

TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE

c/o Self-Governance Communication and Education

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Comments submitted via email at: FFEcomments@cms.hhs.gov

January 15, 2016

Department of Health and Human Services
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

RE: Comments on Draft 2017 Letter to Issuers in the Federally-facilitated Marketplaces

To Whom It May Concern:

The Indian Health Service Tribal Self-Governance Advisory Committee (IHS-TSGAC)¹ offers the following comments on the Draft 2017 Letter to Issuers in the Federally-facilitated Marketplaces (Draft 2017 Issuer Letter). We appreciate the opportunity to comment on this proposed guidance document from the Centers for Medicare and Medicaid Services (CMS) Center for Consumer Information and Insurance Oversight (CCIIO), as we have commented on past Issuer Letters applicable to years prior to 2017. We offer our comments on the Draft 2017 Issuer Letter below and do so in the order of presentation of the issues in the Draft 2017 Issuer Letter.

In the request for comments on the Draft 2017 Issuer Letter, CCIIO asked that, to the extent this document summarizes policies proposed through other rulemaking processes that have not yet been finalized, we should not repeat any comments previously provided on those topics. Recently, TSGAC submitted comments on CMS-9937-P, HHS Notice of Benefit and Payment Parameters for 2017 (2017 Benefit and Payment Parameters). Although some of the issues discussed in those comments overlap with contents of the Draft 2017 Issuer Letter, we will not repeat our comments in this document. Nonetheless, we are attaching the comments on CMS-9937-P for reference.

Analysis and Comments

In large measure, we would like to express support for the ongoing efforts of CCIIO to (a) improve the ability of consumers to compare and assess the value of qualified health plans (QHPs) offered through a Marketplace and to (b) increase the value of the QHPs offered. For instance, the Draft 2017 Issuer Letter includes an initiative to enable enrollees to better understand the QHP options, particularly with regard to cost-sharing protections, through the establishment of standardized options. In addition, there are initiatives to strengthen the availability of “in-network” health care providers in the QHP networks, thereby increasing access and decreasing the cost of receiving medically necessary health care services.

¹ The Tribal Self-Governance Advisory Committee (TSGAC) provides information, education, advocacy and policy guidance for implementation of Self-Governance within the Indian Health Service.

Chapter 1, Section 4. Standardized Options

Issue 1: QHP issuers will be required to offer “standardized options.” Each option is standardized in terms of in-network cost-sharing: deductible, annual limitation on cost-sharing, and copayment or coinsurance for a key set of essential health benefits (EHBs) that comprise a large percentage of the average enrollee’s total spending.

Although American Indians and Alaska Natives (AI/ANs) who meet the definition of Indian under the Patient Protection and Affordable Care Act (Affordable Care Act, or ACA) are eligible for comprehensive cost-sharing protections, AI/ANs can be subject to substantial “balance billing” charges when securing services at an out-of-network provider. The definition of plan cost-sharing does not technically include balance billing charges for purposes of the ACA-provided cost-sharing protections. But for QHP enrollees, balance billing charges can very much represent significant out-of-pocket costs.

Recommendation 1: We encourage CCIIO to include balance billing charges and policies as an element of the standardized options to enable better plan comparisons and to facilitate selection of plans with the greatest value for Marketplaces enrollees.

Chapter 2, Section 2. Service Area

Issue and Recommendation 2: See 2017 Benefit and Payment Parameters comments.

Chapter 2, Section 2. Network Adequacy

Issue and Recommendation 3: See 2017 Benefit and Payment Parameters comments.

Chapter 2, Section 13. Third Party Payment of Premiums and Cost Sharing

Issue and Recommendation 4: See 2017 Benefit and Payment Parameters comments.

Chapter 2, Section 14. Cost Sharing Reductions

Issue and Recommendation 5: See 2017 Benefit and Payment Parameters comments.

Chapter 3, Section 3. Out-of-Pocket Cost Comparison Tool

Issue 6: CCIIO is working to improve the ability of consumers to make comparisons between QHP offerings and to determine the QHP that offers the greatest value depending on a variety of factors. The creation of an out-of-pocket (OOP) cost comparison tool is one initiative that furthers these goals.

In designing the OOP cost comparison tool, it is critical to potential AI/AN enrollees that the tool incorporate the impact of the Indian-specific cost-sharing plan variations (zero cost-sharing plan variation and limited cost-sharing plan variation). Without having some acknowledgement – either in the dollar calculations presented or in a narrative descriptor that

appears on the screen – AI/AN enrollees will not be able to correctly assess the impact of various cost-sharing structures offered by QHP issuers. And AI/AN enrollees then will not be able to weigh accurately the issue of net OOP costs with other key variables, such as plan network and plan premiums.

Our concern with regard to the need to incorporate the impact of the Indian-specific cost-sharing variations in the OOP cost comparison tool parallels our concern with regard to the preparation of Summary of Benefits and Coverage (SBC) documents. (See 2017 Benefit and Payment Parameters comments.) Namely, if AI/AN consumers are not presented with SBC documents that incorporate the benefits available under the Indian-specific cost-sharing variations, potential AI/AN enrollees do not have available to them complete or accurate information.

Recommendation 6: In designing the OOP cost comparison tool, CCIIO should incorporate the impact of the Indian-specific cost-sharing protections. For the 2017 coverage year, if it is not feasible to incorporate this information in the actual calculations presented in the tool, CCIIO should at least provide information indicating to potential AI/AN enrollees that the calculations do not include the impact of the Indian-specific cost-sharing protections.

Chapter 7, Section 4. Summary of Benefits and Coverage

Issue and Recommendation 7: See 2017 Benefit and Payment Parameters comments.

Conclusion

Again, we appreciate the opportunity to comment on these issues. I am available to answer any questions you might have regarding our recommendations at lmalerba@moheganmail.com.

Sincerely,



Marilynn “Lynn” Malerba
Chief, Mohegan Tribe of Connecticut
Chairwoman, TSGAC

Enclosure: TSGAC Comments on CMS-9937-P, Notice of Benefit and Payment Parameters for 2017

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Comments submitted via www.regulations.gov

December 21, 2015

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

RE: Comments on CMS-9937-P, Notice of Benefit and Payment Parameters for 2017

To Whom It May Concern:

On behalf of the Indian Health Service Tribal Self-Governance Advisory Committee (TSGAC), we offer the following comments on CMS-9937-P, Notice of Benefit and Payment Parameters for 2017 (Proposed Rule).¹ Established in 1996, the TSGAC provides information, education advocacy and policy guidance for the implementation for Self-Governance within the Indian Health Service (IHS). We appreciate the opportunity to provide these comments.

We appreciate the opportunity to comment on this proposed rule from the Centers for Medicare and Medicaid Services (CMS), as we have commented on prior versions of the rule applicable to years beginning before 2017. We offer our comments on the Proposed Rule below.

Summary

The following topic areas are of particular importance to the ability of American Indians and Alaska Natives (AI/ANs) to access health care services and to the Indian health care providers (IHCPs) that serve as the primary health care providers to many AI/ANs:

- Application of federal requirements pertaining to network adequacy and essential community providers (ECPs) under the proposed State-Based Exchange on the Federal Platform (SBE-FP);
- Need for qualified health plan (QHP) issuers to issue a Summary of Benefits and Coverage (SBC) statement for each cost-sharing plan variation for plans offered through a Marketplace, as required under §156.420;
- Reconciling of excess amounts paid to QHP issuers as a result of QHP issuers over-estimating the value of cost-sharing protections extended on behalf of enrollees [§153.510(g)];
- Providing a delay in imposing reporting requirements on Tribes, Tribal health organizations, and urban Indian organizations considering purchasing health insurance on behalf of Marketplace enrollees;
- Inclusion of an *additional* criterion in the establishment of rating areas that applies a minimum threshold for the number of residents and / or the percentage of state residents in a rating area;

¹ 80 Fed. Reg. 75488 (December 2, 2015).

- Continuation of the induced utilization factors for coverage of zero cost-sharing plan variation (Z-CSV) enrollees and limited cost-sharing plan variation (L-CSV) enrollees;
- Clarification of the definition of “financial assistance” as it pertains to the calculation of shared responsibility payments and the notification of employers of potential liability for such payments;
- Revising the regulation to confirm the eligibility of family members to enroll with eligible individuals for the monthly special enrollment period; and,
- Need for attention to the process of dis-enrolling from Marketplace coverage and enrolling in to Medicaid coverage.

Analysis and Recommendations

1. Application of Federal Requirements Pertaining to Network Adequacy and ECPs under SBE-FP [45 CFR §155.200(f)]

Analysis: CMS is establishing a federal platform agreement through which a State Exchange can rely on the Federally-Facilitated Exchange (FFE) for certain functions as an SBE-FP [§§155.106(c) and 155.200(f)];

In establishing this option for states, CMS is proposing to require SBE-FPs to promulgate regulations at least as stringent as a number of FFE regulations to maintain consistency of the HealthCare.gov experience [§155.200(f)(2)]. These regulations would, in part, require SBE-FP states to require QHP issuers on an SBE-FP to comply with current and proposed FFE regulations on network adequacy standards (§156.230) and ECP standards (§156.235).²

Recommendation: We strongly concur with the CMS proposal and recommend that CMS retain the proposal to require SBE-FPs to apply standards no less strict than those contained in federal regulations to the SBE-FP. In particular, we support the proposal to apply *current and proposed* requirements pertaining to network adequacy and ECPs under the FFE to the SBE-FP. This proposal addresses, in part, prior Tribal recommendations that CMS require the adoption of standards by SBEs no less strict than federal ECP requirements pertaining to IHCPs.

We further recommend that CMS explicitly state in the preamble to the final rule on CMS-9937 that the implementing guidance issued through the annual CCIIO Issuer Letter also applies to SBE-FP states. This will reduce uncertainty for states and QHP issuers, as well as health care providers and Marketplace enrollees, about which federal regulations and guidance apply to the SBE-FP.

2. Standardized Options for Cost-Sharing Protections

Analysis: In the Proposed Rule, CMS is soliciting comments on proposals to standardize cost-sharing packages for at least a portion of the plan offerings through a Marketplace. According to CMS, doing so would facilitate for enrollees the comparison of QHP offerings available through a Marketplace, and thereby facilitate the selection of QHPs that offer the greatest value to the plan enrollee.

² A set of federal requirements pertaining to network adequacy and ECPs will become effective as of January 1, 2016, and are found at <http://www.ecfr.gov/cgi-bin/text-idx?SID=04d588e3d05458f8f571266a6852736e&mc=true&node=20150227y1.92>.

In addition to the development of these standardized cost-sharing packages, under §156.420, CMS currently requires QHP issuers to prepare and circulate an SBC for each plan variation.³ As indicated in the final rule issued in February 2015 (CMS-9944-F), these SBCs are to be made available by QHP issuers no later than November 1, 2015, for each plan variation. The purpose of the SBCs is to make available to (potential) enrollees information on the health benefits and cost-sharing requirements (and protections) under each plan variation.

As of mid-December 2015, few QHP issuers have made available to enrollees in the Z-CSV and the L-CSV SBCs specific to those CSV types.

Recommendation: We concur with the suggestion to develop a set of standardized cost-sharing packages for use in QHP benefit designs. But more importantly at this point, CMS should ensure that each QHP issuer prepares and makes available to potential and actual enrollees a Z-CSV and L-CSV for each QHP offering on the Marketplace, as required under §156.420.

3. Adjustments Required Pertaining to Cost-Sharing Payments Advanced to Issuers [§153.510(g)]

Analysis: CMS is proposing to make adjustments to amounts paid to QHP issuers to account for overestimates made by QHP issuers and overpayments made by CMS pertaining to cost-sharing protections extended on behalf of Marketplace enrollees.

Under the proposal, if a QHP issuer reported a certified estimate of 2014 cost-sharing reductions on its 2014 Medical Loss Ratio (MLR) and Risk Corridors Annual Reporting Form that is lower than the actual cost-sharing reductions provided, CMS would make an adjustment to the issuer's 2015 risk corridors payment or charge amount.

Whatever the mechanism to achieve this outcome, we strongly concur with the proposal to reconcile the advanced payment of cost-sharing payments to the actual cost-sharing paid out on behalf of enrollees. We believe it is critical that QHP issuers not be incentivized to overestimate the value of cost-sharing protections to be paid out to enrollees and to underprovide the cost-sharing protections actually made on behalf of enrollees.

Given that a reduction or absence of out-of-pocket costs on the part of enrollees (due to application of the federal cost-sharing protections) is viewed as potentially enhancing utilization of covered services for enrollees, there is an inherent misalignment of QHP issuer financial incentives with those of the enrollee. Namely, (a) the lower the cost-sharing requirements on enrollees, (b) the potentially higher the service utilization of enrollees, and therefore (c) the potentially greater the total payments for health services made by QHP issuers for services provided to enrollees paid for by the QHP issuer. Fully compensating

³ The two Indian-specific cost-sharing plan variations (described at 45 CFR §156.420) are:

(b) *Submission of zero and limited cost sharing plan variations.* For each of its health plans at any level of coverage that an issuer offers, or intends to offer in the individual market on an Exchange, the issuer must submit to the Exchange for certification the health plan and two variations of the health plan, as follows—

- (1) For individuals eligible for cost-sharing reductions under §155.350(a) of this subchapter, a variation of the health plan with all cost sharing eliminated; and
- (2) For individuals eligible for cost-sharing reductions under §155.350(b) of this subchapter, a variation of the health plan with no cost sharing on any item or service that is an EHB furnished directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization (each as defined in 25 U.S.C. 1603), or through referral under contract health services.

QHP issuers for funds advanced on behalf of AI/AN enrollees, if any, will strengthen the financial incentives for QHP issuers to enroll individuals under the Indian-specific cost-sharing protections. At the same time, limiting net payments by CMS to QHP issuers to the actual additional cost-sharing payment amounts advanced by QHP issuers on behalf of AI/AN enrollees will reduce the financial incentives for QHP issuers to not provide these cost-sharing protections to AI/AN enrollees.

Recommendation: We concur with the proposal to reconcile amounts owed by QHP issuers to CMS as a result of the QHP issuer overestimating the value of cost-sharing protections extended on behalf of Marketplace enrollees, as we believe it is critical that QHP issuers not be incentivized to overestimate the value of cost-sharing protections to be paid out to enrollees and to under-provide the cost-sharing protections actually made on behalf of enrollees.

4. Modification of Provisions Pertaining to Acceptance of Third Party Payments by QHP Issuers [§156.1250]

Analysis: The Proposed Rule would require entities authorized to make third party payments of premiums to notify CMS of their intent to pay the premiums of individuals enrolling through a Marketplace, a practice sometimes referred to as “sponsorship.” The notices would be required to be made in a format and timeline specified in subsequent guidance. At a minimum, the notification by the sponsoring entities would have to reflect the intent of the entity to make payments of premiums for Marketplace enrollees and to indicate the number of consumers for whom the entity intends to make payments. In addition, in the Proposed Rule, CMS requests comments on this proposed requirement and on what additional information entities should have to provide as part of the notification.

To date, CMS has clarified that requirements imposed on other entities authorized to sponsor individuals through a Marketplace (namely private, non-profit foundations) do not apply to Indian Tribes, Tribal organizations, and urban Indian organizations. These requirements pertain to the eligibility criteria applied to sponsored individuals and the length of sponsorship of Marketplace enrollees.

We believe that requiring Tribes, Tribal organizations, and urban Indian organizations to report on the number of AI/ANs that might potentially enroll in coverage through a Marketplace as a result of sponsorship is redundant to existing reporting and data available to the Marketplace. In addition, we believe the data that are currently readily available to the Marketplace are more accurate and more useful than data generated from projections of potential sponsors of enrollees through a Marketplace.

Information on AI/AN enrollment is already readily available and identifiable to CMS as, at the time of enrollment through a Marketplace, AI/ANs are asked to indicate (1) whether they meet the definition of Indian under the Affordable Care Act, (2) whether they are eligible for services from an IHCP, and (3) whether they identify as AI/AN.

The information that is already available to the Marketplace is derived from AI/ANs who are actually enrolled through a Marketplace, rather than projections on who might enroll, and as such, the information that might be requested from Tribal sponsors would be less useful than the data that is already available to the Marketplace.

Finally, Indian Tribes, Tribal organizations, and urban Indian organizations are just beginning to engage in sponsorship of Tribal members. Imposing reporting requirements at this early

stage that will require an Indian Tribe, Tribal organization, or urban Indian organization to project how many individuals will be sponsored and over what period of time, as well as to report on other factors that might be imposed by CMS, is likely to hinder efforts of Tribal entities to engage in sponsorship.

Recommendation: We ask CMS to clarify, as it has done previously with other requirements placed on some sponsoring entities, that Indian Tribes, Tribal organizations, and urban Indian organizations are not subject to the reporting requirements at this time.

5. Size of Rating Areas

Analysis: We are concerned about the wide variations in the geographic size of rating areas, but more importantly, we are concerned over the wide variations in the number of residents in the rating areas. This is a particular concern as it applies to rural counties and the AI/AN residents of these counties.

Specifically, we are concerned that the spreading of risk across a rating area is not sufficient if there are not a sufficient number of enrollees in the risk area. Narrow rating areas, which might be permissible under current rules, could permit intentional or unintentional discriminatory practices directed toward AI/ANs whereby a rating area is limited to the boundaries of, for example, an Indian reservation that correspond to the boundaries of one or more counties.

Narrow rating areas could lead to a death spiral in the rating area to the extent that higher (projected or actual) claims experience is reflected in higher premiums, thus prompting some potential enrollees to decline enrollment in the Marketplace because of a perception of high cost / low value of the plans offered.

Recommendation: We are suggesting that CMS consider the establishment of an *additional* criterion in the design of rating areas. We recommend that CMS consider applying a minimum threshold for the number of residents in a rating area and / or a minimum population threshold for a rating area that is no less than a specified percentage of residents in the non-metropolitan statistical areas (MSAs) of a state.

For instance, if the number of residents in the non-MSAs of a state is less than a specified numerical threshold, then all non-MSAs must be included in a single rating area. And regardless of whether the number of residents in non-MSAs exceeds the numerical threshold, no rating area covering predominantly non-MSAs could contain fewer residents than the equivalent of a specified percentage (such as 48 percent) of the residents of the non-MSAs of the state.

We would like to highlight that we are recommending that the minimum threshold numbers not be established using the number of Marketplace *enrollees* (but rather residents), as the use of enrollee counts could lead to furthering the isolation of certain rating areas to the extent there is relatively high enrollment of residents in Marketplace coverage in a particular county or counties.

6. Induced Utilization Factors

Analysis: “Induced utilization factors” provide adjustments to payments to QHP issuers for the provision of cost-sharing reductions due to increased utilization of health care services by enrollees who are receiving cost-sharing reductions. We concur with the inclusion of equivalent induced utilization factors / adjustments under the Z-CSV and L-CSV.

As you know, a “referral for cost-sharing” is required under the L-CSV in order to receive the comprehensive cost-sharing protections when receiving services at non-IHCPs but is not required for Z-CSV enrollees.

We believe that the “referral for cost-sharing” should be implemented in a manner that does not create a barrier for L-CSV enrollees to access services at non-IHCPs, and as such, the requirement for a “referral for cost-sharing” should not be projected to reduce overall utilization from that experience by Z-CSV enrollees.

Tribal representatives are hopeful that the comments they have provided to CMS over the past several months on the issue of what are the minimum data elements to include in a “referral for cost-sharing” will be adopted, thereby facilitating (and not hindering) AI/AN enrollee access to medically necessary services.⁴

We support the efforts of CMS to date to ensure that QHP issuers are fully compensated for the costs of covering AI/ANs under the Z-CSV and L-CSV. In addition to the three risk adjustment mechanisms applicable to all plans, CMS has provided (a) full reimbursement of cost-sharing protections advanced by QHP issuers on behalf of AI/AN enrollees under Z-CSV and L-CSV plans and (b) payment of the induced utilization factor to compensate QHP issuers for higher claims experience, if any, resulting from the comprehensive cost-sharing protections. Tribal representatives view these payment mechanisms as tools to minimize financial incentives QHP issuers might otherwise have to avoid enrollment of AI/ANs in QHPs.

Recommendation: We recommend that CMS retain the two equivalent induced utilization factors. Also, we encourage CMS to review the data pertaining to AI/AN enrollees under the Z-CSV and L-CSV to determine if the induced utilization factors are sufficient to fully compensate QHP issuers for the actual utilization of medically necessary health care services under these plan variations.

7. Informing Employers of Employee Financial Assistance Eligibility Determinations [§155.310(h)]

Analysis: CMS proposes to clarify when an employer is notified of an employee receiving financial assistance through a Marketplace, and this clarification is predicated on CMS refining the definition of “financial assistance” for purposes of determining when an employer might be subject to a shared responsibility payment. We concur with the proposed clarification by CMS of what is considered “financial assistance” through the Marketplace. We also note that a similar clarification will be needed on the part of the Internal Revenue Service (IRS) to ensure a companion determination is made in a consistent fashion by IRS.

⁴ See two sets of comments prepared by ANTHC and submitted to CMS regarding failure of a QHP issuer to comply with CMS guidance on referrals for cost-sharing protections: (1) June 30, 2015; Request for Immediate Assistance in Maintaining Access to Needed Health Care Services for Alaska Native and American Indian Marketplace Enrollees in Alaska; and (2) September 30, 2015; Continued Failure of a Qualified Health Plan to Comply with Indian-Specific Cost-Sharing Protections; Response to Request for Tribal Consultation on Referral Form.

The discussion of this topic contained in the preamble to the Proposed Rule is shown below.

“Currently under §155.310(h), the Exchange is directed to notify an employer that an employee has been determined eligible for Exchange financial assistance. We propose to revise this requirement so that the Exchange must notify an employer that an employee has been determined eligible for Exchange financial assistance only if the employee has also enrolled in a QHP through the Exchange. For purposes of this provision, an employee is determined eligible for cost-sharing reductions when the employee is determined eligible for cost-sharing reductions based on income in accordance with §155.305(g) or §155.350(a).” (Emphasis added.)

The regulatory text for the proposed §156.310(h) appears below.

“§155.310 Eligibility process. * * * * *

(h) *Notice of an employee’s receipt of advance payments of the premium tax credit and cost-sharing reductions to an employer.* The Exchange must notify an employer that an employee has been determined eligible for advance payments of the premium tax credit and cost-sharing reductions and has enrolled in a qualified health plan through the Exchange within a reasonable timeframe following a determination that the employee is eligible for advance payments of the premium tax credit and cost-sharing reductions in accordance with §155.305(g) or §155.350(a) and enrollment by the employee in a qualified health plan through the Exchange.”

Under current regulations, CMS does not distinguish between different types of cost-sharing reductions when determining if an employee received “financial assistance” through the Marketplace. By specifying “§155.305(g) or §155.350(a),” CMS is limiting a determination of “financial assistance” to (1) under §155.305(g), the general cost-sharing provisions available to enrollees between 100% and 250% FPL and (2) under §155.350(a), the Z-CSV for AI/ANs. We concur with this clarification. We believe it is consistent with the Affordable Care Act and with the current Marketplace application process, whereby an applicant is asked if he or she wishes to receive a determination of financial assistance.

As such, under this proposed change, if an AI/AN employee enrolled in the Marketplace and secured the L-CSV (and was not determined eligible for premium tax credits), the employer would not receive a notice that an employee secured “financial assistance” through the Marketplace.

This proposed change (defining “financial assistance” as securing an eligibility determination under the Z-CSV but not the L-CSV and / or securing premium tax credits), if finalized, would apply only to the employer notification requirement and would not affect IRS regulations on employer shared responsibility. It will be important to ensure that IRS makes a comparable clarification to its calculation of shared responsibility amounts due (see next paragraph).

Under section 4980H of the Internal Revenue Code (Code), applicable large employers (ALEs) might have to make one of two types of shared responsibility payments if they do not offer affordable health insurance to their full-time employees. As specified in section 4980H(a), the first type of payment applies if, for any month, an ALE does not offer minimum essential coverage to at least 95 percent of its full-time employees (and their dependents) and if at least one full-time employee is certified as “having enrolled for such month in a qualified health plan with respect to which an applicable premium tax credit or cost-sharing reduction is allowed or paid with respect to the employee” (emphasis added). In this case, the ALE must make an

annual payment of \$2,000 for each full-time employee (without regard to whether each employee received a premium tax credit or cost-sharing assistance), after excluding the first 80 or 30 full-time employees (depending upon the year) from the calculation.

Even if an ALE offers minimum essential coverage to a sufficient number of full-time employees (and their dependents) to avoid liability for the first type of shared responsibility payment, under section 4980H(b), an employer generally still will have to make the second type of payment for each full-time employee (if any) who is certified as “having enrolled for such month in a qualified health plan with respect to which an applicable premium tax credit or cost-sharing reduction is allowed or paid with respect to the employee” (emphasis added). In this case, the ALE must make an annual payment of \$3,000 for each full-time employee who received a premium tax credit or cost-sharing assistance.

For both types of shared responsibility payment, Code § 4980H(c)(3) defines “applicable premium tax credit or cost-sharing reduction” as:

- Any premium tax credit allowed under section 36B of the Code;
- Any cost-sharing reduction under section 1402 of ACA; and
- Any advance payment of such credit or reduction under section 1412 of ACA.

As is being done with the CMS proposed rule change, IRS will need to clarify the definition of “cost-sharing reduction under section 1402 of ACA.” If this companion change is not made by IRS, then some employers might not be notified (by CMS) in instances where the employer will be subject to either a \$2,000 payment for all employees or a \$3,000 payment for some employees (by IRS). We seek the assistance of CMS / HHS in securing the companion change by IRS.

Recommendation: We concur with the proposed change to §155.310(h) to refine the definition of “financial assistance” for purposes of reporting to employers when an employer might have to make a shared responsibility payment due to an employee securing financial assistance through a Marketplace. We request the assistance of CMS / HHS in securing a comparable clarification from IRS on the definition of “cost-sharing reduction under section 1402 of ACA.”

8. Special Enrollment Periods [§155.420]

Analysis: At the request of Tribal organizations, CCIIO issued guidance to enrollment assisters on October 15, 2014,⁵ indicating that family members of individuals eligible for the Monthly Special Enrollment Period (M-SEP) for Indians can enroll in Marketplace coverage with the eligible individuals. In the previously proposed Notice of Benefit and Payment Parameters for 2016 (CMS-9944-P), CMS made several modifications to SEP regulations at §155.420. It did not, though, propose to codify in regulations the provision permitting family members to enroll with eligible individuals under the M-SEP.

Tribal representatives in comments on CMS-9944-P recommended that CMS add this provision to the final rule by inserting in §155.420(d)(8) the following language (in bold):

⁵ See “Information and Tips for Assisters: Working with American Indians / Alaska Natives,” available at <https://marketplace.cms.gov/technical-assistance-resources/working-with-aian.pdf>.

“(8) The qualified individual who is an Indian, as defined by section 4 of the Indian Health Care Improvement Act, **or his or her dependent**, may enroll in a QHP or change from one QHP to another one time per month.”

Doing so would make sub-paragraph (d)(8) parallel to the language, for instance, in sub-paragraph (d)(7), which reads:

“(7) The qualified individual or enrollee, or his or her dependent, gains access to new QHPs as a result of a permanent move.”

In the final rule on CMS-9944, CMS did not incorporate the recommended provision. The absence of this provision in the regulations, particularly as similar language is included for other special enrollment periods, appears to have resulted in confusion with the Marketplace Call Center and uncertainty for Tribal organizations that assist and advocate on behalf of Marketplace enrollees.

Recommendation: We urge CMS to continue to facilitate enrollment (and disenrollment) of AI/ANs who meet the definition of Indian under the Affordable Care Act, as well as their family members, during the M-SEP provided for under §155.420(d)(8). We also again request that CMS incorporate the phrase “, or his or her dependent,” into §155.420(d)(8).

9. Termination of Coverage [§155.430]

Analysis: AI/ANs have experienced difficulties in dis-enrolling in Marketplace coverage and enrolling in Medicaid coverage. For example, this has occurred in Alaska when a number of AI/ANs enrolled in the Marketplace through Tribal sponsorship became eligible for Medicaid coverage under newly-expanded eligibility criteria. Difficulty with terminating Marketplace coverage also occurred in Michigan, when a number of enrollees’ projected income declined and the individuals (also sponsored under a Tribal program) attempted to dis-enroll from the Marketplace and enroll in Medicaid coverage.

The delays in dis-enrolling from Marketplace coverage resulted in individuals being in a coverage gap between the declined Marketplace enrollment and the blocked Medicaid enrollment, a situation that threatened access to care for some individuals and impeded access to care for others.

Recommendation: We concur with the proposed addition to the regulations contained in the Proposed Rule at §155.430(b)(1)(iv), but we also recommend and encourage CMS to focus on the disenrollment – enrollment administrative process to ensure a smooth transition between the Marketplace and Medicaid (and *vice-versa*).

10. Eligibility Standards and Process for Exemptions [§155.605]

Analysis: CMS proposes that the Marketplace would no longer make eligibility determinations for a few of the exemption categories based on membership, including exemptions based on status as members of an Indian Tribe. As a component of the revised policy, the Marketplace would permit individuals who have already been granted an exemption certificate number (ECN) from the Marketplace on a continuing basis (such as for members of Indian Tribes and individuals eligible for services through an IHCP) to use their ECN on their federal income tax return to claim this exemption. But whether using a previously-issued ECN

or simply applying through the federal tax-filing process, individuals claiming an exemption would do so by filing Form 8965.

Recommendation: We concur with the recommendation to eliminate the option of securing an ECN through a Marketplace.

11. Network Adequacy Standards

Analysis: CMS is requesting comments on how it might develop time and distance standards appropriate to the FFE using the Medicare Advantage or other standards.

Recommendation: We request that CMS provide more information on the options under consideration in developing network adequacy standards prior to Tribal representatives providing comments on the proposed standards.

12. Additional Network Adequacy Standards

Analysis: In the Proposed Rule, CMS is proposing a variety of approaches to better ensuring adequate networks of providers under QHPs offered through a Marketplace. One such proposal is to provide on HealthCare.gov a rating of each QHP's relative network coverage. AI/ANs, as well as Tribal health organizations and IHCPs acting on their behalf, have experienced deficiencies in the available network providers under QHPs offered through a Marketplace.

In addition, the growth in closed panel QHPs is increasing concerns over access to affordable medically-necessary health care services, as certain providers are no longer available as in-network providers and have become non-network / non-preferred providers with potentially substantial balance billing charges, with some of these providers subsequently being excluded completely under guise of a "closed panel" plan.

Beyond improving the standards and oversight of QHPs offered on Marketplaces, there is a need for better presentation of information on health plans that will permit potential enrollees to make more informed comparisons across the plan offerings. There is a particular lack of transparency when attempting to compare plan options between metal levels based on network, benefits, and cost-sharing.

Recommendation: We urge CMS to continue to pursue options to improve the breadth of provider networks, both in QHPs offered in FFE states and in SBEs, such as issuing a rating of each QHP's relative network coverage.

We recommend, though, that CMS implement a basic reform that will enable Marketplace enrollees to better understand and compare the health plan options available to them. We recommend that CMS present information on plan networks in the form of a matrix that indicates which plans on and across metal levels are in the same "set" (meaning the plans have the same benefit package and provider networks and only differ on cost-sharing structure). Doing so would permit and assist potential enrollees to narrow the comparison of plans in the same set (whether offered on the same metal level or across metal levels) to just differences in cost-sharing (and the associated actuarial value) and premiums. In general application on online sales tools, such a matrix format is often available as a secondary format to a running list of offerings for sale (as is currently the only format provided on HealthCare.gov).

In closing, we appreciate the opportunity to comment on these issues, and we are available to answer any questions you might have regarding our recommendations. Should you need additional information or have questions regarding these comments, please contact me at (860) 862-6192; or via email: lmalerba@moheganmail.com. Thank you.

Respectfully submitted,



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