Response to Open Questions from TSGAC-NPAIHB Webinar
on Indian-Specific Cost-Sharing Protections

Q.6. We have come across some patients who are enrolled in an ACA plan but failed to check Native American/American Indian on their marketplace application. What is the easiest way to rectify that issue?

A.6. Contact a Marketplace Call Center representative to update the application. At minimum, cost-sharing protections going forward will reflect the Indian status of the applicant/enrollee, but the Indian-specific cost-sharing protections *might* be applied retroactively. The applicant/enrollee should consider whether a change in metal levels would be beneficial (*e.g.*, changing to a bronze plan) or whether there is a need to transfer into an individual policy (from a family plan) if other family members do not meet the ACA's definition of Indian.

Q.7. I believe I remember a detailed document prepared by the Medicaid, Medicare, and Health Reform Policy Committee (MMPC) of the National Indian Health Board that presents a table on referral requirements in order for a provider to receive payment. Does such a document exist?

A.7. Yes. Please find attached the document, titled "Tables on Referrals and Payment Rates for Services for American Indians and Alaska Natives Enrolled in Marketplace Plans," prepared by the MMPC, National Indian Health Board on May 23, 2014.

Q.8. At what point might the issuer request a referral? Will the patient be asked to provide the referral, or will the QHP request the referral from the THO?

A.8. It is advised that Indian Health Care Providers (IHCPs) work with Qualified Health Plan (QHP) issuers to establish procedures for providing a referral to the QHP and/or provider.

In general, though, a patient should always get a referral in order to avoid cost-sharing (whether in the form of a referral letter or card) when visiting the provider for a referred service. A copy of the referral should be issued by the I/T/U and provided to the patient to give to the provider.

Alternatively, some IHCPs might establish a process with a QHP issuer under which: (1) the IHCP would issue a comprehensive referral at the time of initial enrollment in the QHP; and, (2) the QHP issuer would record in the patient's eligibility file that the patient is eligible for elimination of all cost-sharing requirements for essential health benefits, as a referral is on file with the QHP issuer. Under this alternative, streamlined process, at the time a patient is accessing a health service, the provider would be able to determine that no cost-sharing is due either by viewing the information on the QHP-issued enrollment card, accessing an online data base, or calling/e-mailing the QHP issuer.

Q.9. For a Tribe without a clinic, a closed panel plan might be the best option for the member. Our goal has to be to make sure all members receive the care they need.

A.9. A closed panel QHP could be the best option for a Marketplace enrollee (even for an enrollee who meets the definition of Indian). However, before selecting a closed panel plan, the enrollee should first consider the limitations of electing this option.

With limited exceptions, a closed panel plan only makes payment for services rendered by providers within the plan's provider network. And because the services provided by non-network providers are considered "non-covered services" by the QHP, cost-sharing protections do not apply to these services. (An exception applies to emergency services, for which payment would be provided and cost-sharing protections would apply.)

Although a Tribe might not own a clinic, if the patient wishes to see other IHCPs (or non-IHCPs) that are not in the QHP's network, services rendered by these IHCPs are likely to be considered non-covered services. As non-covered services, the QHP generally will not make payment for these services. And again, cost-sharing protections do not apply to non-covered services.

Under section 206 of the Indian Health Care Improvement Act (IHCIA), IHCPs can seek reimbursement for services provided to closed panel plan enrollees. However, because the services are considered non-covered services by the QHP issuer and cost-sharing protections do not apply to non-covered services, any cost sharing that does apply will be deducted from any payments the QHP issuer makes to an IHCP. Given that most Marketplace enrollees meeting the definition of Indian will enroll in bronze-level coverage, a sizeable deductible might be applied to the payment to the IHCP under IHCIA section 206, significantly reducing or completely eliminating any payment to the IHCP.

For services provided by non-network, non-IHCPs, no payment at all would be made to the provider for services provided to a Marketplace enrollee. The enrollee, or a Tribal health organization's PRC program on behalf of the enrollee, would be liable for payment to the non-network, non-IHCP.

Q.10. How can you get the cost-sharing protections, if the Marketplace would not allow you to enroll. This has been an issue as approximately 10-15 members' identity could not be verified. Has anyone else had this issue, and how did you resolve it?

A.10. An individual must be enrolled in coverage through a Marketplace in order to secure the comprehensive Indian-specific cost-sharing protections. If you have not already done so, it is recommended that you contact the Marketplace Call Center to complete the application. If this is not successful, consider submitting a complaint through a Marketplace Call Center if this issue appears to be an error on the part of the Marketplace. In addition, feel free to submit a request through the Self-Governance Communication and Education website at: www. TribalSelfGov.org "Q&A" mechanism for TSGAC assistance in seeking resolution directly with CMS/CCIIO.

Q.11. To secure the comprehensive Indian-specific cost-sharing protections, a family member who is not a member of a federally recognized Tribe should enroll in an individual plan separate from the family plan. In this case, does the family member still use the "household" income when applying for coverage?

A.11. Yes. All Marketplace eligibility determinations that are based on income use “household” income. This is true whether applying for enrollment in an individual or family plan, and whether or not other family members seek Marketplace coverage at all.