

TRIBAL GLOSSARY





The material contained in this glossary was compiled based on information from [healthcare.gov](https://www.healthcare.gov), federal regulations and guidance, with input from our federal partners and the CMS Tribal Technical Advisory Group.

ADVANCED PREMIUM TAX CREDIT (APTC)

A tax credit that can help you afford coverage bought through the Marketplace. Sometimes known as APTC, “advance payments of the premium tax credit,” or premium tax credit. Unlike tax credits you claim when you file your taxes, these tax credits can be used right away to lower your monthly premium costs. If you qualify, you may choose how much advance credit payments to apply to your premiums each month, up to a maximum amount. If the amount of advance credit payments you get for the year is less than the tax credit you’re due, you’ll get the difference as a refundable credit when you file your federal income tax return. If your advance payments for the year are more than the amount of your credit, you must repay the excess advance payments with your tax return.

Members of federally recognized tribes and shareholders in ANCSA Corporations may use the APTC to purchase a qualified health plan at any metal level.

AFFORDABLE CARE ACT (ACA)

The comprehensive health care reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name “Affordable Care Act” is used to refer to the final amended version of the law.

The ACA also includes the permanent reauthorization of the Indian Health Care Improvement Act, which extends current law and authorizes new programs and services within the Indian Health Service.

The ACA established the Health Insurance Marketplace which includes special protections for members of federally recognized tribes and shareholders in ANCSA Corporations (regional or village):

- Special monthly enrollment periods
- Cost-sharing reductions through Limited and Zero Cost-sharing Plans
- Can apply for an exemption from the Shared Responsibility Payment



ALASKA NATIVE CLAIMS SETTLEMENT ACT (ANCSA) SHAREHOLDER (REGIONAL OR VILLAGE)

An individual who owns shares in any Alaska Native village corporation, Alaska Native urban corporation, or Alaska Native regional corporation as defined in, or established pursuant to, the Alaska Native Claims Settlement Act, 43 U.S.C. 1601 et seq. A list of ANCSA corporations is available from the State of Alaska Department of Natural Resources at: <http://dnr.alaska.gov/mlw/trails/17b/corpinde.cfm>

AMERICAN INDIAN/ALASKA NATIVE (AI/AN)

Below are the definitions of AI/AN for various health care programs:

ACA/MARKETPLACE

A member of a federally recognized tribe, or Alaska Native tribe, band, nation, Pueblo, village, or community that the Department of the Interior (DOI) acknowledges as an Indian tribe, including ANCSA regional and village corporations. There are over 560 federally recognized tribes in the U.S.

You may see the full list of federally recognized tribes and Alaska Native entities by visiting the Bureau of Indian Affairs (BIA) Tribal Directory at: <http://www.bia.gov/WhoWeAre/BIA/OIS/TribalGovernmentServices/TribalDirectory/>

MEDICAID/CHIP

An American Indian or Alaska Native or other individual who is eligible for health services through the Indian Health Service, tribes and tribal organizations, or urban Indian organizations (I/T/U).

INDIAN HEALTH SERVICE (IHS)

INDIANS

Individuals of Indian descent belonging to the Indian community served by the local facilities and program of the Indian Health Service are eligible for services. An individual may be regarded as within the scope of the Indian Health Service program if he or she is regarded as an Indian by the community in which he or she lives as seen by such factors as tribal membership, enrollment, residence on tax-exempt land, ownership of restricted property, active participation in tribal affairs, or other relevant factors in keeping with general Bureau of Indian Affairs practices in the jurisdiction. Eligibility based on one's status as a California Indian, Eskimo, Aleut, or other Alaska Native is included within this framework.

NON-INDIANS

Additionally, the following non-Indians are eligible for services from the Indian Health Service:

A. A child under the age of 19 who is the natural child, adopted child, stepchild, foster child, legal ward, or orphan of an eligible Indian,



- B. Spouses of an eligible Indian, if the tribe passed a tribal resolution that makes spouses eligible to receive services from the Indian Health Service, or
- C. Non-Indian women who are pregnant with the child of an eligible Indian.

URBAN INDIANS

The Indian Health Service also contracts with urban Indian organizations to provide services to urban populations for which special statutory eligibility criteria apply. To be eligible for the exemption as an urban Indian, an individual must reside in an urban center where an IHS funded urban Indian health program is located and meet one or more of the following four criteria:

- A. Be 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 descendant, in the first or second degree, of any such member,
- B. Be an Eskimo or Aleut or other Alaska Native,
- C. Be considered by the Secretary of the Interior to be an Indian for any purpose
- D. Be determined to be an Indian under regulations promulgated by the Secretary

AMERICAN RECOVERY AND REINVESTMENT ACT (ARRA)

The American Recovery and Reinvestment Act of 2009 was created to jumpstart the economy, create or save millions of jobs, and put a down payment on addressing long-neglected challenges so our country can thrive in the 21st century.

Section 5006 of ARRA provides Protections for American Indians and Alaska Natives under Medicaid/CHIP:

- Exempts AI/ANs from Medicaid coinsurance, deductibles and copayments for services if they have received services from an I/T/U or through Contract Health Services/Purchased and Referred Care. Any AI/AN eligible for I/T/U services or referral is exempt from premiums and enrollment fees. Exempts Indian trust income and resources in determining eligibility for Medicaid and CHIP.
- Exempts Indian trust income and resources from Medicaid estate recovery in Medicaid.
- Allows AI/ANs enrolled in Managed Care to go to I/T/Us, whether in or outside of the network, protects payments for I/T/Us when AI/AN in managed care seek services there and establishes criteria for Indian Managed Care Entities.
- Requires States to solicit advice from I/T/Us on Medicaid and CHIP issues that have a direct effect on Indian Health Programs.



BALANCE BILLING

When a provider bills you for the difference between the provider's charge and the allowed amount your health plan will pay. For example, if the provider's charge is \$100 and the allowed amount is \$70, the provider may bill you for the remaining \$30. A preferred provider may not balance bill you for covered services.

This is not allowed in Medicaid, CHIP or for a service that has been authorized by CHS/PRC.

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

Insurance program jointly funded by state and federal government that provides health coverage to low-income children and, in some states, pregnant women in families who earn too much income to qualify for Medicaid but can't afford to purchase private health insurance coverage.

Since states have choices in how they design their program, CHIP may have a different name in your state. Please visit www.insurekidsnow.gov to find more info on your state's program.

COINSURANCE

Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is \$100 and you've met your deductible, your coinsurance payment of 20% would be \$20. The health insurance or plan pays the rest of the allowed amount.

- AI/AN enrolled in zero cost sharing plans through the Marketplace may not be charged co-insurance when receiving care from an I/T/U or when receiving essential health benefits through a QHP. There is no need for a referral from an I/T/U when receiving care through a QHP.
- AI/AN enrolled in limited cost sharing plans through the Marketplace may not be charged co-insurance when receiving care from an I/T/U or when receiving essential health benefits through a QHP. However, these individuals will need a referral from their I/T/U to avoid paying co-insurance.
- AI/AN who are eligible to receive services from an I/T/U are exempt from co-insurance in Medicaid and CHIP.



CONTRACT HEALTH SERVICES OR PURCHASED/ REFERRED CARE (CHS OR PRC)

Contract Health Services (CHS) means “any health service that is, (A) delivered based on a referral by, or at the expense of an Indian health program, IHS, a Tribe or Tribal Organization carrying out a CHS program of the IHS under the Indian Self-Determination and Education Assistance Act, including for this purpose a referral made by an Urban Indian organization (as that term is defined in 25 U.S.C. 1603(h); and, (B) provided by a public or private medical provider or hospital that is not a provider or hospital of the Indian health program. The name was changed to Purchased/Referred Care (PRC) in 2014. Under the ACA, a person enrolled in a limited cost sharing plan through the Marketplace will need to obtain a CHS/PRC referral or a referral from an urban Indian organization in order to avoid co-payments and deductibles when receiving essential health benefits outside the IHS or Tribal facility.

COPAYMENT (CO-PAYS)

A fixed amount (for example, \$15) you pay for a covered health care service, usually when you get the service. The amount can vary by the type of covered health care service.

- AI/AN enrolled in zero cost sharing plans through the Marketplace may not be charged co-payments when receiving care from an I/T/U or when receiving essential health benefits through a QHP. There is no need for a referral from an I/T/U when receiving care through a QHP.
- AI/AN enrolled in limited cost sharing plans through the Marketplace may not be charged co-payments when receiving care from an I/T/U or when receiving essential health care benefits through a QHP. However, these individuals will need a referral from their I/T/U to avoid paying co-payments.
- AI/AN who are eligible to receive services from an I/T/U are exempt from co-payments in Medicaid and CHIP.

COST SHARING

The share of costs covered by your insurance that you pay out of your own pocket. This term generally includes deductibles, coinsurance, and copayments, or similar charges, but it doesn't include premiums, balance billing amounts for non-network providers, or the cost of non-covered services. Cost sharing in Medicaid and CHIP also includes premiums.

Enrolled members of federally recognized Tribes and ANCSA shareholders who enroll in limited or zero cost-sharing plans through the Marketplace are exempt from most cost-sharing (i.e. deductibles, co-pays and co-insurance) when receiving EHBs. This does not include balance billing.

Under Medicaid and CHIP, AI/AN who have ever used I/T/U or CHS/PRC services are exempt from deductibles, coinsurance, copayments and premiums as well as balance billing.



DEDUCTIBLE

The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is \$1,000, your plan won't pay anything until you've met your \$1,000 deductible for covered health care. The deductible may not apply to all services.

- AI/AN enrolled in zero cost sharing plans through the Marketplace may not be charged deductibles when receiving care from an I/T/U or when receiving essential health benefits through a QHP. There is no need for a referral from an I/T/U when receiving care through a QHP.
- AI/AN enrolled in limited cost sharing plans through the Marketplace may not be charged deductibles when receiving care from an I/T/U or when receiving essential health care benefits through a QHP. However, these individuals will need a referral from their I/T/U to avoid paying deductibles.
- AI/AN who are eligible to receive services from an I/T/U are exempt from deductibles in Medicaid and CHIP.

ESSENTIAL HEALTH BENEFITS (EHB)

The Affordable Care Act ensures health plans offered in the individual and small group markets, both inside and outside of the Health Insurance Marketplace, offer a comprehensive package of items and services, known as essential health benefits. Insurance policies must cover these benefits in order to be certified and offered in the Health Insurance Marketplace. States expanding their Medicaid programs must provide these benefits to people newly eligible for Medicaid.

EHB must include items and services within at least the following 10 categories:

1. Outpatient care you get without being admitted to a hospital (ambulatory patient services)
2. Visits to the emergency room
3. Hospitalization
4. Maternity and newborn care
5. Mental health, behavioral health, and substance abuse treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices (such as physical, occupational, or speech therapies that help improve skills for daily living)
8. Laboratory services
9. Preventive and wellness services and chronic disease management (such as screenings, check-ups, and monitoring and coordinating treatment)
10. Pediatric services (including oral and vision care)

Members of federally recognized Tribes and ANSCA shareholders enrolled in zero or limited cost-sharing plans may be charged cost-sharing for non-EHB services provided outside of the I/T/U system. Consult your plan documents for more information.



EXEMPTION

Under the Affordable Care Act, most people must pay a fee if they don't have health coverage that qualifies as "minimum essential coverage."

You may qualify for an exemption if:

- You're uninsured for less than 3 months of the year
- The lowest-priced coverage available to you would cost more than 8% of your household income
- You don't have to file a tax return because your income is too low (Learn about the filing limit.)
- You're a member of a federally recognized tribe or eligible for services through an Indian Health Services provider
- You're a member of a recognized health care sharing ministry
- You're a member of a recognized religious sect with religious objections to insurance, including Social Security and Medicare
- You're incarcerated (either detained or jailed), and not being held pending disposition of charges
- You're not lawfully present in the U.S.

FEDERAL POVERTY LEVEL (FPL)

A measure of income level issued annually by the Department of Health and Human Services. Federal poverty levels are used to determine your eligibility for certain programs and benefits. For purposes of the Marketplace, use 2014 FPLs. For Medicaid, use 2015 FPLs.

2014 income levels for 100% FPL:

- \$11,670 for individuals
- \$15,730 for a family of 2
- \$19,790 for a family of 3
- \$23,850 for a family of 4

2015 income levels for 100% FPL:

- \$11,770 for individuals
- \$15,930 for a family of 2
- \$20,090 for a family of 3
- \$24,250 for a family of 4

Federal Poverty Level amounts are higher in Alaska and Hawaii. FPL changes annually. For updated information go to: www.aspe.hhs.gov

FEDERALLY RECOGNIZED TRIBE

Any Indian or Alaska Native tribe, band, nation, pueblo, village or community that the Department of the Interior acknowledges to exist as an Indian tribe. For updated information visit: www.bia.gov/WhoWeAre/BIA/OIS/TribalGovernmentServices/TribalDirectory/

HEALTH INSURANCE MARKETPLACE (ALSO KNOWN AS THE EXCHANGE)



A resource where individuals, families, and small businesses can: learn about their health coverage options; compare health insurance plans based on costs, benefits, and other important features; choose a plan; and enroll in coverage. The Marketplace also provides information on programs that help people with low to moderate income and resources pay for coverage. This includes ways to save on the monthly premiums and out-of-pocket costs of coverage available through the Marketplace, and information about other programs, including Medicaid and the Children's Health Insurance Program (CHIP). The Marketplace encourages competition among private health plans, and is accessible through websites, call centers, and in-person assistance. In some states, the Marketplace is run by the state. In others it is run by the federal government.

HOME AND COMMUNITY BASED SERVICES (HCBS)

Services and support provided by most state Medicaid programs in your home or community that gives help with such daily tasks as bathing or dressing. This care is covered when provided by care workers or, if your state permits it, by your family.

INDIAN HEALTH CARE IMPROVEMENT ACT (IHCA)


The Indian Health Care Improvement Act (IHCA), the cornerstone legal authority for the provision of health care to American Indians and Alaska Natives, was made permanent when President Obama signed the bill on March 23, 2010, as part of the Patient Protection and Affordable Care Act.

INDIAN INCOME

Indian income describes a broad range of income derived from tribally related resources, including trust income. There are several types of Indian income:

- Distributions from ANCSA corporations and settlements trusts
- Per capita payments or distributions from trust or reservation property
- Income derived from property and rights related to hunting, fishing, and natural resources
- Income from the sale of cultural or subsistence property

In general, when applying for health insurance on the Marketplace, Medicaid, or CHIP, you only report income that is taxable by the IRS. Therefore, most Indian income is not counted when determining eligibility for these programs. However, income derived from Indian gaming is taxable and is therefore counted when determining eligibility for health insurance on the Marketplace, Medicaid, and CHIP.



This term includes the Indian Health Service (IHS), a Tribe (or tribal organization) carrying out a program of the IHS under the Indian Self-Determination and Education Assistance Act, or an urban Indian health organization.

LIMITED COST SHARING

A limited cost sharing plan is a plan variation available to members of federally recognized Tribes and ANCSA shareholders whose income is above 300% of FPL. Individuals enrolled in this plan:

- Don't pay co-pays, deductibles, or coinsurance when receiving care through an I/T/U
- Do need a referral from an I/T/U when receiving EHBs through a QHP to avoid paying co-pays, deductibles, or co-insurance
- Can enroll at any metal level on the Marketplace, a bronze plan may be the best choice as it costs the least

LONG TERM CARE

Services that include medical and non-medical care provided to people who are unable to perform basic activities of daily living such as dressing or bathing. Long-term supports and services can be provided at home, in the community, in assisted living or in nursing homes. Individuals may need long-term supports and services at any age. Medicare and most health insurance plans don't pay for long-term care.

MEDICAID

A state-administered health insurance program for low-income families and children, pregnant women, the elderly, people with disabilities, and in some states, other adults. The federal government provides a portion of the funding for Medicaid and sets guidelines for the program. States also have choices in how they design their program, so Medicaid varies state by state and may have a different name in your state. Visit www.medicaid.gov to find your state's program.

MEDICARE

A federal health insurance program for people who are age 65 or older and certain younger people with disabilities. It also covers people with end-stage renal disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD). Different parts of Medicare help cover specific services if you meet certain conditions.

Under the ACA, elders who have at least Medicare Part A have met the requirement for minimum essential coverage.

METAL LEVELS



There are four categories or “metal levels” of coverage in the Marketplace. Plans in each category pay different amounts of the total costs of an average person’s care. This takes into account the plan’s monthly premiums, deductibles, copayments, coinsurance, and out-of-pocket maximums. The actual percentage you’ll pay in total or per service will depend on the services you use during the year.

BRONZE: Your health plan pays 60% on average. You pay about 40%.

SILVER: Your health plan pays 70% on average. You pay about 30%.

GOLD: Your health plan pays 80% on average. You pay about 20%.

PLATINUM: Your health plans pays 90%. You pay about 10%.

All metallic plans offered on the Marketplace provide the same essential health benefits. The only difference between plans are plan networks, the cost of premiums and the level of cost-sharing. Limited and zero cost sharing plan variations are available at each metallic level for AI/AN.

Note: If members of federally recognized tribes and shareholders in ANCSA corporations are enrolled in a zero or limited cost sharing plan, they are exempt from most cost sharing. A bronze level plan provides the same level of coverage at the lowest cost.

MINIMUM ESSENTIAL COVERAGE (MEC)

The type of coverage an individual needs to have to meet the individual responsibility requirement under the Affordable Care Act. This includes:

- Individual market policies
- Job-based coverage
- Medicare
- Medicaid and CHIP
- Certain VA coverage: Veterans Health Care Program
 - TRICARE
 - CHAMPVA
 - Spina Bifida Health Care Benefits Program
- Certain other coverage

Note: IHS is not considered MEC. Individuals who receive care from an I/T/U and do not have additional coverage should apply for an exemption from the shared responsibility payment in order to avoid a tax penalty.

MODIFIED ADJUSTED GROSS INCOME (MAGI)



The figure used to determine eligibility for lower costs in the Marketplace and for Medicaid and CHIP. Generally, MAGI is your adjusted gross income plus any tax-exempt Social Security, interest, or foreign income you have.

Monies derived from protected Indian trust income and resources are deducted from the MAGI for Medicaid and CHIP.

NETWORK

The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Your I/T/U provider does not need to be in-network in order for you to continue receiving services there without cost sharing. You should tell your I/T/U clinic if you have insurance because your clinic can help coordinate your care and make referrals to medical specialists. They can make sure your bills get paid when you have insurance and help you with the paperwork of insurance and explain what everything means.

OPEN ENROLLMENT PERIOD

The period of time during which individuals who are eligible to enroll in a QHP can enroll in a plan in the Marketplace. For coverage starting in 2015, the Open Enrollment Period is November 15, 2014–February 15, 2015. Individuals may also qualify for Special Enrollment Periods outside of Open Enrollment if they experience certain events. You can apply for Medicaid or CHIP, at any time of the year.

Members of federally recognized tribes and ANCSA shareholders may enroll in, change, or cancel a Marketplace plan once every month and are not limited to open enrollment periods.

OUT OF NETWORK

A provider who does not have a contract with your health insurer or plan to provide services to you. You will pay more to use them. Even if your I/T/U provider is out-of-network, you can continue to receive services without additional costs.

OUT OF POCKET COSTS



Your expenses for medical care that aren't reimbursed by insurance. Out-of-pocket costs include:

- Deductibles
- Coinsurance
- Copayments
- Plus all costs for services that aren't covered

The maximum out-of-pocket cost limit for any individual Marketplace plan for 2014 can be no more than \$6,350 for an individual plan and \$12,700 for a family plan.

PER CAPITA

Generally refers to payments made per person to tribal members from tribal income, including payments or distributions from:

- Certain settlements
- Tribal trust income derived from tribal land
- Other tribal revenues that are distributed to tribal members on a per person basis
- Payment made from gaming revenue, which is taxable income

For more information about per capita payments as Indian income, see "Indian Income" in this glossary.

PRE-EXISTING CONDITION


A health problem you had before the date that new health coverage starts. Health insurance companies cannot refuse to cover you or charge you more just because you have a pre-existing condition. They also can't charge women more than men.

PREMIUM

The amount that must be paid for your health insurance or plan. You or your employer usually pays it monthly, quarterly, or yearly.

Note: While zero and limited cost sharing plans that are available to members of federally recognized tribes and shareholders to ANCSA corporations (regional or village) exempt plan holders from cost sharing in most circumstances this does not include premiums. Premiums for these plans must be paid regularly in order to continue receiving coverage.

PREVENTIVE SERVICES



Routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems. Many preventive services are considered EHBs under the ACA. For a list of covered preventative services, please visit: <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>

PRIMARY CARE PROVIDER

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Some insurance companies require that patients identify a primary care provider. You may designate your I/T/U provider as your primary care provider.

QUALIFIED HEALTH PLAN (QHP)

Under the Affordable Care Act, starting in 2014, an insurance plan that is:

- Certified by the Health Insurance Marketplace
- Provides essential health benefits
- Follows established limits on cost sharing (like deductibles, copayments, and out-of-pocket maximum amounts)
- Meets other requirements

SHARED RESPONSIBILITY PAYMENT (FEE)

Starting January 1, 2014, if someone doesn't have a health plan that qualifies as minimum essential coverage, he or she may have to pay a fee. This payment will either be a flat fee or a percentage of taxable household income, depending on which amount is higher. The fee will be:

- **2014:** \$95 per adult, \$285 for a family or 1% of taxable income
- **2015:** \$325 per adult, \$975 for a family or 2% of taxable income
- **2016:** \$695 per adult, \$2085 for a family or 2.5% of taxable income

The fee for children is half the adult amount. The fee is paid on the 2014 federal income tax form, which is completed in 2015. People with very low incomes and others may be eligible for waivers.

Members of federally recognized tribes and ANCSA shareholders and individuals who are otherwise eligible for I/T/U services may apply for an exemption from this fee thru the marketplace or they may apply for the exemption when filing their 2014 income tax.

SPECIAL ENROLLMENT PERIOD



A time outside of the open enrollment period during which you and your family have a right to sign up for health coverage. In the Marketplace, you qualify for a special enrollment period 60 days following certain life events that involve a change in family status (for example, marriage or birth of a child) or loss of other health coverage. Job-based plans must provide a special enrollment period of 30 days.

Important: Members of federally recognized tribes and shareholders in ANCSA Corporations can enroll in Marketplace coverage any time of year. There is no limited enrollment period and you can change plans as often as once a month.

SPECIALIST

A specialist focuses on a specific area of health care to diagnose, manage, prevent, or treat certain types of symptoms and conditions. Your primary doctor may refer you to a specialist.

ZERO COST SHARING

A zero cost sharing plan is a QHP variation available to members of federally recognized tribes and ANCSA shareholders whose income is at or below 300% of FPL. Individuals enrolled in this plan:

- May not have to pay co-pays, deductibles, or coinsurance when receiving care from an I/T/U or when receiving EHBs through a QHP
- Don't need a referral from an I/T/U when receiving EHBs through a QHP
- Can enroll at any metal level on the Marketplace, a bronze plan may be the best choice as it costs the least



CMS TRIBAL AFFAIRS

<http://go.cms.gov/AIAN>
www.healthcare.gov/tribal

CMS Product No. 11900