obtain trust-obligated health care without charge to the individual at I/T/U facilities and that forces many Tribal employers to purchase coverage for workforces largely comprised of Tribal members who are (1) exempt from the ACA's individual mandate to obtain coverage and (2) eligible to obtain health care through the I/T/U system. Finally, application of the employer mandate will be simply unaffordable to many Tribes and Tribal organizations and act as a barrier to the provision of critical governmental services.

With the employer mandate deadline taking effect on January 1, 2015, we request consultation on the need for Tribal relief from the rule as soon as possible.

I. Background.

Congress has recognized that "[f]ederal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people."[3] The federal trust responsibility and laws enacted pursuant thereto provide ample authority for the federal agencies of the Executive Department to design, implement and tailor federal programs in a manner that

[2] We illustrate these various scenarios in the examples below.

[3] 25 U.S.C. § 1601(1).

recognizes and supports the unique government to government relationship between sovereign Tribal governments and the United States.[4]

Congress has also recognized that it is a "major national goal . . . to provide the resources, processes, and structure that will enable Indian tribes and tribal members to obtain the quantity and quality of health care services and opportunities that will eradicate the health disparities between Indians and the general population of the United States."[5] In recognition of this federal trust responsibility, AI/ANs are eligible to receive care through the Indian Health Service (IHS) system without charge to the individual patient.[6]

In light of the federal government's trust responsibility, many Tribal employers have not historically offered health coverage to their employees. Not only are the majority of many Tribal workforces eligible for IHS services, but the remote location of many I/T/U facilities creates additional difficulties in locating plans that treat Tribal facilities as in-network or otherwise preferred providers. This often leaves the I/T/U as the only viable health service option for the employee population, regardless of coverage status. In addition, insurance plans in these remote areas are frequently expensive, have high cost-sharing amounts, or are less comprehensive than plans available in urban settings.[7] Federal responsibility for the provision of health services allows Tribal governments to expend scarce resources elsewhere rather than obtaining high cost, low quality employee insurance.[8]

II. Discussion.

With these unique circumstances in mind, the application of the employer mandate to Tribal employers presents three primary problems: (1) it undercuts multiple ACA provisions designed to encourage AI/AN enrollment in the Marketplaces; (2) it undercuts the federal government's trust responsibility by forcing AI/ANs to "pay" for health coverage (whether directly or by proxy through their Tribal employer); and (3) compliance with the mandate requires a significant diminution in Tribal governmental services. We discuss each issue in turn.

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[4] Additional background on the authority of federal agencies to tailor their programs to meet the unique needs of federally-recognized tribes and American Indians and Alaska Natives is provided in Appendix B to the CMS TTAG Strategic Plan, "Appendix B: Legal Basis for Special CMS Provisions for American Indians and Alaska Natives." A copy of Appendix B is appended to this letter.

[5] 25 U.S.C. § 1601(2).

[6] 42 C.F.R. §§ 136.11 and 136.12.

[7] *See, e.g.*, Letter from Monica J. Linden, Commissioner, Montana Department of Securities and Insurance, to Kathleen Sebelius, Secretary, U.S. Department of Health and Human Services (Mar. 10, 2014) (recognizing practical difficulties for Tribal employers in finding and offering adequate coverage and seeking Tribal exemption from employer mandate).

[8] We note that the federal government's budgeting and expenditures do not come close to meeting the requirements of the trust responsibility: IHS is only funded at approximately 56% of need, and the most recent contract support cost shortfall was estimated at $90 million. NATIONAL TRIBAL BUDGET FORMULATION WORKGROUP'S RECOMMENDATIONS ON THE INDIAN HEALTH SERVICE FISCAL YEAR 2015 BUDGET 3, 6 (2013).

1. The Employer Mandate Undercuts the ACA's Indian-Specific Protections.

Applying the employer mandate to Tribal employers directly undercuts the ACA's Indian-specific protections in three ways. First, it punishes Tribes for assisting AI/AN enrollment in the Marketplaces, despite the multiple ACA provisions designed specifically to encourage such activities. Second, it can disqualify AI/ANs from eligibility for premium tax credits in Marketplace plans, thus leaving them unaffordable. Third, it ignores the fact that AI/ANs are exempt from the individual mandate and forces Tribal employers to pay for AI/AN insurance plans as a proxy for the individual. None of these outcomes benefit Tribal employers, individual AI/ANs, or the federal government.

The ACA contains several provisions designed to maximize AI/AN participation in Marketplace plans: for example, Indian-specific cost-sharing protections that help defray the cost of health coverage,[9] special AI/AN enrollment periods,[10] and the ability for Tribes to assist with Marketplace plan premium payments for Tribal members.[11] Many Tribes and Tribal organizations have aggressively sought to facilitate AI/AN enrollment in Marketplace plans in order to take advantage of these protections. However, the employer mandate actively discourages AI/AN Marketplace participation, in direct contradiction to the provisions described above.

First, Tribes may find it more affordable to offer Marketplace premium assistance to Tribal member employees than it is to pay for employee-sponsored coverage. However, it is our understanding that Tribal premium sponsorship for member employees does not satisfy the employer mandate. Tribes will therefore be forced to either continue offering premium assistance and pay the employer mandate penalty (thus diminishing the funding available for premium assistance and AI/AN Marketplace enrollment) or else purchase employer coverage and discontinue premium assistance (which may not be financially viable and which forecloses Tribes from obtaining a benefit that Congress deliberately granted included in the ACA).

Second, even if a Tribe does offer employer coverage, AI/AN employees will almost certainly be personally responsible for paying premium costs and (depending on the type of plan and location of services) for deductibles, co-payments, and co-insurance. Recognizing that eligibility for IHS services acts as a natural disincentive for AI/AN enrollment in any insurance plan (employer-sponsored or otherwise) that requires such expenditures, Congress further incentivized AI/AN Marketplace participating through the availability of premium tax credits: various types of Indian-specific income is excluded when calculating AI/AN eligibility for the tax credits, thus leaving it comparatively easier for AI/ANs to qualify[12] and making many individual Marketplace

[9] 42 U.S.C. § 18071(d).

[10] 42 U.S.C. § 18031(c)(6)(D).

[11] 25 U.S.C. §§ 1642, 1644.

[12] *See* 26 U.S.C. § 36B(d) (tying tax credit eligibility to modified adjusted gross income); *see also* 43 U.S.C. § 1620; 25 U.S.C. § 1407; 25 U.S.C. § 171b(a) (exempting various AI/AN-specific income from modified adjusted gross income calculation).

plans significantly more affordable or comprehensive to AI/ANs than employer-sponsored coverage. However, employees are automatically disqualified from tax credit eligibility upon receiving a qualifying offer of coverage from their employer.[13] So, even if a Tribe provides employer-based insurance that is less affordable or comprehensive than a plan available through the individual Marketplace, the mere offer of coverage eliminates the ability of AI/ANs to obtain the tax credits that make the individual plan affordable in the first instance.

Finally, Congress exempted AI/ANs from the ACA's individual mandate out of recognition that AI/ANs are entitled to federal health care benefits and therefore should not be forced to pay for non-IHS coverage. Requiring Tribal employers to provide AI/ANs with such coverage anyway, and penalizing them if they do not, functionally invalidates the AI/AN exemption from the individual mandate by shifting the penalty from the individual to the Tribe itself. This also leaves AI/AN employees with two choices: either accept the coverage and be personally responsible for any applicable employee share of premiums or cost-sharing (again invalidating the individual mandate) or else reject the coverage and lose eligibility for Marketplace tax credits. Under either scenario, the individual AI/AN is "paying" for health coverage.

The following examples illustrate the various ways in which the employer mandate uniquely disadvantages Tribal employers and AI/ANs:

1. **The Tribal employer complies with the employer mandate and offers minimum essential coverage to all employees.**
    a. Tribal employer offers minimum essential coverage to all of its employees, the majority of which are Tribal members.
    b. Due to extremely limited and zero sum nature of Tribal budgets, the Tribe is forced to diminish basic governmental services to make up for the cost of coverage.
    c. In partnership with CCIIO, the Tribe is actively encouraging Tribal members to enroll in the Marketplaces. Tribal members who are employees are disqualified from Marketplace tax credits due to the offer of coverage.
    d. By providing coverage to Tribal member employees, the Tribe is required by proxy to comply with the individual mandate "on behalf" of AI/AN employees, thus nullifying the AI/AN individual mandate exemption.

2. **The Tribal employer does not offer health insurance to any employees, and instead pays the "first" employer mandate penalty of $2,000 per employee per year.**[14]

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[13] 26 U.S.C. § 36B(2)(B); 26 U.S.C. § 5000A(f)(1)(B), (f)(2).

[14] This penalty applies when (1) an employer offers health coverage to less than 95% of its full-time employees and their dependents in a calendar month, and (2) at least one of the full-time employees then enrolls in a QHP through a Marketplace and receives an advance premium tax credit or cost sharing reduction. 26 U.S.C. § 4980H(a); 26 C.F.R. § 54.4980H–4(a). In such cases, the penalty amount for each applicable month is equal to the number of the employer's full-time employees for the month (subtracted by thirty), multiplied by 1/12 of $2,000. 26 U.S.C. § 4980H(c)(2)(D); 26 C.F.R. § 54.4980H–1(a)(41).

a. The Tribe does not offer coverage to its employees.
b. The Tribe must pay $2,000 per employee per year in penalties to the IRS. The Tribe is forced to reduce government services in order to make up for the penalty costs.
c. Tribal member employees do not have an offer of coverage and can take advantage of premium assistance and AI/AN cost-sharing exemption on the Marketplaces, but the Tribe must "pay" the IRS a penalty in order for those AI/AN employees to qualify for those statutory rights.
d. Due to the zero sum funding of Tribal governments, the Tribe will be receiving federal funding to provide services to their members and then paying it back to the IRS in the form of an employer mandate penalty.

3. **The Tribal employer offers employees a "low end" plan (high deductible, few covered services, etc.) that satisfies the first employer mandate penalty but not the "second" employer mandate penalty.**[15]
    a. The Tribe purposefully designs its coverage options to result in significantly expensive plans for their employees. The Tribe is liable for payment of the "second" employer mandate penalty if employees go onto the Marketplace and obtain a premium tax credit or cost-sharing reduction.
    b. Tribal member employees are not likely to accept that coverage, as it results in high personal costs and they have a right to care through the IHS system.
    c. Tribal member employees are also not likely to obtain coverage through the Marketplaces, as they have a right to care through the IHS system, thus foregoing their statutory benefits under the ACA.
    d. In order to encourage members to take advantage of Marketplace premium assistance and AI/AN cost-sharing exemptions, the Tribe will have to pay the IRS a penalty of up to $3,000 per Tribal member employee that receives a tax credit or cost-sharing reduction in order to ensure that those members qualify for their statutory benefits.
    e. Due to the zero sum funding of Tribal governments, the Tribe will be receiving federal funding to provide services to their members and then paying it back to the IRS in the form of an employer mandate penalty.
    f. The Tribe is still responsible for paying for coverage for employees (AI/AN or otherwise) who do enroll in the employer-sponsored plan.

These scenarios underscore the employer mandate's inherent incompatibility with both the unique nature of the Tribal health system and the AI/AN-specific provisions of the ACA. Applying the mandate in any circumstances results in either a significant diminution in Tribal governmental services, a functional elimination of the AI/AN exemption from the individual

[15] This penalty applies when an employer does offer health coverage to at least 95% of its full-time employees and their dependents, but (1) at least one full-time employee receives a premium tax credit or cost sharing reduction to help pay for coverage in a Marketplace because the coverage was either unaffordable or failed to provide minimum essential coverage. 26 U.S.C. § 4980H(b)(1); 26 C.F.R. §§ 54.4980H–5(e)(1). In such cases, the penalty amount is calculated by taking the number of full-time employees who receive a premium tax credit in a given month and multiplying that amount by 1/12 of $3,000. 26 U.S.C. § 4980H(b)(1); 26 C.F.R. § 54.4980H–1(a)(41).

mandate, or a disqualification of AI/ANs from their statutorily-established Marketplace benefits and protections. The end result is that the Tribe must either bear the burden of paying for expensive and/or low-quality coverage or else subject itself to significant employer mandate penalties, while the AI/AN employee must choose between accepting whatever coverage is offered and losing tax credit eligibility, remaining uninsured, or having their Tribe "pay" the IRS so that they can qualify for the benefits and protections in the Marketplace to which they are legally entitled. This fundamentally undercuts congressional intent in crafting the ACA and requires a Tribal exemption from the mandate.

2. The Employer Mandate Runs Counter to the Federal Government's Trust Responsibility by Requiring Tribes to Either Pay the Federal Government Penalties or Subsidize Private Insurance Companies.

As noted above, the federal government owes a trust responsibility towards AI/ANs, through which they are eligible to receive health care through the IHS system without cost to the individual. However, IHS is chronically underfunded and AI/ANs continue to suffer the highest health disparities of any ethnic group in the United States and are disproportionately likely to be uninsured.[16] The employer mandate forces Tribes to divert funding necessary to sustain Tribal health programs, which by right should come from the federal government, and redirect it to the purchase of employee health insurance.

This contradicts the trust responsibility by resulting in a redundant payment cycle in which (1) Tribal employers use their own funding (most likely a combination of federal funding and outside revenue) to purchase employee insurance; (2) many employees visit the local IHS health program for services; and (3) the employee's insurer then reimburses IHS. In the alternative, the Tribal employer does not purchase insurance and instead simply pays penalties to the IRS, another federal agency.

In these circumstances, the employer mandate essentially results in Tribes funding the federal government: either they take their limited Tribal funding (some or all of which might be federal funding anyway) and pay it to the IRS in the form of a tax penalty, or they purchase insurance from private companies, which then pay IHS after keeping between 15-20% of the premium payments off the top.[17] Tribal subsidization of the United States does not respect either the trust responsibility or the government-to-government relationship between Tribes and the United States. It is also inefficient, as federal funds will be used to circuitously pay for the cost of insurance premiums or for tax penalties rather than directly funding health care through the IHS system. The trust responsibility neither envisions Tribes as middlemen for transactions between private insurers and IHS nor Tribal "funding" of federal agencies through the payment of penalties.

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[16] *See generally* SAMANTHA ARTIGA ET AL., HENRY J. KAISER FAMILY FOUNDATION, HEALTH COVERAGE AND CARE FOR AMERICAN INDIANS AND ALASKA NATIVES (2013), *available at* http://kff.org/disparities-policy/issue-brief/health-coverage-and-care-for-american-indians-and-alaska-natives/ (last visited July 18, 2014).

[17] *See* 45 C.F.R. § 158.210 (establishing acceptable insurance medical-loss ratios in the large group, and individual health markets).

3. The Employer Mandate Will Be Unaffordable for Tribal Governments.

Compliance with the employer mandate forces Tribes to either absorb the cost of employee health insurance or else pay non-compliance penalties of up to $2,000 per year per full-time employee.[18] Not only is this potentially devastating for Tribes that are already faced with significant financial hardships, but it fails to recognize the fundamental distinction between Tribal employers and private businesses.

It is our understanding that the IRS views the application of the mandate to Tribal employers similarly to that of non-governmental businesses: essentially as a revenue-driven cost-benefit analysis. This is simply not the case in the Tribal context. Tribes are sovereign, governmental entities that are directly responsible for the health and welfare of their people, and are often the only major employers in Tribal territories. Forcing Tribes to pay millions of dollars in penalties – or, alternatively, to purchase costly insurance for Tribal member employees who are otherwise exempt from the individual mandate and eligible for IHS services – will not just affect Tribal business decisions concerning hiring or expansion, but will directly limit their ability to provide basic social, health, safety, and other governmental services on which their members and other reservation residents rely. Tribes cannot "pass on" the costs of compliance by raising prices on goods or services. Tribal governmental funding is a zero sum game, and any funding used to either comply with the mandate or pay the penalties will necessarily come from coffers used to provide what may be the only constituent services for hundreds of miles.

While it is true that all employers must account for insurance costs when making decisions concerning expansion or hiring, the stakes are comparatively much higher when a Tribe might have to choose between complying with the mandate and funding an adequate reservation police force or other Tribal entity. If applied to Tribal governments, the mandate has the potential to critically undercut Tribal governmental functions.

4. The Internal Revenue Service Should Issue a Regulatory Exemption from the Employer Mandate.

The IRS has previously recognized the burden that the ACA's employer-specific provisions place on Tribal employers: for example, the IRS explicitly excludes "federally recognized Indian tribal governments or . . . any tribally chartered corporation wholly owned by a federally recognized Indian tribal government" from an otherwise-applicable requirement that employers report the cost of coverage under an employer-sponsored group health plan on their employees' W-2 forms.[19] As discussed above, the IRS should similarly exempt Tribes and Tribal organizations from the employer mandate.

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[18] *See generally* 26 C.F.R. §§ 54.4980H–4, H-5.

[19] *See* Internal Revenue Service, "Employer-Provided Health Coverage Informational Reporting Requirements: Questions and Answers," *available at* http://www.irs.gov/uac/Employer-Provided-Health-Coverage-Informational-Reporting-Requirements:-Questions-and-Answers (Dec. 19, 2013).

The IRS has the legal authority to issue such an exemption. The ACA's definition of the "applicable large employers" subject to the mandate does not explicitly include Indian Tribes.[20] Statutes of general applicability that interfere with exclusive issues of self-governance, such as the relationship between Tribal employees and on-reservation businesses, generally require "a clear and plain congressional intent" that they apply to Tribes before they will be so interpreted.[21] Although Congress repeatedly referenced Indian Tribes within the ACA,[22] it did not include any such reference in the employer mandate, therefore indicating that the mandate does not apply of its own force to Tribal employers.[23] Because the sole explicit application of the employer mandate to Tribes is found in IRS regulations,[24] the IRS may accordingly promulgate the following standalone exemption in 26 C.F.R. § 54.4980H–2:

> **26 C.F.R. § 54.4980H–2 Applicable large employer and applicable large employer member.**
> **(a) In general.** Section 4980H applies to an applicable large employer and to all of the applicable large employer members that comprise that applicable large employer.
>
> **(b) Determining applicable large employer status—**
>
> . . . .
>
> **(5) Indian Tribes and Tribal Entities.** For the purposes of any penalty or assessment under 26 U.S.C. § 4980H or 26 C.F.R. § 54.4980H, the term "applicable large employer" shall not include any Indian tribe, tribal health program, tribal organization, or urban Indian organization (as defined in 25 U.S.C. § 1603).

[20] *See* 26 U.S.C. § 4980H(c)(2)(A) (defining the term as "with respect to a calendar year, an employer who employed an average of at least 50 full-time employees on business days during the preceding calendar year").

[21] *E.E.O.C. v. Fond du Lac Heavy Equip. & Const. Co., Inc.*, 986 F.2d 246, 249 (8th Cir. 1993) (Age Discrimination in Employment Act did not apply to employment discrimination action involving member of Indian Tribe, Tribe as employer, and reservation employment); *accord Snyder v. Navajo Nation*, 382 F.3d 892, 896 (9th Cir. 2004) (Fair Labor Standards Act did not apply to dispute between Navajo and non-Navajo Tribal police officers and Navajo Nation over "work [done] on the reservation to serve the interests of the tribe and reservation governance").

[22] *See, e.g.*, Section 1402(d)(2) (referring to health services provided by an Indian Tribe); Section 2901(b) (referring to health programs operated by Indian Tribes); Section 2951(h)(2) (referring to Tribes carrying out early childhood home visitation programs); Section 2953(c)(2)(A) (discussing Tribal eligibility to operate personal responsibility education programs); Section 3503 (discussing Tribal eligibility for quality improvement and technical assistance grant awards).

[23] *See, e.g.*, *Dean v. United States*, 556 U.S. 568, 573 (2009) ("[W]here Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposeful in the disparate inclusion or exclusion.").

[24] Internal Revenue Service, Shared Responsibility for Employers Regarding Health Coverage; Final Rule, 79 Fed. Reg. 8,544 (Feb. 12, 2014); 26 C.F.R. § 54.4980H–1(a)(23).

III. Conclusion.

The ACA employer mandate creates an impossible choice for Tribal governments, forcing them to either pay for the cost of insurance for Tribal member employees who are otherwise exempt from having to obtain coverage, or pay a tax penalty in order to ensure that Tribal member employees qualify for the benefits and protections to which they are entitled. The mandate discourages Tribes from facilitating AI/AN Marketplace enrollment, requires Tribes to pay an individual mandate penalty by proxy on behalf of its AI/AN employees, and precludes AI/AN eligibility for tax credits. The mandate also acts as a federal directive that many AI/ANs pay for their health care in circumvention of the trust responsibility. Finally, the mandate is unaffordable for many Tribes, as Tribes will pay for both the penalties and the insurance payments with already-scarce resources that would be far better allocated towards funding direct Tribal services and programs. We therefore ask that the IRS exercise its legal authority to provide categorical relief for Indian Tribes, Tribal organizations, and Urban Indian Organizations from the employer mandate.

Thank you for the opportunity to engage with us on this matter. We stand ready to work with you on any necessary follow up issues and look forward to a continued open dialogue on the employer mandate.

Sincerely,

Lester Secatero, Chairman,
The National Indian Health Board

Brian Patterson, President
United South and Eastern Tribes, Inc.