The Affordable Care Act and
American Indian and Alaska Natives

Frequently Asked Questions

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

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

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

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

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

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

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

The current IHS eligibility guidelines do not require a person to sign up for Medicaid or enroll in a Marketplace plan in order to be eligible for IHS direct care. The eligibility guidelines for the Contract Health Service (CHS) program do require individuals to sign up for alternate resources if they are eligible for them before CHS funds can be used. However, CHS does not require people to pay insurance premiums to acquire alternate resources.

5. What is the difference between the Exchanges and Marketplaces?

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

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

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

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

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

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

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

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

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

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

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

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

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

10. What are the Essential Health Benefits?

There are 10 essential health benefits (EHB) that every health insurance plan must have starting in 2014. They are:

- Ambulatory patient services (medical care by doctors and others)
- Emergency services
- Hospitalization
- Pregnancy and newborn care
- Behavioral health treatment
- Prescription drugs
- Rehabilitation
- Laboratory tests
- Prevention and chronic disease management
- Dental and vision services for children

The tax credits and cost sharing reductions only apply to the EHBs. All plans are expected to offer prevention services without cost sharing.

11. What is included in the term "cost sharing"?

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

12. What is the difference between CHS referrals and authorizations?

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

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

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

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

14. What is the Indian monthly special enrollment period?

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

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

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

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

15. Should I drop my current insurance and enroll in a Marketplace plan?

You should probably keep your current insurance under the following circumstances:

- If you have insurance from your employer and it is considered affordable (the premiums are less than 9.5 percent of your household income), then you cannot get tax credits or cost sharing reductions for Marketplace plans.
- If you have Medicare Part A (and any other Medicare coverage), you cannot get tax credits or cost sharing reductions for Marketplace plans if you drop your Medicare.

If you are currently purchasing insurance directly from an insurance company with no help from any employer or a government program, then you should look on the Marketplace to see if you could get a better policy at a lower cost. If you have Indian status under ACA, then you may see savings from not having co-pays or deductibles.

16. Should I get a family plan or individual plans for each member of my family?

Sometimes, the premiums are less expensive for a family plan, as compared to separate plans for each family member. A family can save money on premiums by purchasing a family plan if they have more than 3 children under 21 years old, since the additional children are not charged premiums in the family plan. However, if anyone covered by the family plan is <u>not</u> a Tribal member, then the Tribal members will not be able to enroll in a special AI/AN plan with zero cost sharing or limited cost sharing. However, families with incomes below 250 percent of the federal poverty level would be eligible for cost sharing reductions that are available for the general population. Families that are mixed should compare the costs of family plans with individual plans, taking into consideration the potential for cost sharing reductions.

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

The ACA regulations do not treat spouses as dependents. Therefore, employers do not have to offer insurance to spouses. If the employer does offer insurance for spouses, those spouses are not required get health care coverage that way, although they may choose to do so. If health insurance is purchased on the Marketplace, the family may receive a tax credit (if the household income is below 400 percent FPL).

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

Employer-sponsored insurance that provides minimum essential coverage (MEC) is considered affordable for the employee if the cost for the employee is less than 9.5 percent of the household income. Income from the spouse (and everyone in the tax filing unit) is included in the household income. If the employee has affordable MEC, then he/she is not eligible for tax credits for premiums or cost sharing reductions in the Marketplace.

19. What is MAGI and how is it determined?

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

20. How has the Affordable Care Act changed Medicaid eligibility?

Before ACA, Medicaid used both income and assets (like a house or a car) to determine eligibility. Starting January 1, 2014, all states must use MAGI only to determine eligibility for all Medicaid programs, except those for the elderly and people with disabilities (long term care). Before ACA, states could disallow a percentage of income for people to qualify for Medicaid and this varied considerably from state to state. The new approach under ACA requires a 5 percent disregard of income under MAGI, bringing all states under the same eligibility rules. In addition, ACA provides the option for state to expand Medicaid to cover adults who do not have children in their household.

21. Are the American Indian and Alaska Native (AI/AN) cost-sharing exemptions in Medicaid different from plans in the Marketplace?

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

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

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

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

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

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

Some people who self-identify as Indians will not be able to qualify for these exemptions. For example, members of state-recognized Tribes (that are not also federally-recognized) who do not live in communities that have an urban Indian clinic may not meet the IHS hardship eligibility requirements, but they may be eligible for other types of hardship exemptions. For example, there are exemptions for people for whom insurance is unaffordable (including smokers where the tobacco rating increases premiums in the Marketplace above 8.5 percent of their income), adults with incomes between 100-138 percent FPL who live in states that did not opt for Medicaid Expansion, people living in disaster areas, and people who are incarcerated.

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

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

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

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