Indian Health Care Improvement Act: Reauthorization in 2010

Avera Health
Sioux Falls, SD
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Objectives

1. Describe the history of the IHCIA

2. Explain the impact of the 2010 IHCIA reauthorization on AI health

HISTORY OF IHCIA

ENACTED September 30, 1976

As Pub. L. 94-437

Amended by:

- Pub. L. 96-537 (12/17/80)
- Pub. L. 100-579 (10/31/88)
- Pub. L. 100-690 (11/18/88)
- Pub. L. 100-713 (11/23/88)
- Pub. L. 101-630 (11/28/90)
- Pub. L. 102-573 (10/29/92)
- Pub. L. 104-313 (10/19/96)
- Pub. L. 105-277 (10/21/98)
- Pub. L. 105-362 (11/10/98)
- Pub. L. 106-417 (11/1/2000)
- Pub. L. 111-148 (3/23/2010), Section 10221

https://www.ncsl.org/documents/health/indhlthcarereauth.pdf

HISTORY OF IHCIA

Public Law 94–437
94th Congress

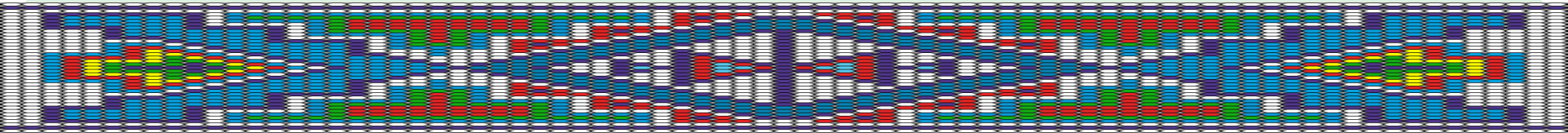
An Act

To implement the Federal responsibility for the care and education of the Indian people by improving the services and facilities of Federal Indian health programs and encouraging maximum participation of Indians in such programs, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Indian Health Care Improvement Act".

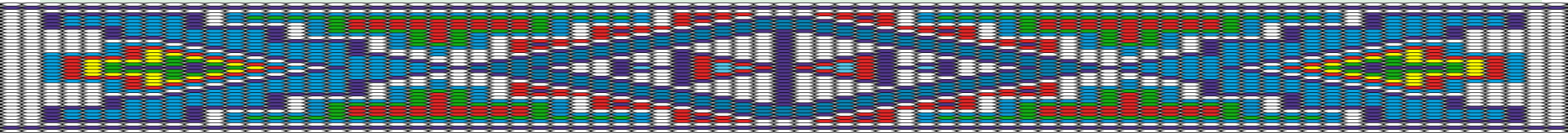
House Report 94-1026
April 9, 1976

"The most basic human right must be the right to enjoy decent health. Certainly, any effort to fulfill Federal responsibilities to the Indian people must begin with the provision of health services. In fact, health services must be the cornerstone upon which rest all other Federal programs for the benefit of Indians."



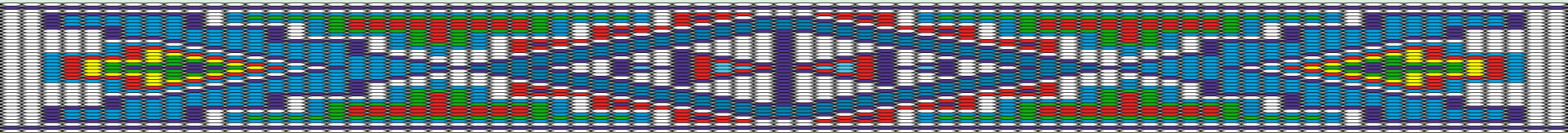
President Ford signs IHCIA into Law October 1, 1976

"I am signing the Indian Health Care Improvement Act. This bill is not without faults, but after personal review I have decided that the well-documented needs for improvement in Indian health manpower, services, and facilities outweigh the defects in the bill. Indian people still lag behind the American people as a whole in achieving and maintaining good health. I am signing this bill because of my own conviction that our first Americans should not be the last in opportunity."



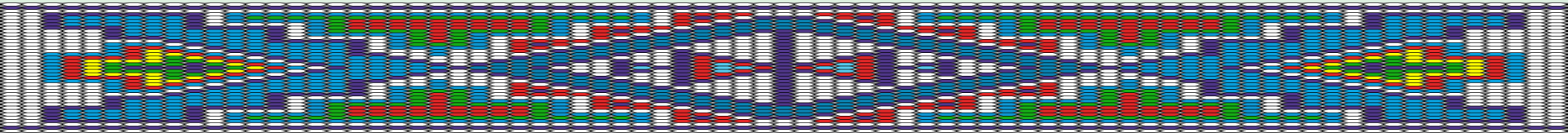
Indian Health Care Improvement Act of 1976 "Beyond the Snyder Act"

- The IHCIA, along with the Snyder Act, serves as the ***statutory basis*** for the Federal government's responsibility to provide health services.
- The IHCIA clearly acknowledged the legal and moral responsibility for providing the "highest possible health status to Indians.. With all the resources necessary to effect that policy."



IHCIA DID NOT ALL CHANGE
with Reauthorization as part of ACA

- Purpose, Policy & Definitions
- Title I Health Professions
- Title II Health Programs
- Title III Facilities
- Title IV Funding and Access (to 3rd party collections)
- Title V Urban Indian Programs
- Title VI IHS Organization
- Title VII Behavioral Health
- Title VIII Miscellaneous



IHCIA
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111TH CONGRESS
1ST SESSION

S. 1790

To amend the Indian Health Care Improvement Act to revise and extend that Act, and for other purposes.

"SEC. 3. 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 professionals in each Service area is raised to at least the level of that of the general population;

IHCIA
Reauthorization as part of ACA

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

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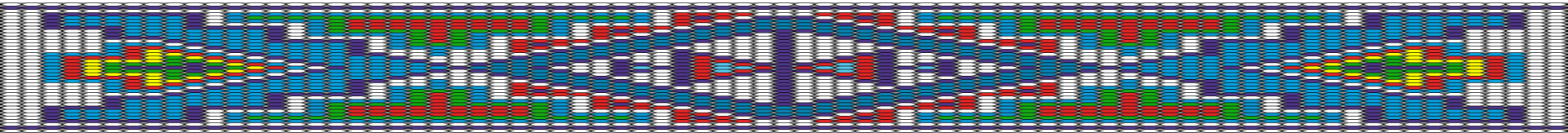
Health Issue	Current Problem	IHCIA Solution
Health Care Provider Shortage	**High Vacancy Rates** of Health Professionals at IHS and tribal sites are primarily the result of the remote geographic locations of the sites. • *Dental Professionals = 24%* • *Nurses = 26%* • *Physicians = 21%* • *Pharmacists = 11%* *(Source: IHS, 2009)*	**Strengthens** programs to help recruit and retain health professionals for the IHS and tribal sites: • *Scholarship and Loan Repayment Programs similar to the National Health Service Corps recruitment programs* (§104, 106, 110 and 123) ** • *Specific programs to recruit Indian students into psychology and behavioral health professions* (§105 and 126) ** • *Community health provider programs and training for community health providers at tribal colleges* (§118 and 121) **



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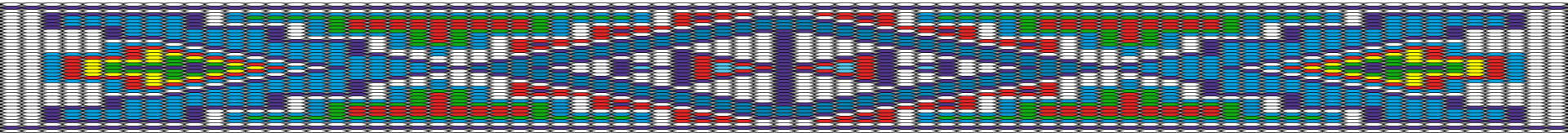
Facilities & Sanitation	**IHS and tribal health care facilities/equipment and sanitation facilities are old or non-existent:** • *Average age of IHS facilities is 30 years.* • *$476 million worth of maintenance needs backlog* • *10% of Indian homes lack of safe & adequate water supply (vs. 1% in U.S.)* • *3,200 construction projects in the sanitation facility backlog*	**Authorizes** innovative ways to overcome deficient and non-existent health care facilities and sanitation systems and construction backlogs. (*Title III*) ** **Updates** existing authorities for the construction of health facilities and sanitation facilities *(§302)* ** **Provides** authorities for innovate approaches for facility construction and funding through grants, joint venture



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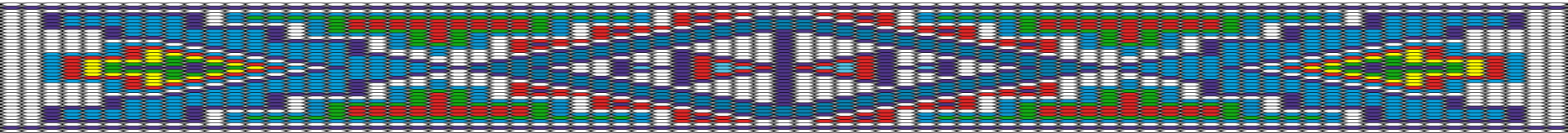
Elder/Long Term Care	**Lack of authority and facility space to provide care to the elderly and the disabled** • *Nursing homes and assisted living centers are not available on most reservations, less than 25 exist across Indian Country* • *Elderly and disabled have to travel hundreds of miles to obtain care*	**Authorizes** the creation of elder care programs that focus on behavioral health. (*§701*) * **Authorizes** programs for hospice, assisted living, long-term care and home and community based services. *(§204 ** and 212 *)*



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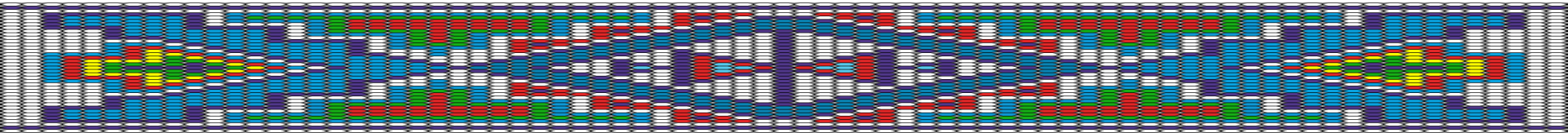
Cancer	**Lack of authority to provide cancer screenings, except mammograms**
	• *Poorest cancer survival rates among all ethnic groups due to:*
	  ○ *Genetic risk factors*
	  ○ *Late detection of cancer*
	  ○ *Lack of timely access to diagnostic and/or treatment methods*
	• *AI/AN women are 40% more likely to have kidney/renal pelvis cancer as non-Hispanic white women (CDC, 2008)*
	• *Mortality rate from cervical cancer is 1.9x higher in AI/ANs than in all other races (IHS, 2009)*
		Expands preventive services to cover cancer screenings based on national standards and recommendations of the US Preventive Services Task Force. Some of the new cancer screenings would include:
		• *Prostate Cancer*
		• *Cervical Cancer*
		• *Skin Cancer*
		• *Colon Cancer*
		(*§206*) **
		
		American Cancer Society statistics document early detection of cancer results in higher survival rates and saves lives.



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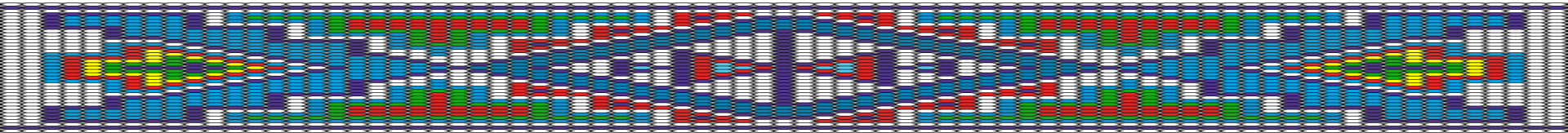
Diabetes	**AI/ANs die at higher rates than other Americans from diabetes.** • *AI/ANs diagnosed with diabetes at rate 2.3 times higher than whites (CDC, 2008)* • *Death rate is 190% higher in AI/ANs (IHS, 2009)* • *AI/ANs ages 10-20 have the highest prevalence of Type 2 diabetes (CDC, 2009)*	**Reauthorizes** effective diabetes projects, such as screening and prevention activities, and creates the ability to manage diabetes through culturally appropriate IHS and tribal programs. (*§203*) **



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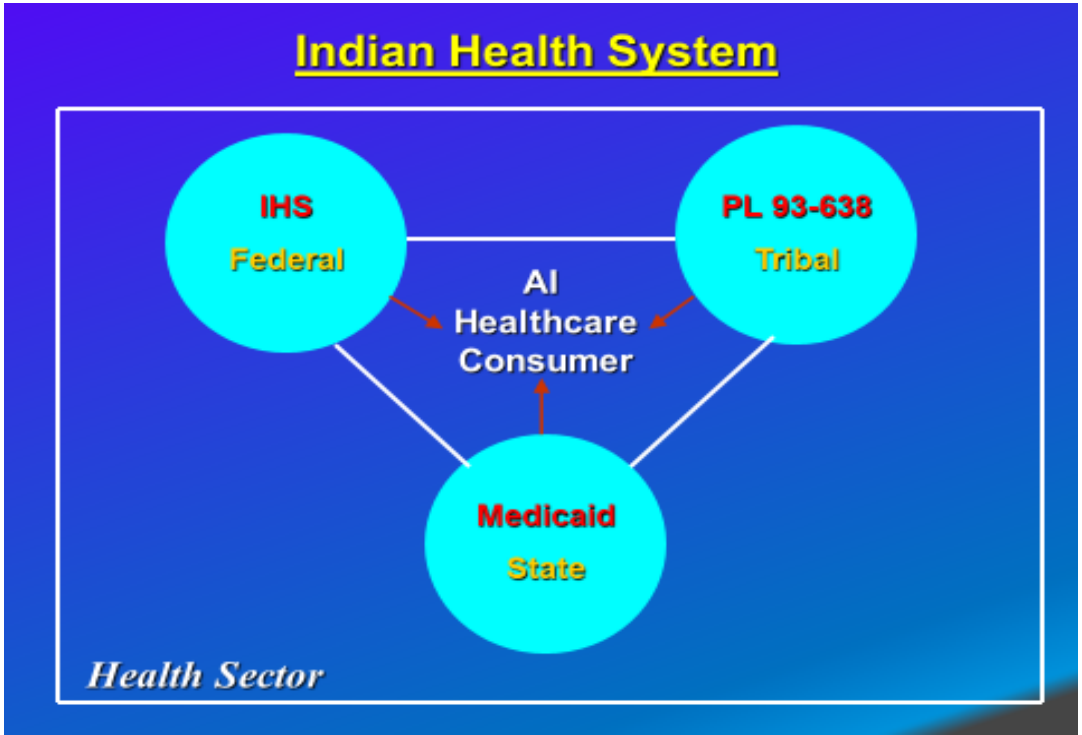
Medicare & Medicaid (M/M)	**Lack of access** to Medicate & Medicaid services due to rural and remote locations of tribal communities **Under-enrollment** of AI/ANs in Medicaid programs, especially on reservations which have high poverty rates.	**Updates** existing authorities for IHS and tribal facilities to provide services and collect Medicare & Medicaid (M&M) reimbursements, grant opportunities for M & M enrollment and outreach activities, and to collect reimbursements from other third party payers. (*Title IV*) **



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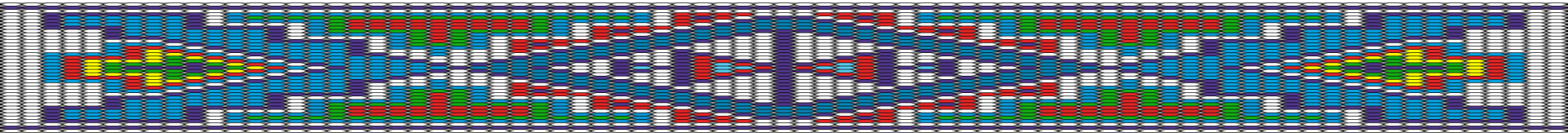
Behavioral Health	**Lack of authority to create new programs** to address rising need for services and treatment for mental health, alcoholism, and substance abuse. • *Suicide rate is 1.9 higher than the national average in AI/ANs ages 15 to 34 and the 2nd leading cause of death for AI/ANs ages 15 – 24 years* • *1/3 of demands on AI/AN health facilities are related to mental health, alcoholism and substance abuse.* *(IHS, 2009)*	**Consolidates** existing authorities to provide for a comprehensive approach to behavioral health assessment, treatment and prevention. (*Title VII*) ** **Expands** grant opportunities for in-person behavioral health and telemental health programs to include **youth suicide** and other new prevalent behavior health problems not previously listed. (*§209, 210, 701, 707, 708, and 713*) **

http://indiancountrytodaymedianetwork.com/2015/02/19/spate-youth-suicides-shake-pine-ridge-reservation-159222



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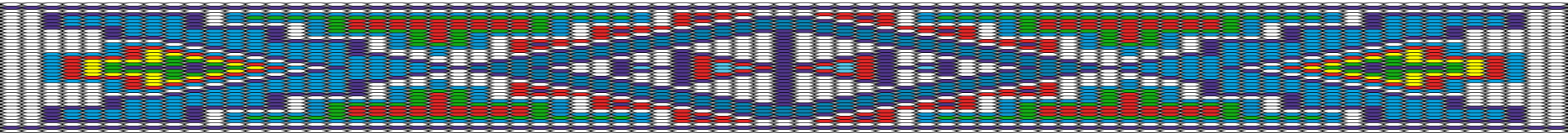
Infant Mortality & Maternal Health Rates	**Lack of modern authorities to address maternal and infant health issues:** • *Infant mortality rate is 1.4 times higher in AI/ANs than non-Hispanic whites.* • *AI/AN infants are twice as likely as non-Hispanic white babies to die from Sudden Infant Death Syndrome (SIDS).* *(CDC, 2008)*	**Authorizes** health promotion and disease prevention programs: • *To provide prenatal, pregnancy and infant care (§706)*** • *To avoid fetal alcohol spectrum disorders through education health programs (§712) ***

https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=38

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4035880/



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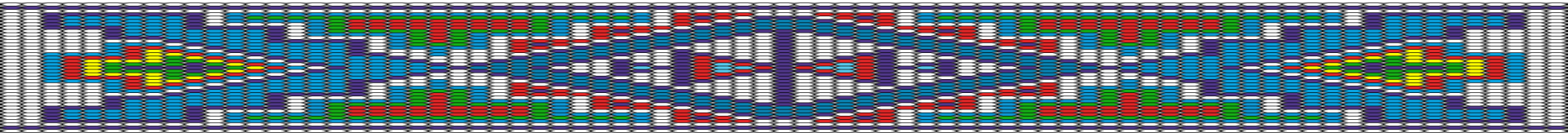
Unintentional Injuries	**Lack of modern authorities to address high incidence of unintentional injuries:** • *Injuries are the leading cause of death of AI/ANs ages 15 to 24 years* • *Injury mortality rates are 2 to 4 times higher in the AI/AN population compared to other Americans* • *Injuries result in 41% of years of productive life lost for AI/ANs* *(IHS, 2009)*	**Authorizes the IHS and tribal** Epidemiology Centers to access data, data sets, monitoring systems, delivery systems, and other protected health information for the purpose of preventing and controlling disease, injury or disability. *(§208)* ** **Promotes** the elimination, reduction, and prevention of environmental hazards and contaminants that create unhealthy household conditions. *(§214)* **

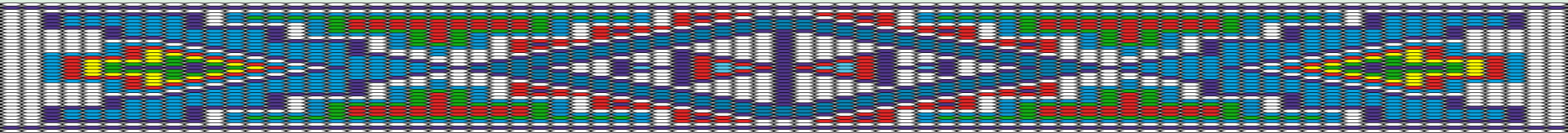


Opportunities that are NOT in the IHCIA amendments or ACA

***Medicare Like Rates –** MMA Sec. 506 (42 U.S.C. § 1395cc(a)(1)(U)); 42 CFR Part 136**.**

A Medicare enrolled hospital may not receive more than a Medicare Like Rate for services provided to an American Indian or Alaska Native (AI/AN) for any medical care purchased under the contract health services (CHS) program *[Now called Purchased and Referred Care / PRC]* or UIO purchase for urban Indian. IHCIA Sec. 4(5) defines CHS to include referrals without commitment to pay.

***Applies to Urban Indian Organizations (UIO), also**



What Did Not Change in Title V

Sec. 501 Purpose – establish programs in urban centers to make health services more accessible to urban Indians

Sec. 502 Contracts and Grants with UIO – Authority pursuant to Snyder Act

Sec. 503 Contracts and Grants for Provision of Health Care and Referral Services

Sec. 504 Contracts and Grants for Determination of Unmet Health Care Needs

Sec. 505 Evaluations; Renewals

Sec. 506 Other Contract and Grant Requirements

Sec. 507 Reports and Records

What Else Did Not Change in Title V

Sec. 508 Limitation on Contract Authority – Cannot exceed amounts appropriated for such purposes

Sec. 509 Facilities Renovation – to assist with maintaining The Joint Commission requirements

Sec. 510 Urban Indian Health Branch

Sec. 511 Grants for Alcohol and Substance Abuse Related Services

Sec. 513 Urban NIAAA Transferred Programs

Definitions That Did Not Change

Sec. 4 –

(13) Indians or Indian

(27) Urban Center – any community which has a sufficient urban Indian population with unmet health needs to warrant assistance under title V, as determined by the Secretary

(28) Urban Indian – any individual who resides in an urban center, as defined in subsection (27) and who meets one or more of the criteria in subsection (13)(1) through (4) [same as 42 CFR 447.50(ii)(A) through (D)]

(28) Urban Indian Organization

Who Is an "Indian" under the ACA?

"The term "Indian tribe" means any Indian tribe, band, nation, pueblo, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act, which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status of Indians."

IRC Sec. 45A(c)(6) only

IHCIA Sec. 4(14), ISDEAA Sec. 4(d), AND IRC Sec. 45A(c)(6)

IHCIA Sec. 4(14) only

Who Is an "Indian" under the ACA?

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IRC Sec. 45A(c)(6) only
IHCIA Sec. 4(14), ISDEAA Sec. 4(d), AND IRC Sec. 45A(c)(6)
IHCIA Sec. 4(14) only

"Indian" means a person who is a member of an Indian tribe (includes Alaska Natives). *See*, definitions above, 42 CFR 36 (IHS Eligibility Regulations) and 42 CFR 447.50 (CMS implementation of ARRA cost sharing protections)

How Does CMS Define "Indian"?

For purposes of Medicaid, ***Indian*** means any individual defined at 25 USC 1603(c), 1603(f), or 1679(b), or who has been determined eligible as an Indian, pursuant to Sec. 136.12. This means the individual:

(i) Is a member of a Federally-recognized Indian tribe;

(ii) Resides in an urban center and meets one or more of the following four criteria:

(A) Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendent, in the first or second degree, of any such member;

(B) Is an Eskimo or Aleut or other Alaska Native;

(C) Is considered by the Secretary of the Interior to be an Indian for any purpose; or

(D) Is considered to be an Indian under regulations promulgated by the Secretary;

(iii) Is considered by the Secretary of the Interior to be an Indian for any purpose; or

(iv) Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services , including as a California Indian, Eskimo, Aleut, or other Alaska Native.

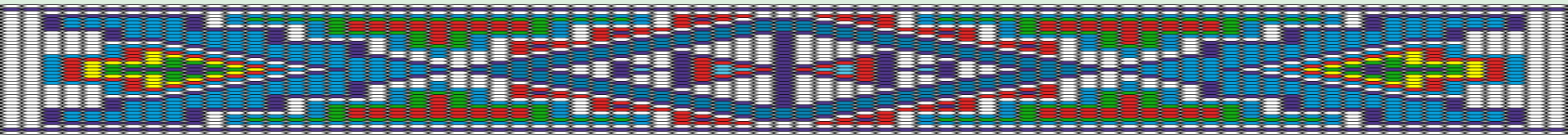
Where are we with the *definition of Indian*?

Advocates have asked for HHS and IRS to rely on the Medicaid regulation to clarify the meaning of the statutory definition.

CMS has agreed that the IHCIA and ISDEAA definitions are operationally identical. Improvement over proposed rule, but . . .

Members of Congress considering whether to try to fix it

Implementation of the IHCIA Amendments



New Definitions

Sec. 4 –

(12) Indian health program means (A) any health program administered directly by the Service; (B) any tribal health program; and (C) any Indian tribe or tribal organization to with the Secretary provides funding pursuant to section 23 of the Act of June 25, 1910 (25 USC 47) (commonly known as the 'Buy Indian Act').

(25) Tribal Health Program means an Indian tribe or tribal organization that operates any health program, service, function, activity, or facility funded, in whole or part, by the Service through, or provided for in, a contract or compact with the Service under the ISDEAA.

Consultation *and* Conference

***Policy Sec. 3(5)** "to require that all actions under the IHCIA be carried out with active and meaningful *consultation with Indian tribes* and tribal organizations, and *conference* with *urban Indian organizations*, to implement the IHCIA . . .

***Sec. 514 *Conferring* with Urban Indian Organizations (UIOs).** IHS must confer, "to the maximum extent practicable, with UIOs in carrying out the IHCIA.

Sec. 206 THIRD PARTY RECOVERY

25 U.S.C. § 1621e

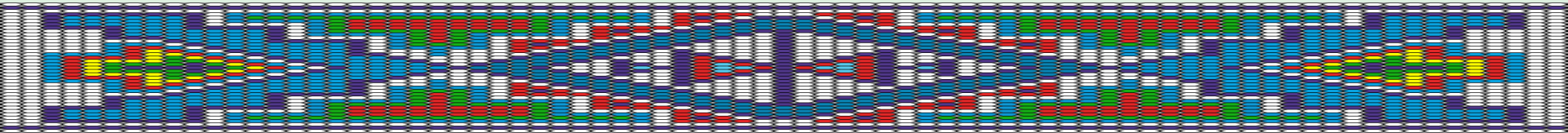
***Right to recover reasonable charges or highest amount the payer would pay a non-governmental provider**

- From insurance companies, HMOs, employee benefit plans, and any other responsible or liable third party
- Recovery from tortfeasors
- Allows THOs to use the *Federal Medical Care Recovery Act*
- No special claims processing rules can be imposed
- Allows THOs to recover costs and attorney's fees if they prevail
- Applies to urban Indian organizations (*see* subsection (i))
- Protects existing laws, including medical lien laws

https://www.ihs.gov/ihm/index.cfm/index.cfm?module=dsp_ihm_circ_main&circ=ihm_circ_0602

*Sec. 401 Reimbursement from Medicare, Medicaid, and CHIP

- Expanded to Children's Health Insurance
- Applies to all programs (rather than facilities)
- 100% pass through to program providing services (up from 80% for IHS directly operated)
- Expands allowable "use of funds," including to achieve the objectives under Sec. 3 of the Act
- No preferential treatment for beneficiary with Medicaid, Medicare or CHIP
- I/T/U must provide IHS a list of each provider enrollment number (or other identifier)



*Sec. 207 Crediting Reimbursement and Protection Against Offset

(a) All reimbursements received by I/T/U shall be credited to the unit that generated it. *(All 3rd party revenue is to go back to the service unit that provided the services and billed—cannot "pool" 3rd party funds to offset funding shortfalls at other sites)*

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(a) All reimbursements received by I/T/U shall be credited to the unit that generated it. *(All 3rd party revenue is to go back to the service unit that provided the services and billed—cannot "pool" 3rd party funds to offset funding shortfalls at other sites)*

(b) The IHS may not offset or limit any amount obligated to any Service Unit or entity receiving funding from the Service because of the receipt of reimbursements under subsection (a).

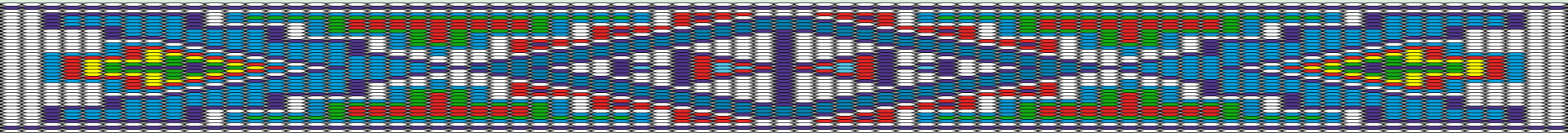
(IHS cannot limit direct funds to service units based on improved 3rd party revenue)

Purchasing Health Insurance

***Sec. 402 Purchasing Health Care Coverage.**

- IHS funds made available to an I/T/U (including ISDEAA funds) may be used to purchase health benefits coverage for beneficiaries
- May consider need of beneficiaries
- May cover expenses for a self-insured plan, including administration and insurance to limit financial risks

(Tribes can "638" PRC funds to buy insurance for tribal members! Can use marketplace to buy insurance on behalf of tribal members.)



New Employee Insurance Option

***Sec. 409 Access to Federal Insurance.** Allows a tribe or tribal organization carrying out programs under the ISDEAA, or an urban Indian organization with IHS funding, to buy federal health insurance for the employees of the tribe, tribal organization, or urban Indian organization. *(Federal Employee Health Benefits Program—most tribes are finding that insurance purchased in the marketplace is less expensive than using FEHB)*

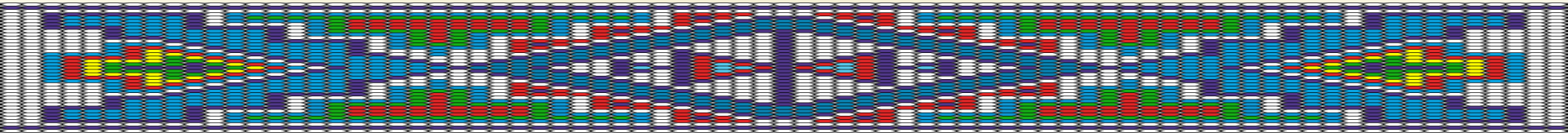
Office of Personnel Management (OPM) is implementing.

Overview of Section 409 Access to FEHB

Section 157: Access to Federal Insurance

Title IV of the Indian Health Care Improvement Act (25 U.S.C. 1641 et Seq.) (as amended by section 15) is amended by adding the following:

> *"Sec. 409. Access to Federal Insurance...an Indian tribe or tribal organization carrying out programs under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) or an urban Indian Organization carrying out programs under title V of this Act shall be entitled to purchase coverage, rights, and benefits for the employees of such Indian tribe or tribal organization, or urban Indian organization, under chapter 89 of title 5, United States Code..."*



Eligibility

- Tribes and Tribal organizations carrying out programs under the Indian Self-Determination and Education Assistance Act (ISDEAA), and urban Indian Organizations carrying out programs under title V, are eligible to purchase FEHB and FEGLI coverage

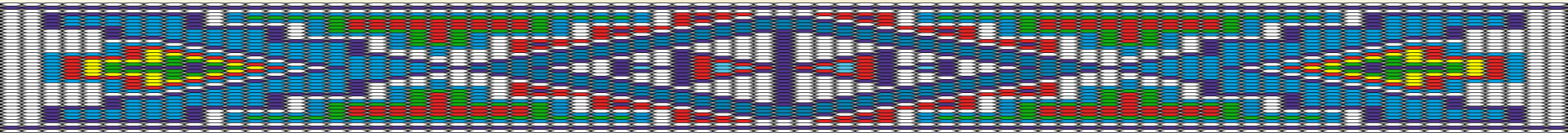
- Tribes carrying out programs under the ISDEAA and title V may purchase coverage for all Tribal employees meeting the common law employee standard

Advantages

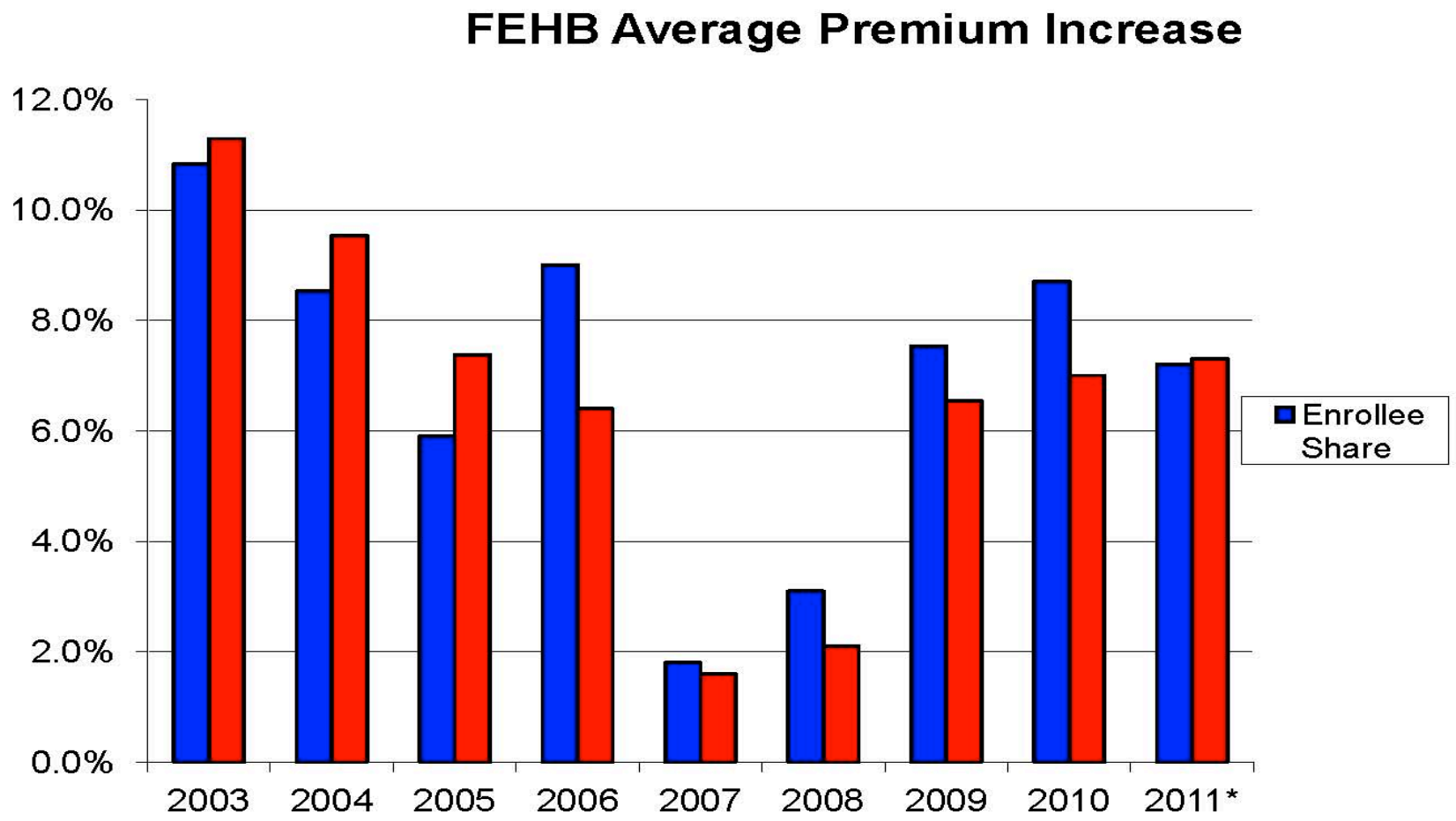
- *May be less expensive*
- *Employees may choose from multiple plans*
- *No waiting periods*
- *No pre-existing conditions limitations*

Disadvantages

- *No control over plan management*
- *No control over plan design*
- *Only 2 Coverage Tiers, Single / Family*
- *Some plans do not offer dental and vision*
- *No control over annual increases*
- *Tribe has to pay "at least" employer amount*
- *No coverage for non-employed Tribal members*
- *Rates set by OPM*
- *May be more expensive*
- *May be difficult to reenter commercial market*



FEHBP Rate History



FEES PARITY

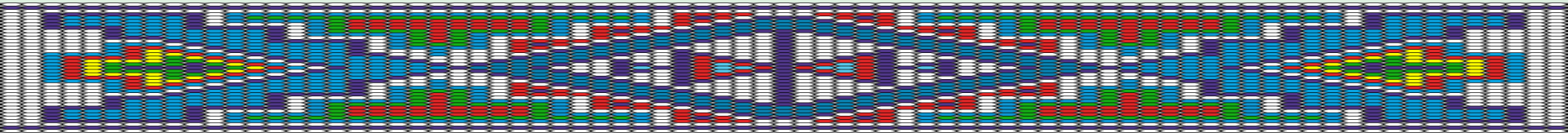
***Sec. 124 Exemption from certain fees.**

Employees of tribal and urban health programs are exempt from fees imposed by federal agencies to the same extent that IHS employees and commissioned corps officers are exempt (e.g., DEA registration fees).

OTHER PROVISIONS

***Sec. 805 Medical Quality Assurance Records & Qualified Immunity.** Provides authority for peer review to occur without compromising confidentiality of medical records and the review process

Sec. 831 Traditional Health Care Practices. Expressly authorizes the Secretary to promote traditional health care practices, but limits liability of United States for provision of such services *(What might the liability entail?)*



What Did Change in Title V (Urban)

Sec. 512 Treatment of Certain Demonstration Projects. Tulsa Clinic and Oklahoma City Clinic demonstration projects shall –

(1) Be permanent programs within the Service's direct care program;

(2) Continue to be treated as Service units and operating units in the allocation of resources and coordination of care: and

(3) Continue to meet the requirements and definitions of an urban Indian organization in this Act, and shall not be subject to the provisions of the ISDEAA.

https://www.ihcrc.org/

Other Opportunities for UIOs

Sec. 515. Expanded Authority.

Notwithstanding any other provision of the IHCIA, IHS may establish programs, including grants to UIOs, "that are identical to any programs established" under sections 218 (prevention, control and elimination of communicable diseases), 702 (behavioral health prevention and treatment services), and 708(g) (multidrug abuse program).

Other Opportunities for UIOs

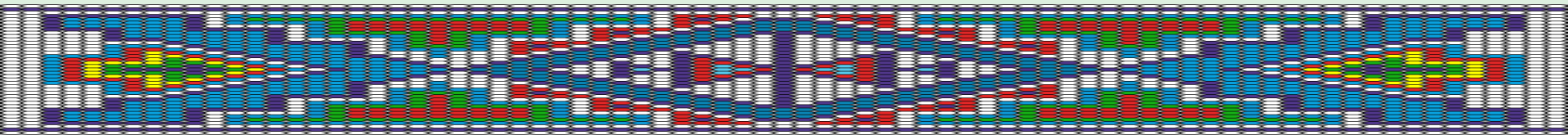
Sec. 516. Community Health Representatives – IHS may allow UIOs to employ CHRs trained under section 107.

Sec. 517. Use of Federal Facilities and Sources of Supply

Sec. 518. Health Information Technology grants.

https://www.indianz.com/News/2018/02/13/indian-health-service-budget-includes-fu.asp

OTHER CHANGES IMPORTANT TO TRIBAL HEALTH PROGRAMS

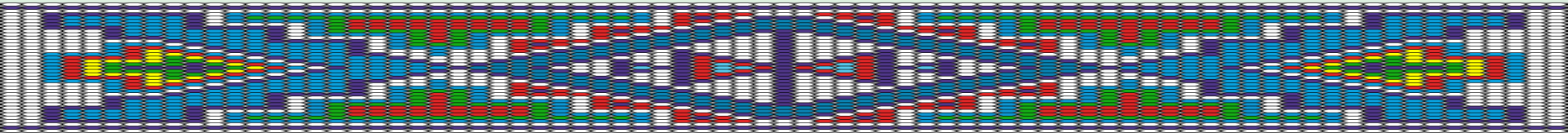


AI/ANs VETERANS
Streamlining and Opportunity

Sec. 405(a) Authorizes sharing arrangements between IHS, Tribes and Tribal Organizations, and VA and DoD.

Sec. 405(c) Requires VA and DoD to reimburse IHS and Tribal health programs for services provided to beneficiaries of VA or DoD

Sec. 407 Authorizes collaborations between VA and IHS/Tribal health programs at Indian health program locations



OTHER OPPORTUNITIES

Sec. 822 Shared Services for Long-Term Care.

Expressly authorizes sharing staff and other services between IHS or tribal health program and tribally operated long term care or related facility.

Sec. 307 Indian Health Care Delivery Demo. Projects

Encourages demonstration projects through IHS, tribes, or tribal health programs to test alternative means of delivering health services to AI/ANs through facilities and through alternative and innovative methods like community health centers and cooperative agreements with other community providers for sharing or coordinating use of facilities, funding, and other resources

Sec. 205 SUPPORTIVE SERVICES
PROGRAM EXPANSION FOR INDIAN HEALTH PROGRAMS

Assisted living service, as defined in 12 USC 1715w(b), except need not be licensed, but must meet applicable standards for licensure

Home- and community-based service means 1 or more services specified in 42 USC 1396t(a)(1)-(9) that are or bill be provided in accordance with applicable standards

Hospice care all items and services in 42 USC 1395x(dd)(1)(A)-(H) and "such other services the THO determines are necessary and appropriate in furtherance Of that care

Long-term care services as defined in section 7702B(c) of the Internal Revenue Code of 1986

Sec. 119 COMMUNITY HEALTH AIDE PROGRAM
Expanding Outside Alaska

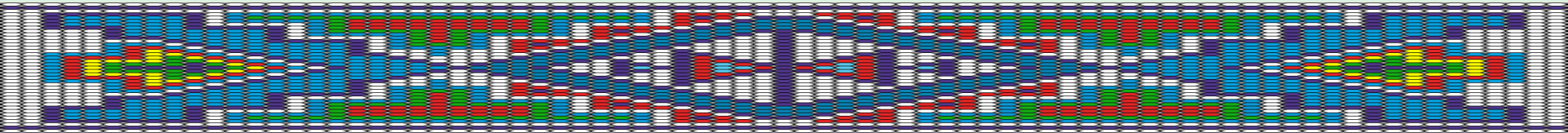
Extends program outside Alaska, except DHATs

- Provided funding must be found—NOT IHS…
- Consider grants for alternative care providers and third-party reimbursement (Medicaid can pay for CHAP services)

No limit on services by other dental health aides

Allows Tribes to use mid-level dental providers on the same basis *as authorized by the State*

SB 2354 in ND…Failed last legislative session…



AUTHORITY AND PROTECTION

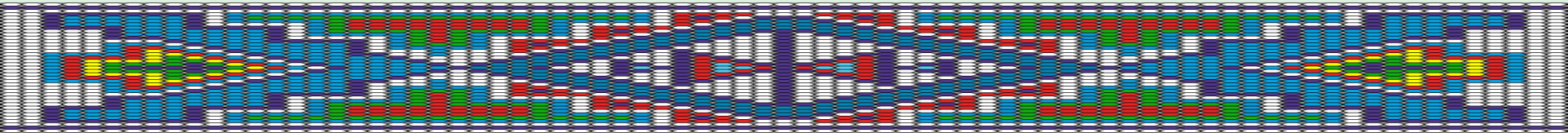
Sec. 828 Tribal Health Program Option for Cost Sharing.

Acknowledges authority of tribal health programs to charge Indians for services, but retains the limit on being required to do so.

Continues the prohibition on IHS charging AI/ANs for services or requiring any Tribal health pro to charge.

Sec. 206(f) IHS Recovery from Tribal Self-Insurance

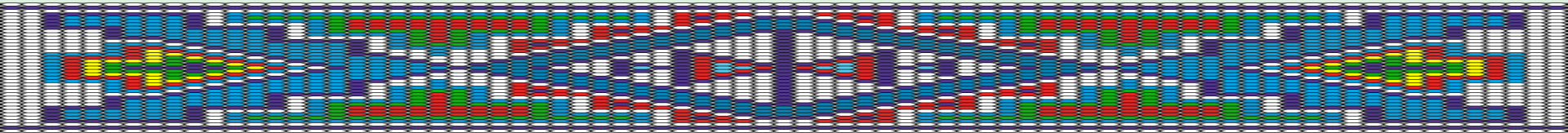
Prohibition continues *unless the Tribe expressly authorizes it* for periods that cannot exceed one year *(IHS cannot bill tribal self-insurance programs unless the tribe authorizes it)*



ACA and the IHCIA

***Payer of Last Resort** – ACA Sec. 2901(b); 25 U.S.C. § 1623(b). Health Programs operated by I/T/U are the payers of last resort for services provided to AI/ANs for services provided through such programs "notwithstanding any Federal, State, or local law to the contrary."

No Cost Sharing for Under 300% FPL** – ACA Sec. 1402(d) and 2901(a); 25 U.S.C. § 1623(a). AI/ANs with income at or below 300% of FPL enrolled in coverage under the exchange (Marketplace) are ***exempt from cost sharing.

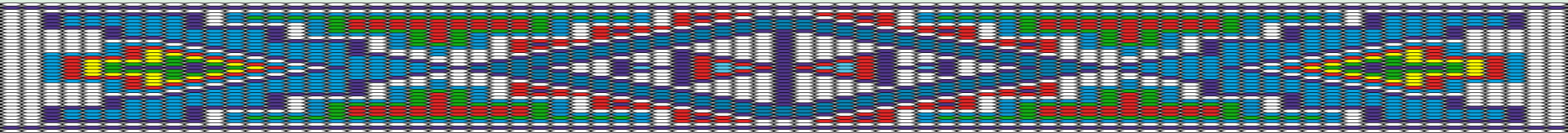


More from the ACA

Indian Specific Protections in Health Reform

Tax Penalty Exemption –Indians exempt from tax penalty for failure to maintain minimum essential coverage

Gross Income Exclusion – For tax purposes does not include the value of health care services or insurance purchased by poses the value of health services or insurance provided or purchased by a Tribe or Tribal Organization (“or through a third-party p rogram funded by the IHS”) is excluded from gross income not include the value of health care services or insurance purchased



Thank You Myra Munson

Myra M. Munson is a partner in the Juneau office of Sonosky, Chambers, Sachse, Miller & Munson LLP, which specializes in representing tribal interests in Alaska and throughout the United States.