Health Care Reform in Indian Country

Self-Governance Communication & Education

Self-Governance Tribes Striving Towards Excellence in Health Care

Advancing Sovereignty

-- Tribal Sponsorship and

Other ACA and IHCIA-related Topics --

August 17, 2016

Agenda

- HHS Essential Community Provider List: Status Update
- Summary of Benefits and Coverage: HHS release of AI/AN templates
- Tribal Sponsorship (for health insurance coverage through a Marketplace)
  - Title I contracting process, Self-Governance approaches, and other issues

Disclaimer

- *This analysis is for informational purposes only and is not intended as tax or legal advice.*
- *Please talk with your accountant or attorney for specific tax or legal questions related to your Tribe, Tribal entities, and individual tribal members.*

Section 1: Reference Materials

Acronyms

Acronyms:

- IHCP: Indian health care provider, also referred to as I/T/U
- I/T/U: IHS, Tribe, Tribal health organization, urban Indian organization
- THO: Tribal health organization
- ACA: Patient Protection and Affordable Care Act
- PTCs: Premium tax credits
- APTCs: Advanced payment of premium tax credits
- CSRs: Cost-sharing reductions
- CSVs: Cost-sharing variations
- IHS: Indian Health Service
- HHS: (Federal) Department of Health and Human Services
- CMS: Centers for Medicare and Medicaid Services, HHS
- CCIIO: Center for Consumer Information and Insurance Oversight, CMS/HHS
- QHP: Qualified Health Plan
- FFM: Federally-Facilitated Marketplace
- ECP: Essential community provider

Accessing ACA and Federal Regulations and Guidance

- Affordable Care Act (ACA)
  http://housedocs.house.gov/energycommerce/ppacacon.pdf
- Code of Federal Regulations (CFR)
  http://www.ecfr.gov/cgi-bin/ECFR?SID=7f8540b42be198e365873efe5f15dcb8&page=browse
- Guidance document: CCIIO 2016 Issuer Letter
  https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016-Letter-to-Issuers-2-20-2015-R.pdf
- Tribal Self-Governance Advisory Committee materials
  http://tribalselfgov.org/health-reform/webinars/

Open Enrollment - 2017

- American Indians and Alaska Natives meeting the definition of Indian under the Affordable Care Act (*e.g.*, enrolled Tribal member) are able to enroll through a Marketplace all year
  - Family members not meeting the ACA's definition of Indian are able to enroll with them throughout the year
- Initial Open Enrollment dates for 2017 coverage year are:
  - **November 1, 2016**: Open Enrollment starts
  - **December 15, 2016**: Last day to enroll in or change plans for new coverage to start January 1, 2016
  - **January 1, 2017**: 2016 coverage starts for those who enroll or change plans by December 15, 2015
  - **January 15, 2017**: Last day to enroll in or change plans for new coverage to start February 1, 2016
  - **January 31, 2017**: 2016 Open Enrollment ends for general populati

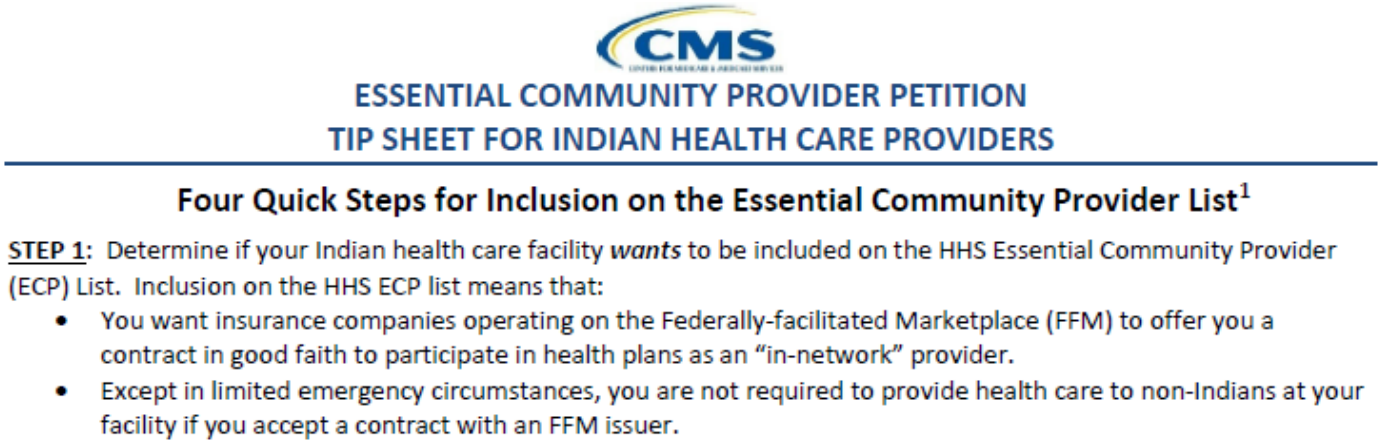
Section 2: HHS Essential Community Provider List: Status Update

QHP Contracting Requirements and Need to Update Entry on HHS ECP List

- In FFM states, QHPs must meet contracting requirements regarding Indian Health Care Providers (IHCPs)
  - QHP must include 30% of all essential community providers (ECPs)
  - QHP must make good faith contract offer to IHCPs in QHP's service area
  - Contract offer must include the contents of the QHP (Indian) Addendum
    - https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Model_QHP_Addendum_Indian_Health_Care_Providers_04-25-14.pdf
- HHS maintains the "HHS ECP List", which includes IHCPs
  - https://data.healthcare.gov/cciio/ecp_petition
- IHCPs must be on the HHS ECP List in order for QHPs to be required to proactively send contract offers to IHCPs
- All IHCPs, even those currently on HHS ECP List, need to confirm accuracy of information – and make sure there is no missing information – in order to remain on the list for coverage year 2018
  - ***Updates on the HHS ECP List need to be completed by August 22 [which is likely to be extended to October 7]***
  - ***Additions to the HHS ECP List must be completed by August 22 [which is likely to be extended to October 7]***

HHS "Tip Sheet"

- HHS recently released a "Tip Sheet" providing a four-step process for updating or entering a health care facility on the HHS ECP List



CMS

ESSENTIAL COMMUNITY PROVIDER PETITION
TIP SHEET FOR INDIAN HEALTH CARE PROVIDERS

Four Quick Steps for Inclusion on the Essential Community Provider List[1]

STEP 1: Determine if your Indian health care facility ***wants*** to be included on the HHS Essential Community Provider (ECP) List. Inclusion on the HHS ECP list means that:

- You want insurance companies operating on the Federally-facilitated Marketplace (FFM) to offer you a contract in good faith to participate in health plans as an "in-network" provider.
- Except in limited emergency circumstances, you are not required to provide health care to non-Indians at your facility if you accept a contract with an FFM issuer.

- Link to HHS Tip Sheet is: http://www.tribalselfgov.org/wp-content/uploads/2016/08/ECP-Petition-Tip-Sheet-for-Indian-Health-Care-Providers-07-27-16-002.pdf

State Marketplace Types, 2016*

State Marketplace Types, 2016 (1 of 3)		
State	**Marketplace Type**	**CCIIO ECP Contracting Requirements Apply**
Alabama	Federally-Facilitated Marketplace	Yes
Alaska	Federally-Facilitated Marketplace	Yes
Arizona	Federally-Facilitated Marketplace	Yes
Arkansas	State-Partnership Marketplace	Yes[1]
California	State-Based Marketplace	No
Colorado	State-Based Marketplace	No
Connecticut	State-Based Marketplace	No
Delaware	State-Partnership Marketplace	Yes[1]
District of Columbia	State-Based Marketplace	No
Florida	Federally-Facilitated Marketplace	Yes
Georgia	Federally-Facilitated Marketplace	Yes
Hawaii	State-Based Marketplace[2]	No
Idaho	State-Based Marketplace	No
Illinois	State-Partnership Marketplace	Yes[1]
Indiana	Federally-Facilitated Marketplace	Yes
Iowa	State-Partnership Marketplace	Yes[1]
Kansas	Federally-Facilitated Marketplace[3]	Yes
Kentucky	State-Based Marketplace	No

* A “yes” indicates the mandatory offer to contract with all IHCPs applies.

State Marketplace Types, 2016*

State Marketplace Types, 2016 (2 of 3)		
State	**Marketplace Type**	**CCIIO ECP Contracting Requirements Apply**
Louisiana	Federally-Facilitated Marketplace	Yes
Maine	Federally-Facilitated Marketplace[3]	Yes
Maryland	State-Based Marketplace	No
Massachusetts	State-Based Marketplace	No
Michigan	State-Partnership Marketplace	Yes[1]
Minnesota	State-Based Marketplace	No
Mississippi	Federally-Facilitated Marketplace	Yes
Missouri	Federally-Facilitated Marketplace	Yes
Montana	Federally-Facilitated Marketplace[3]	Yes
Nebraska	Federally-Facilitated Marketplace[3]	Yes
Nevada	State-Based Marketplace[2]	No
New Hampshire	State-Partnership Marketplace	Yes[1]
New Jersey	Federally-facilitated Marketplace	Yes
New Mexico	State-Based Marketplace[2]	No
New York	State-Based Marketplace	No
North Carolina	Federally-Facilitated Marketplace	Yes
North Dakota	Federally-Facilitated Marketplace	Yes
Ohio	Federally-Facilitated Marketplace[3]	Yes
Oklahoma	Federally-Facilitated Marketplace	Yes
Oregon	State-Based Marketplace[2]	No

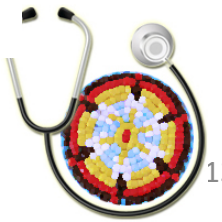
* A “yes” indicates the mandatory offer to contract with all IHCPs applies.

State Marketplace Types, 2016*

State Marketplace Types, 2016 (3 of 3)		
State	**Marketplace Type**	**CCIIO ECP Contracting Requirements Apply**
Pennsylvania	Federally-Facilitated Marketplace	Yes
Rhode Island	State-Based Marketplace	No
South Carolina	Federally-Facilitated Marketplace	Yes
South Dakota	Federally-Facilitated Marketplace[3]	Yes
Tennessee	Federally-Facilitated Marketplace	Yes
Texas	Federally-Facilitated Marketplace	Yes
Utah	Federally-Facilitated Marketplace	Yes
Vermont	State-Based Marketplace	No
Virginia	Federally-Facilitated Marketplace[3]	Yes
Washington	State-Based Marketplace	No
West Virginia	State-Partnership Marketplace	Yes[1]
Wisconsin	Federally-Facilitated Marketplace	Yes
Wyoming	Federally-Facilitated Marketplace	Yes

[1] State conducts plan management and consumer assistance activities; CMS reviews state recommendations on QHP certification to confirm they comport with federal regulatory standards and has responsibility for final QHP certification decisions.
[2] SBM, except that the state relies on the FFM IT platform.
[3] FFM, except that the state conducts plan management activities.

* A "yes" indicates the mandatory offer to contract with all IHCPs applies.



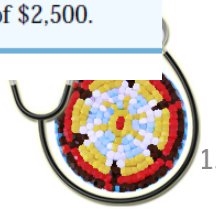
Section 3: Summary of Benefits and Coverage (SBCs)

Summary of Benefits and Coverage (SBCs)

- Summary of Benefits and Coverage (SBCs) documents explain things like what a health insurance plan covers, what it doesn't cover, and what your share of costs will be
- SBCs are approximately 9 pages and include 2 – 3 sample medical events (such as: having a baby; managing diabetes; and treating a broken leg)

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual + Family | **Plan Type:** PPO

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.modahealth.com	Value drugs	$0 copay	$0 copay	Covers up to a 90-day supply retail and mail order drugs. Copay per 30 day supply. Covers up to a 30-day supply specialty drugs. Prior authorization may be required.
	Select tier drugs	$0 copay	$0 copay	
	Preferred brand drugs	0% coinsurance	0% coinsurance	
	Non-preferred brand drugs	0% coinsurance	0% coinsurance	
	Specialty drugs	0% coinsurance	0% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	0% coinsurance	Prior authorization required to avoid a penalty of 50% up to a maximum deduction of $2,500.
	Physician/surgeon fees	0% coinsurance	0% coinsurance	
	Emergency room services	0% coinsurance	0% coinsurance	----------none----------

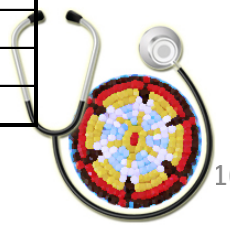


SBC to Be Prepared for Each Plan Cost-Sharing Variation

- Since before 2016 open enrollment (*i.e.*, October 2015), QHP issuers were to make SBC documents available to (potential) enrollees
  - An SBC for each health plan offered on each metal level, and
  - An SBC for each plan on a metal level that has a different type of cost-sharing variation (CSV)
- Two of the plan variations for each QHO offered are Indian-specific

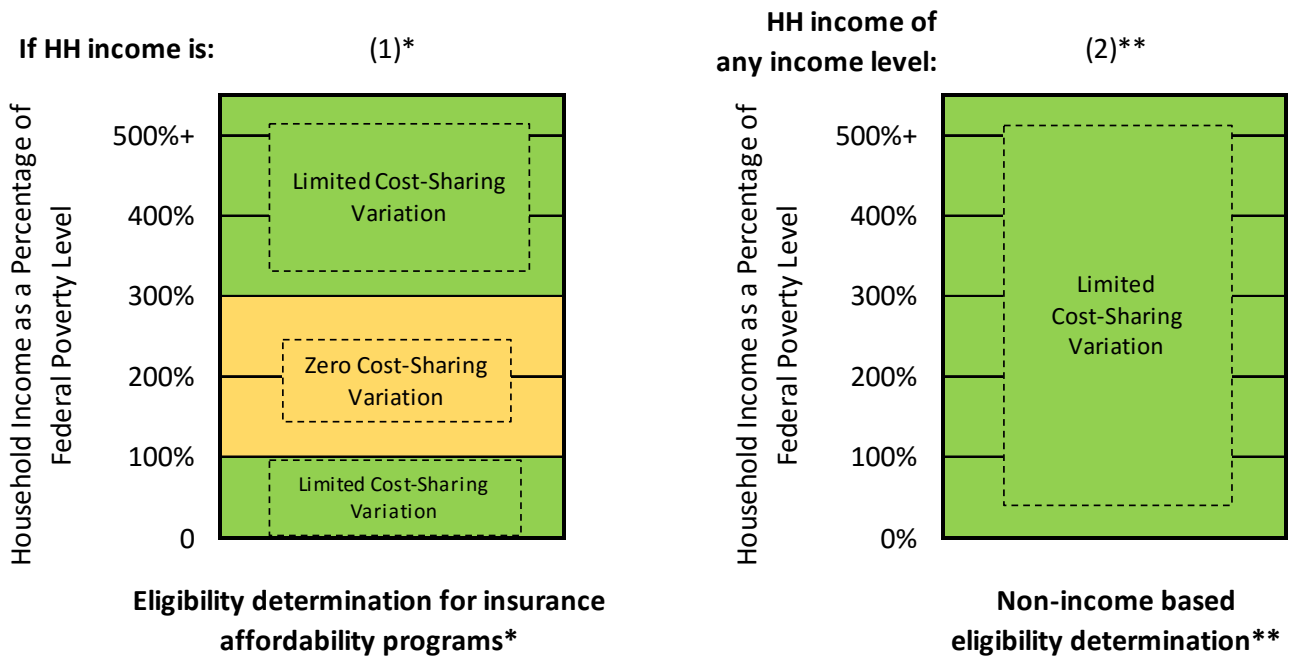
Requirement on Qualified Health Plans to Prepare SBCs for Each Plan Variation*						
	Cost-sharing variation code ("plan variation")					
	01	*02*	*03*	*04*	*05*	*06*
Metal Level	Standard variant: no additional cost-sharing protections	Meet ACA Definition of Indian: **Between 100% and 300% FPL** ("zero" CSV)	Meet ACA Definition of Indian: **Any income level** ("limited" CSV)	**73% AV Level Silver Plan CSV** (200% FPL - 250% FPL)	**87% AV Level Silver Plan CSV** (150% FPL - 200% FPL)	**94% AV Level Silver Plan CSV** (100% FPL - 150% FPL)
Bronze	✓	✓	✓			
Silver	✓	✓	✓	✓	✓	✓
Gold	✓	✓	✓			
Platinum	✓	✓	✓			

* "AV" indicates actuarial value, or percentage of average health care expenditures.



Eligibility Criteria for Indian-Specific Cost-Sharing Protections

Eligibility for Indian-Specific Cost-Sharing Protections:
(1) Eligibility determinations for "insurance affordability programs"
and (2) non-income based eligibility determinations



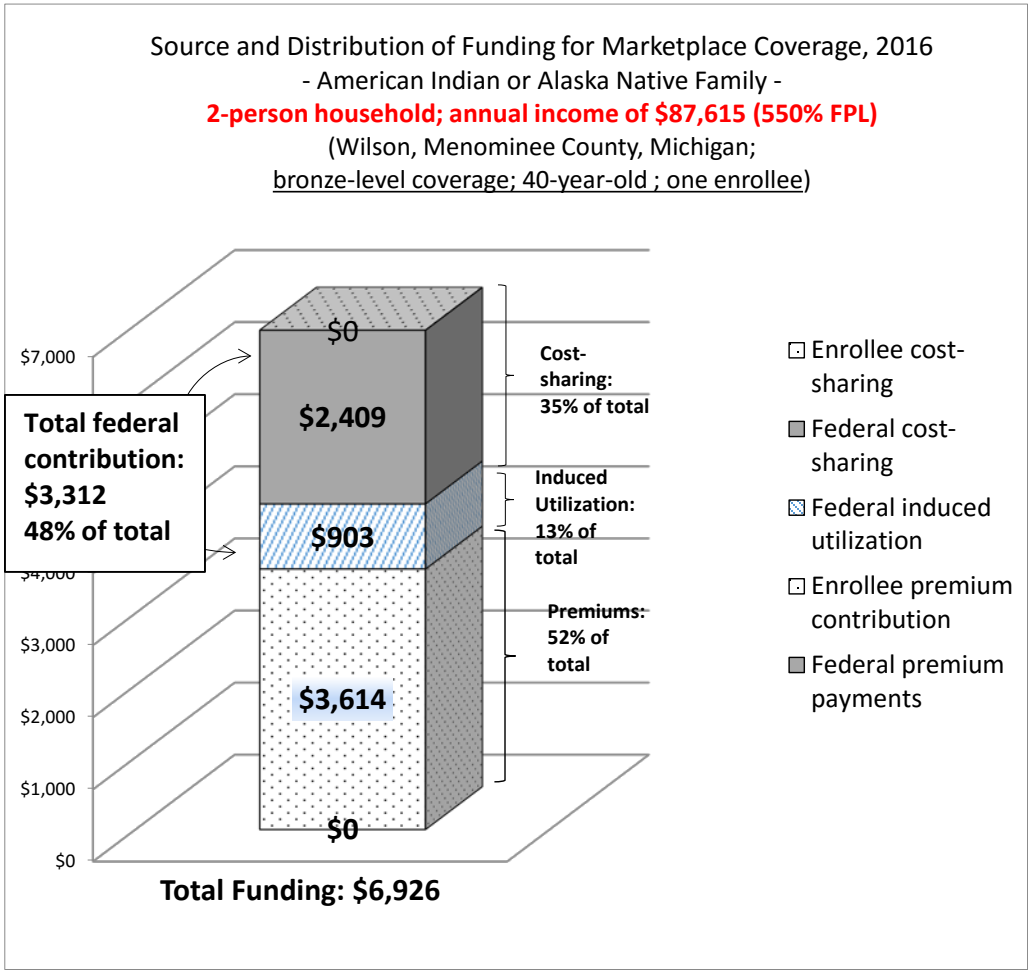
45 CFR § 155.350(a) Special eligibility standards and process for Indians.

* 45 CFR § 155.350(a) Eligibility for cost-sharing reductions.

** 45 CFR § 155.350(b) Special cost-sharing rule for Indians regardless of income.

Structure of Federal Financial Assistance through Marketplace Coverage

- Availability of premium tax credits (PTCs) and cost-sharing reductions (CSRs)



Standardized Templates for SBCs

- Example of SBCs offered by health plan issuer in Michigan:
  - http://www.bcbsm.com/index/health-insurance-help/documents-forms/sbc.html

Income 150-200 percent above the federal poverty level:
- Blue Cross® Partnered Silver Saver 87 (PDF)
- Blue Cross® Partnered Silver 87 (PDF)
- Blue Cross® Partnered Silver Extra 87 (PDF)
- Blue Cross® Select Silver Saver 87 (PDF)
- Blue Cross® Select Silver 87 (PDF)

- Many of the SBCs prepared for the Indian-specific cost-sharing variations were inaccurate, or no SBC was prepared
- At request of Tribal leaders, CCIIO/CMS/HHS has issued a "sample template" for issuers to draw from for each QHP variation

Sample Completed Template for Indian-Specific SBCs: "zero / 02" and "limited / 03"

- On July 13, 2016, CMS released sample completed SBCs for a limited cost-sharing variation (L-CSV) plan and a zero cost-sharing variation (Z-CSV) plan
- The sample completed L-CSV SBC shows the cost-sharing the consumer would have at an Indian health care provider (IHCP) or a non-IHCP
- The sample completed L-CSV SBC also explains under the limitations, exceptions, and other important information section that, if a consumer goes to an out-of-network provider that charges more than the allowed amount, the consumer might have to pay the difference (often referred to as balance billing)

- SBC Limited / "03": The sample completed L-CSV SBC is available at -- http://www.tribalselfgov.org/wp-content/uploads/2016/08/SBC_2017_Template_AI_AN_limited_6-7-16_508.pdf
  - And on CMS website -- http://files.kauffmaninc.com/projects/cms/documents/SBC_2017_Template_AI_AN_limited_6-7-16_508.pdf
- SBC Zero / "02": The sample completed Z-CSV SBC is available at -- http://www.tribalselfgov.org/wp-content/uploads/2016/08/SBC_2017_Template_AI_AN_zero_6-7-16_508.pdf

Indian-Specific SBCs

- Page 1 section:

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
Insurance Company 1: AI/AN Limited Cost Sharing

Coverage Period: 01/01/2018-12/31/2018
Coverage for: Individual + Spouse | **Plan Type**: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, [insert contact information]. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.[insert].com or call 1-800-[insert] to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0 at Indian Health Care Provider (IHCP) or with IHCP referral at non-IHCP; or $500 individual / $1,000 family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.

- Page 2 section:

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
	Primary care visit to treat an injury or illness	No Charge	$35 copay/office visit and 20% coinsurance for other outpatient services; deductible does not apply	40% coinsurance	Cost sharing waived at non-IHCP with IHCP referral. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).

Accessing Indian-Specific Cost-Sharing Protections

- TSGAC Webinar on Indian-specific cost-sharing protections
  - http://sgce.taopowered.net/health-reform/webinars/webinar-indian-specific-cost-sharing-protections-updates-on-federal-policies-and-implementation/
- When enrolled in family coverage through a Marketplace—
  - Cost-sharing protections for the whole family are based on the least generous cost-sharing protections that any one family member is eligible
    - If one family member is eligible for Indian-specific "02" or "zero cost-sharing protections" and another family member the "05" cost-sharing protections, the family is eligible for the "05" protections
      - But, only if enrolled in a silver-level plan (not bronze level)
  - If some family members meet the ACA's definition of Indian and some do not, enroll in separate plans
    - *e.g.*, enroll one in an "individual" "02"plan; enroll three family members in a "family" plan with "05" protections

Section 4: Tribal Sponsorship:
Title I contracting; Self-Governance approaches;
and other issues

Sponsorship Topics

- DST –SGT Joint Initiative
  - Direct Service Tribes Advisory Committee to IHS and Self-Governance Tribes Advisory Committee to IHS
- Authority for conducting Sponsorship
- Draft IHS circular on Sponsorship (Circular No. 2016-08; released July 18, 2016)
- Title I contracting process
- Self-Governance approaches

DST-SGT Joint Initiative on Sponsorship (1 of 2)

- In May 2015, the first joint meeting took place of the Direct Service Tribes (DST) Advisory Committee and the Tribal Self-Governance (SGT) Advisory Committee to IHS
- One initiative generated was the "DST-SGT Joint Initiative on Sponsorship"
  - Goal of Joint Initiative is to ensure that each Tribe, no matter where on the direct service-to-self governance spectrum, is able to use a portion of the congressional IHS appropriation for the Tribe for the purpose of Sponsorship of Tribal members
  - Tribes have authority whether to conduct Sponsorship of Tribal members or not
- DSTs, SGTs and IHS are working to create a set of tools to facilitate Sponsorship, including—
  - Agreement with IHS that a portion of funds currently managed by IHS can be transferred to Tribe to conduct Sponsorship
    - Or Tribe can use appropriations and 3rd party revenues the Tribe is managing
  - Working to ensure that IHS Areas provide regular reports on aggregate revenues generated at IHS facilities from a Tribe's sponsorship of Tribal members through a Marketplace

Joint Initiative (2 of 2)

- As part of the Joint Initiative, analyses are being conducted with a few Tribes on options for Sponsorship
  - Analyses are designed to facilitate participating Tribe's decision-making on Sponsorship
  - Analyses are being shared (after removing identifying information) to provide examples to other Tribes of potential results of conducting Sponsorship
- In addition, analyses are being conducted with a set of Tribes on Employer Options under the Affordable Care Act
  - These analyses assist participating Tribes in determining how best to meet the employer requirements under the ACA
    - These analyses also will be shared with other Tribes
  - These analyses are also informing efforts underway with the Treasury Department and Congress to secure relief from ACA's employer mandate on Tribal governments

Authority to Engage in Tribal Sponsorship

- Tribes and urban Indian organizations have authority under IHCIA § 402 to purchase health insurance coverage on behalf of Tribal members (IHS beneficiaries)
  - Tribal members are defined here as persons eligible for services from the Indian Health Service, Indian Tribes and Tribal organizations, and urban Indian organizations
- Payments made by a Tribe or Tribal organization on behalf of certain individuals are excluded from federal taxation
  - Sponsorship payments considered a "qualified Indian health care benefit"
  - http://www.gpo.gov/fdsys/pkg/USCODE-2010-title26/pdf/USCODE-2010-title26-subtitleA-chap1-subchapB-partIII-sec139D_2.pdf
  - Exemption from income applies to enrolled Tribal members or ANCSA shareholders and a dependent or spouse of an enrolled Tribal member or ANCSA shareholder
    - Exemption from income taxes does not apply to non-enrolled individuals who are no longer dependents of an enrolled member / shareholder

Greater Flexibility for Use of IHS Appropriated Funds under Reauthorized IHCIA

- Reauthorized IHCIA allows for expenditure of congressionally-appropriated funds and third party revenues from Medicaid, CHIP and Medicare to purchase health insurance coverage for IHS beneficiaries, referred to as Tribal "Sponsorship"
- On **TribalSelfGov.org**, a TSGAC memo is available on authorities to purchase health insurance for IHS beneficiaries, titled "Tribal Sponsorship through a Marketplace"

Health Care Reform in Indian Country

Self-Governance Communication & Education

Self-Governance Tribes Striving Towards Excellence in Health Care

Tribal Sponsorship through a Marketplace[1]

January 12, 2015

This brief seeks to provide guidance to Tribes that might use federally-appropriated funding or third party revenues to purchase health insurance for Tribal members[2] enrolled through a Marketplace.

Indian Tribes, Tribal organizations, and urban Indian organizations (T/TO/Us) can pay for health insurance coverage on behalf of their Tribal members enrolled through a Marketplace ("Tribal sponsorship").

Draft IHS Circular on Sponsorship (1 of 2)

- On July 18, IHS issued a draft circular and Dear Tribal Leader Letter (DTLL) on Sponsorship (Circular No. 2016-08)
- **Tribes should not be delayed in entering into a Title 1 contract with IHS during the period the draft Circular is being reviewed**
  - IHS confirmed this on July 25, 2016 Tribal consultation conference call
- On July 29, HHS issued a second DTLL announcing that IHS will extend the comment period on the draft Circular to October 31 and hold two in-person consultation sessions
  - 1st In-person Session: NIHB Annual Consumer Conference in Scottsdale, Arizona, on September 19, 2016, from 11 a.m. to 11:50 a.m
  - 2nd In-person Session: National Congress of American Indians 73rd Annual Convention and Marketplace in Phoenix, Arizona, on October 9, 2016, from 3:45 p.m. to 5 p.m
- Copies of DTLLs and Circular available at https://www.ihs.gov/newsroom/triballeaderletters/

Draft IHS Circular on Sponsorship (2 of 2)

- TSGAC and other Tribal organizations are engaging with IHS to better understand and provide comments on the draft Circular
  - Circular is offered "to provide further detailed guidance to IHS Area Office regarding the current IHS policy if a [T/TO/U] wishes to purchase coverage for IHS beneficiaries with ISDEAA funding or other IHS-appropriated funds."
  - Although many of the policies in the Circular are labeled as "recommended" rather than required, concern that the Circular is overly proscriptive and, ultimately, would unnecessarily constrain Tribes, particularly Title V compacting Tribes
  - Concern that Circular references an earlier (withdrawn) Dear Tribal Leader Letter (from October 2013) that restricts enrollment criteria a Tribe may apply
    - IHCIA § 402 clarifies that enrollment criteria T/TO/Us use "may be based on the financial needs of such beneficiaries", but does not require use of this criteria nor limit criteria to this one factor

Title I Contracting Process

Issues:

- Funding sources
  - Purchased/Referred Care (PRC); Hospitals & Clinics (H&C)
- IHS Reporting on Service Unit Third Party Collections and Expenditures
  - 3rd party collections (IHCIA § 207); and 3rd party expenditures (IHCIA § 401(c)(1)(B))
- Eligibility criteria: Tribal members; other Active Users
- Enrollment criteria: financial need; medically needy; and other criteria
- Contract support costs: Pre-Award; Start-Up; Indirect; and Direct

Self-Governance Approaches and Issues

- Title V Compacting Tribes should add “sponsorship” language to existing Tribe-IHS contract / funding agreement
- History of Sponsorship of Medicare beneficiaries for –
  - Medicare Part B premiums
  - Medicare Part B supplemental insurance
  - Medicare Part D pharmaceutical coverage
- Some Tribes have decided to meet employer requirements under the Affordable Care Act by—
  - (1) As employer, pay” shared responsibility payment to IRS ($2,160 per full-time employee in 2016)
  - (2) As Tribal government, sponsor uninsured Tribal member employees along with other uninsured Tribal members
  - (3) As employer, provide income supplement to non-Tribal member employees not eligible for Tribal government Sponsorship program

Tribal Option:
Steps to Sponsor Tribal Members

The Tribe, along with IHS, could implement the following steps to initiate sponsorship of Tribal members in Marketplace coverage –

- Identify funding source for Sponsorship program, such as–
  - For Title I Contracting Tribes: Purchased/Referred Care (PRC) program or Hospitals & Clinics (H&C) funds controlled by IHS or Tribe
  - For Title V Compacting Tribes: Appropriations or third party revenues
- Establish contract vehicle—
  - For Title I Contracting Tribes: Enter into a Title I contract with IHS to establish and fund the Sponsorship function
  - For Title V Compacting Tribes: Insert "sponsorship" language in existing Tribe-IHS contract / funding agreement
- Indicate amount of funding required in Year 1
- Tribe establishes enrollee eligibility criteria for Sponsorship program
- Transfer funds to Sponsorship program
- Enroll initial tribal members
- Tribe begins Year 2 process by identifying funding needed for Year 2

DST-SGT Joint Initiative: Process and Funding Flow

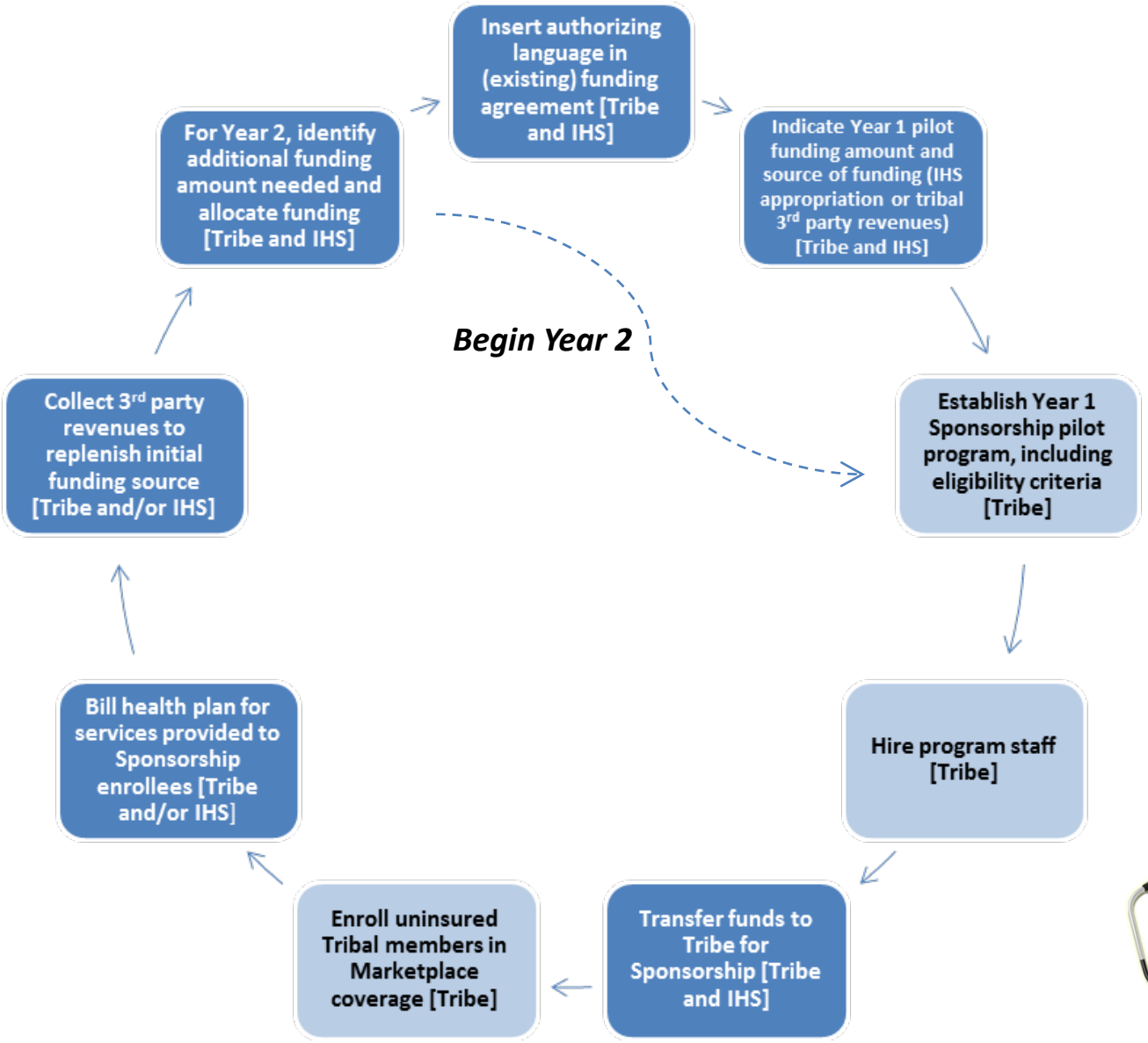


Illustration of Coverage of IHS Beneficiaries: Funding Source, by Insurance Type

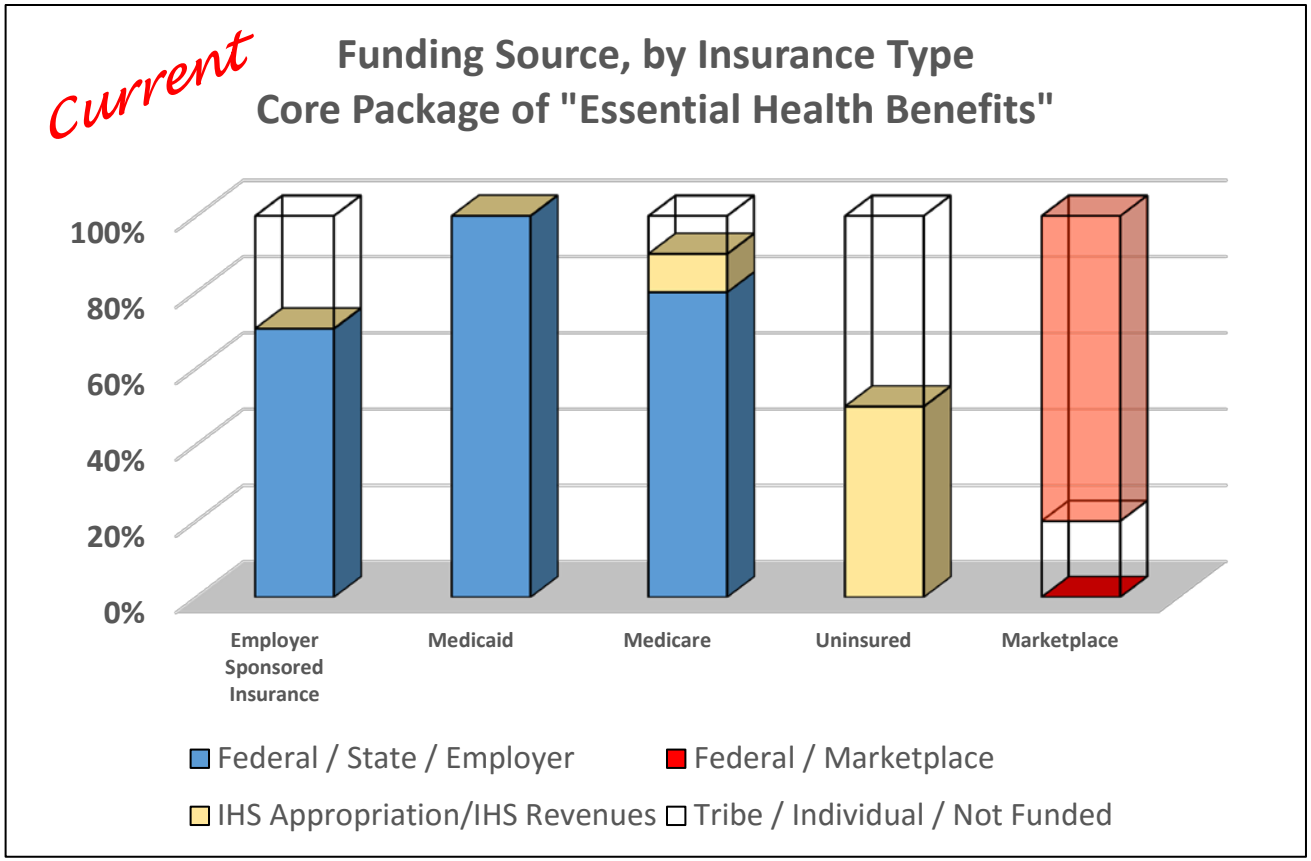
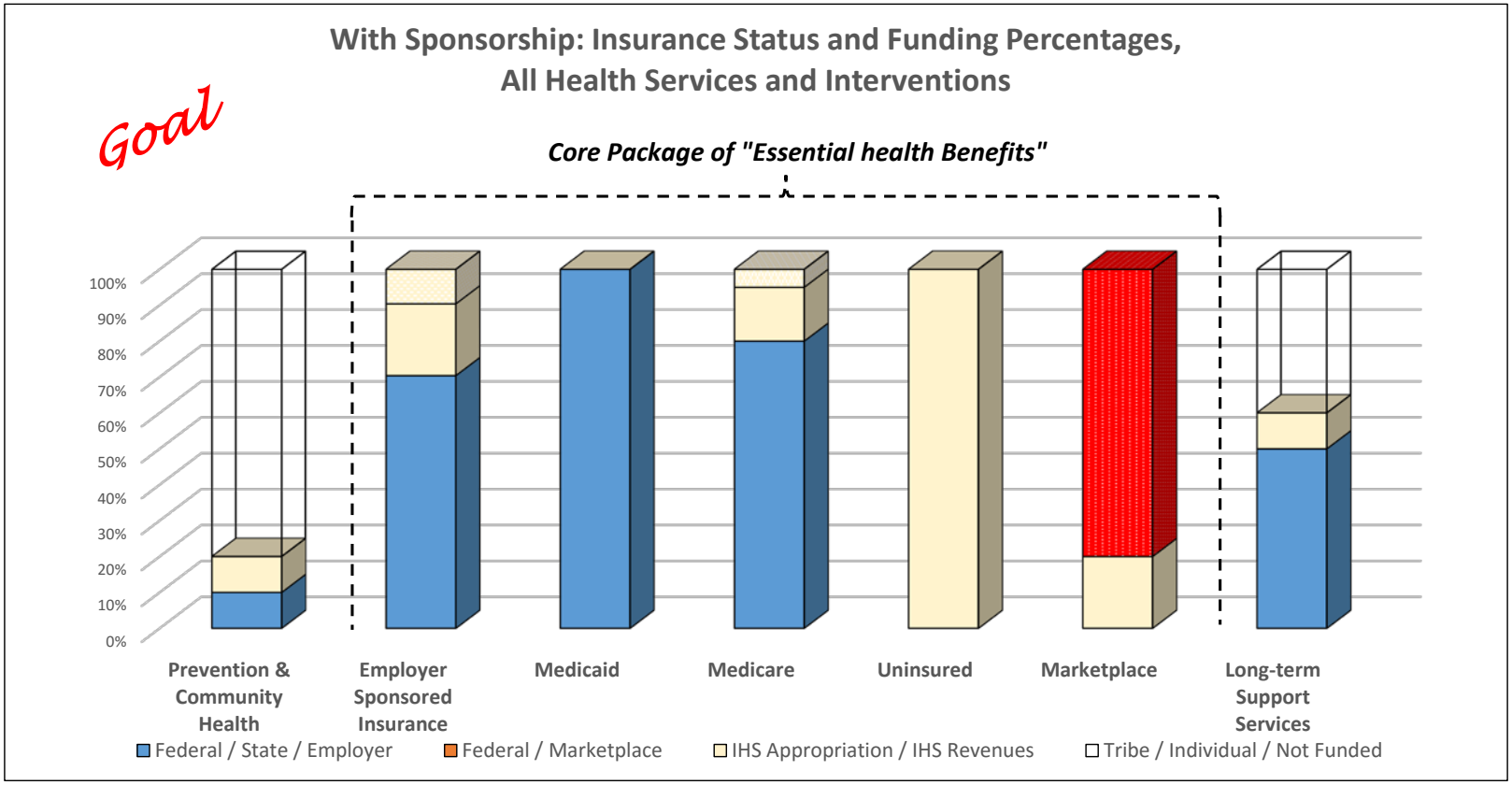
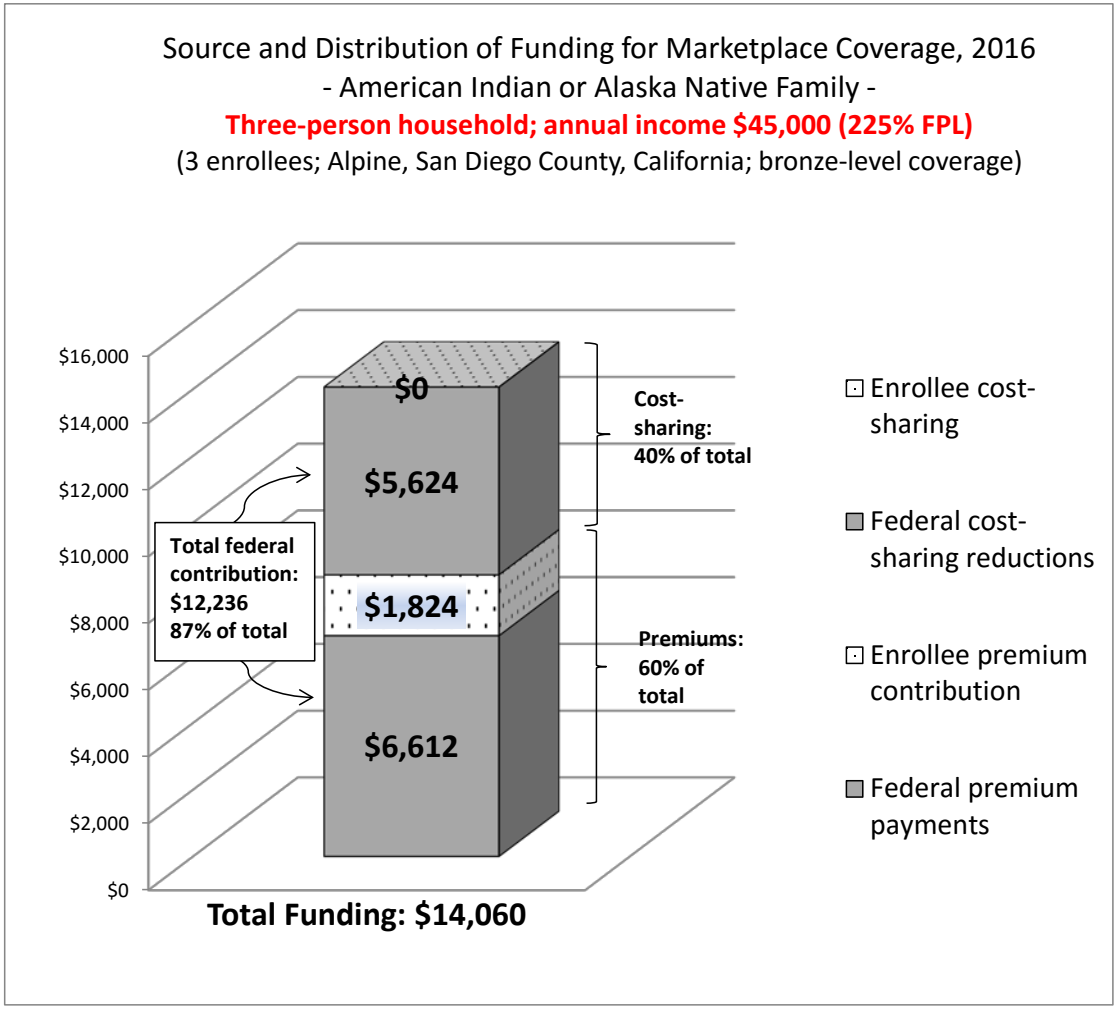


Illustration of Potential Impact of Sponsorship through Marketplace: Insurance Coverage and Funding Sources



New Resources Made Available through Marketplace

(Example of family of three; $45,000 in household income)

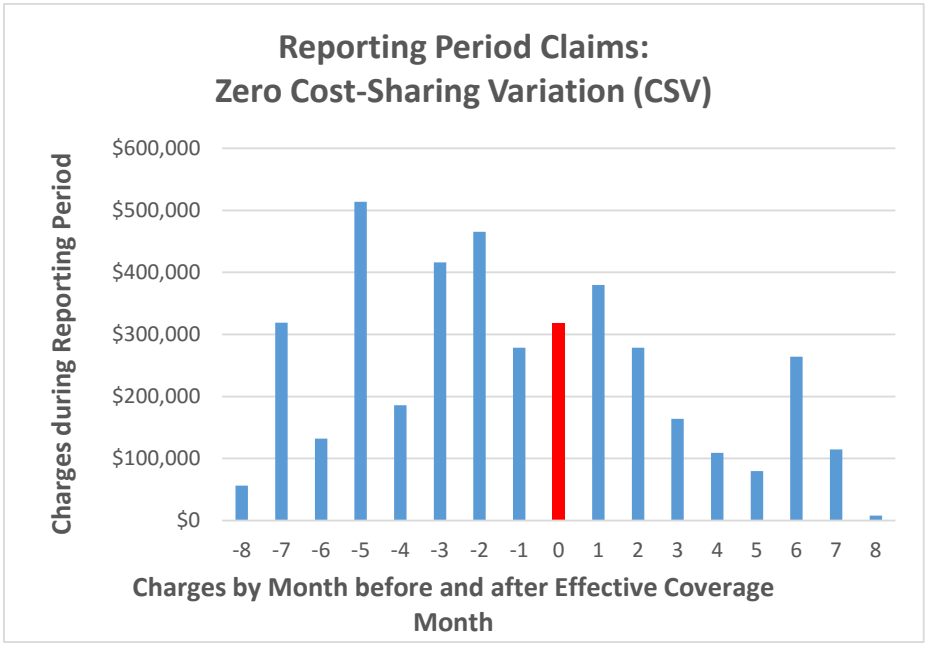


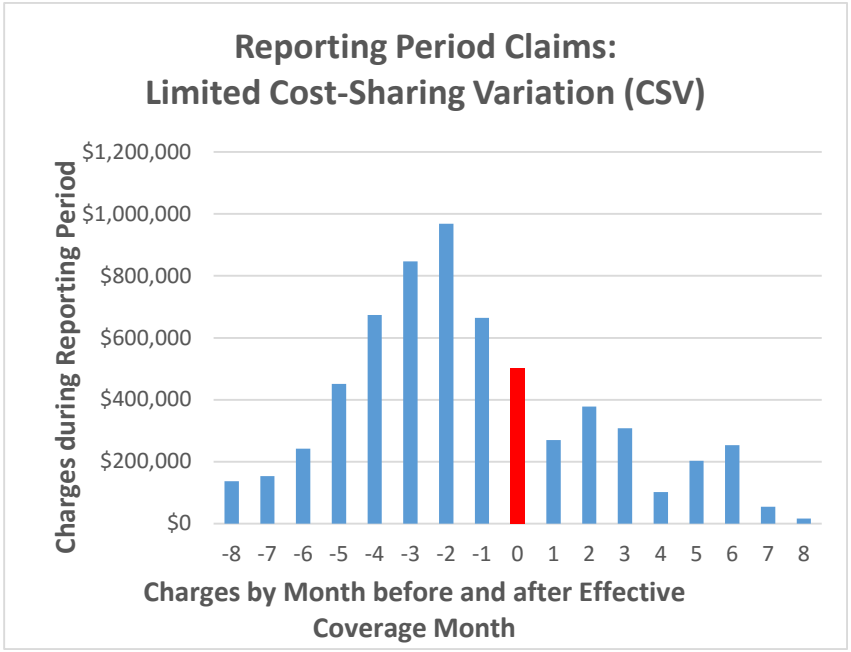
- AI/ANs are encourage to enroll in bronze level plans
  - Premiums are lowest
  - Federal contribution for CSRs is greatest
- Families with AI/AN and non-AI/AN members enroll in separate plans to maximize cost-sharing protections

Section 4: When and Who to Sponsor

- Timing
- Interaction and Integration of Sponsorship with Employer Options

Timing of Enrollment In Marketplace





Marketplace Coverage: All-in?

- Comparison of AI/AN family of three covered through Marketplace
  - All three family members (two adults; one child) covered through Marketplace
  - One family member (one adult) covered through Marketplace

3 Enrollees; All 3 Family Members Enrolled through Exchange

Tax Credit Calculation: Family of 3 in Red Mesa, Arizona

Income	$50,225	(250% FPL)	
Contribution %	8.18%		
	$4,108		
Premium: 2nd lowest cost silver plan		$3,744	27
		$6,381	50
		$2,269	child
Total premium	$12,394		
Tax credit amount:	**$8,286**		
Premium: lowest bronze*		$3,492	27
		$5,952	50
		$2,116	child
Total premium	$11,560		
Apply tax credit	$8,286		
Household premium owed	**$3,275**	- all 3 family members enrolled	

1 Enrollee in Marketplace; Other two offered coverage through employer

Tax credit calculation: Family of 3 in Red Mesa, Arizona

Income	$50,225	(250% FPL)	
Contribution %	8.18%		
	$4,108		
Premium: 2nd lowest cost silver plan		$3,744	27
			50
			child
Total premium	$3,744		
Tax credit amount:	**$0**		
Premium: lowest bronze*		$3,492	27
			50
			child
Total premium	$3,492		
Apply tax credit	$0		
Household premium owed	**$3,492**	- 1 adult family member enrolled	
	$218	**- net higher cost**	

* Bronze plan selected includes pediatric dental coverage and has an open provider network.