

IHS TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE

c/o Self-Governance Communication and Education

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Submitted via: www.regulations.gov

October 5, 2016

The Honorable Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9934-P
P.O. Box 8016
Baltimore, MD 21244-8016

**RE: Comments on HHS Notice of Benefit and Payment Parameters for 2018
(CMS-9934-P)**

Dear Acting Administrator Slavitt:

I write on behalf of the Indian Health Service (IHS) Tribal Self-Governance Advisory Committee (TSGAC) to comment on the proposed rule published in the Federal Register on September 6, 2016, and titled "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018", CMS-9934-P (Proposed Rule).¹ Established in 1996, the TSGAC provides information, education advocacy, and policy guidance for the implementation of Self-Governance within the IHS. We appreciate the opportunity to provide these comments.

The Proposed Rule sets forth payment parameters and provisions related to the risk adjustment program; cost-sharing parameters and cost-sharing reductions; and user fees for Federally-Facilitated Exchanges (FFE) and State-Based Exchanges on the Federal Platform (SBE-FPs). It also provides additional guidance relating to standardized options; qualified health plans (QHPs); consumer assistance tools; network adequacy; the Small Business Health Options Program; stand-alone dental plans; fair health insurance premiums; guaranteed renewability; the medical loss ratio program; eligibility and enrollment; appeals; and other related topics. The TSGAC would like to draw attention to a number of items in the Proposed Rule and has provided discussion and recommendations on each of these issues below.

Summary

The following topic areas in the Proposed Rule are of particular concern to Tribes, Tribal health organizations, and American Indians and Alaska Natives (AI/ANs):

- Special Enrollment Periods (§ 155.420)
- FFE User Fee for the 2018 Benefit Year (§ 156.50)
- Levels of Coverage: Bronze Plans (§ 156.140)
- Network Adequacy Standards (§ 156.230)

Discussion and Recommendations

Special Enrollment Periods (§ 155.420)

¹ 81 Fed. Reg. 61456.

DISCUSSION: During special enrollment periods, individuals who experience certain life events that involve a change in family status (e.g., marriage or the birth of a child) or the loss of other health insurance can enroll in a QHP outside of the open enrollment period for 60 days (30 days for employment-based health plans). Under the Affordable Care Act (ACA), AI/ANs (as defined by section 4 of the Indian Health Care Improvement Act) can enroll in a QHP at any time of the year and can change plans as often as once per month, as AI/ANs qualify for monthly special enrollment periods (M-SEPs).

At the request of Tribes, CMS previously extended the M-SEP to the family members of AI/ANs who meet the definition of Indian under the ACA, if the family members enroll in Marketplace coverage along with the AI/AN individual. This provision was provided for, for example, in the CMS publication, “Information and Tips for Assistors: Working with American Indians/Alaska Natives.”² In addition, in comments submitted in response to the proposed HHS Notice of Benefit and Payment Parameters 2017 (CMS-9937-P), Tribal organizations requested that the provision providing for the inclusion of family members in the M-SEP be codified in regulations.³ In the Proposed Rule, CMS proposes to codify at § 155.420(d)(8)(ii) the special enrollment period for dependents⁴ of AI/ANs who enroll in a QHP at the same time as the AI/AN individual. In explaining the rationale for codifying this provision, which is currently provided for in adding this clarification in the regulations, CMS stated:

We also considered not standardizing the availability of the special enrollment period for Indians to non-Indian dependents enrolling at the same time as the Indian. However, we believe that codifying these special enrollment periods provides needed permanence and clarity for these special enrollment periods. This is important to ensure that they continue to be available, are equitably applied across Exchanges, and that consumers, assistors, issuers, and other stakeholders have a common understanding of the parameters and coverage effective dates associated with each of these special enrollment periods. In this rule, we seek to ensure transparency, stability, and appropriate utilization of special enrollment periods by codifying certain special enrollment periods that we have made available in prior guidance. After weighing our options, we determined that codifying these currently available special enrollment periods is in the best interest of consumers and other Exchange stakeholders.

Codifying this provision will ensure that AI/AN and non-AI/AN members of a household will continue to be able to secure and maintain the same coverage. By including this provision in the regulations along with other similar protections, CMS will help ensure that this special enrollment period gets applied consistently across Exchanges.

² See <https://marketplace.cms.gov/technical-assistance-resources/working-with-aian.pdf>.

³ See TSGAC, Comments on CMS-9937-P, Notice of Benefit and Payment Parameters for 2017, December 21, 2015.

⁴ For purposes of this provision, “dependent” is defined at §155.420(a)(2). The definition reads, “For the purpose of this section, ‘dependent’, has the same meaning as it does in 26 CFR 54.9801-2, referring to any individual who is or who may become eligible for coverage under the terms of a QHP because of a relationship to a qualified individual or enrollee.” Under 26 CFR 54.9801-2, “dependent” is defined as “any individual who is or may become eligible for coverage under the terms of a group health plan because of a relationship to a participant.” As such, a spouse would be included as a dependent.

Again, the TSGAC has long supported this modification and expresses its appreciation to CMS for moving to codify in the regulations the provision on M-SEPs for the dependents of AI/ANs. The absence of this provision in the regulations, particularly as similar language is included for other special enrollment periods, in the past has resulted in uncertainty for Tribal organizations that assist and advocate on behalf of QHP enrollees, and possibly confusion on the part of Marketplace Call Center staff.

RECOMMENDATION: In the final rule, CMS should retain the proposal to codify in the regulations at § 155.420(d)(8)(ii) the special enrollment period for dependents of AI/ANs.

FFE User Fee for the 2018 Benefit Year (§ 156.50)

a. Outreach and Education Funding

DISCUSSION: Section 1311(d)(5)(A) of the ACA allows an Exchange to charge user fees on participating health insurance issuers as a means of generating funding to support its operations. At § 156.50(c), CMS specifies that a participating issuer offering a plan through an FFE must remit to HHS each month a user fee equal to the product of the monthly user fee rate specified in the annual HHS Notice of Benefit and Payment Parameters for the applicable benefit year and the monthly premium charged by the issuer for each policy under the plan where enrollment occurs through an FFE. In the Proposed Rule, CMS proposes to set the 2018 user fee rate for all participating FFE issuers at 3.5%, the same rate as the 2014 through 2017 user fee rate.

As part of the proposal, CMS notes that some commenters previously have suggested that the FFE could increase enrollment by allocating more funds to outreach and education, or reallocating resources from other funding sources when available to pay for those expenses, if necessary. CMS seeks comment on how much funding to devote to outreach and education, the method to determine such funding, and the effectiveness of certain outreach investments to inform future FFE funding allocations. In addition, CMS seeks comment on whether HHS should expressly designate a specific portion or amount of the FFE user fee for outreach and education activities.

Promotion of outreach and education activities is critical to enrolling eligible individuals in Marketplace coverage, especially for special populations, such as AI/ANs, that are less likely to enroll. Efforts to enroll AI/ANs in Marketplace coverage face many inherent challenges, including network adequacy issues, cultural and linguistic barriers, documentation requirements, and lack of Internet access. At present, the 3.5% user fee reflects a planned resource allocation such that 3% of premiums collected by the FFE are needed to support information technology (IT) and call center functions, with 0.5% available for all other outreach and education, plan management, and oversight activities.⁵ Allocation of a greater share of the FFE user fee funding to outreach and education is warranted. Specifically, additional funding for outreach and enrollment activities aimed at AI/ANs is necessary in order to increase enrollment of AI/ANs in the Marketplace.

⁵ See Covered California comments on the Notice of Benefit and Payment Parameters for 2017, dated December 21, 2015, at http://board.coveredca.com/meetings/2016/1-21/CoveredCA_comments_9937-P_User-Fee_12-21-15.pdf.

RECOMMENDATION: In the final rule, CMS should expressly designate a greater amount of premiums collected by the FFE for outreach and education, plan management, and oversight activities, either funded through an increase in user fees or a reallocation of resources from other funding sources; the agency also should earmark a portion of this funding specifically for outreach and education activities targeted at AI/ANs and other special populations.

b. Transition Year for User Fee for SBE-FPs

DISCUSSION: At § 156.50(c)(2), CMS specifies that SBE-FPs must remit a user fee to HHS, in the timeframe and manner established by HHS, equal to the product of the sum of the monthly user fee rate specified in the annual HHS Notice of Benefit and Payment Parameters for SBE-FPs for the applicable benefit year, unless the SBE and HHS agree on an alternative mechanism to collect the funds. CMS proposes to charge issuers offering QHPs through an SBE-FP a user fee rate of 3.0% of the monthly premium charged by the issuer for each policy under a plan offered through an SBE-FP in 2018. In the 2017 Notice of Benefit and Payment Parameters, CMS set the user fee rate for SBE-FPs at 1.5% of premiums charged, rather than the full rate of 3.0%, to provide a transition year during which states could adjust to the assessment of a user fee in SBE-FPs. In the Proposed Rule, CMS seeks comments on whether it should continue this policy in 2018.

As discussed in section 1.a. above, setting the user fee rate for SBE-FPs at 1.5% of premiums charged would not provide adequate funding for a number of critical Exchange activities, such as education and outreach targeted at AI/ANs and other special populations.

RECOMMENDATION: In the final rule, CMS should not extend the transition year during which states could adjust to the assessment of a user fee in SBE-FPs and should set the user fee rate at the full 3.0% of premiums charged.

Levels of Coverage: Bronze Plans (§ 156.140)

DISCUSSION: As noted in the Proposed Rule, section 1302(d)(1) of the ACA requires the level of coverage for a bronze plan to have an actuarial value (AV) of 60%. In addition, section 1302(d)(3) states that the HHS Secretary must develop guidelines to provide for a *de minimis* variation in the actuarial valuations used in determining the level of coverage of a plan to account for differences in actuarial estimates. Currently, § 156.140(c) allows a *de minimis* variation of +/-2 percentage points. In the Proposed Rule, CMS proposes to permit bronze plans that cover and pay for at least one major service before the deductible, other than preventive services, to have an allowable variance in AV of -2 percentage points and +5 percentage points. CMS also proposes that, if bronze plans meet the federal requirements to be high-deductible health plans (HDHPs), they could have a variation in AV of -2 percentage points and +5 percentage points and would not have to cover at least one major service before the deductible, outside of certain preventive services.

According to CMS, the agency seeks these proposed changes to ensure flexibility in bronze plan designs—particularly, to permit the design of bronze plans that would satisfy AV requirements and still remain at least as generous as catastrophic plans and to ensure that bronze plans could remain eligible to be HDHPs. These proposed changes, however, would have the effect of increasing premiums for consumers. For example, if a bronze plan with an

AV of 60% has an annual premium of \$5,000, raising the AV to 65% would increase the premium to \$5,416. An increase in the premiums of available bronze plans is particularly likely in instances where there are few issuers offering bronze-level plans in the Marketplace. For example, in Alaska, it is anticipated that only Premiera Blue Cross will offer Marketplace plans in 2017.

The proposed changes would have a particularly negative impact on AI/ANs, who do not pay any cost-sharing for Marketplace plans. Under sections 1402(d)(1) and (2) of the ACA, AI/ANs can enroll in either a zero or limited cost-sharing plan, depending on their income level; Indians with household income between 100% and 300% of the federal poverty level (FPL) qualify for zero cost-sharing plans, and all other Indians qualify for limited cost-sharing plans. Under both of these plan variations, enrollees pay no deductibles, co-insurance, or copayments when receiving essential health benefits (EHBs). As such, when enrolled in a bronze plan, AI/ANs are responsible for 60% of the cost of the plan, and the federal government covers the remaining 40% of the cost. The proposed changes, however, would result in higher premiums, shifting as much as 5% of the cost of a bronze plan (\$416 in the above example) from the federal government to AI/ANs.

RECOMMENDATION: In the final rule, CMS should retain its current policy of restricting bronze plans to an allowable variance in AV of -2 percentage points and +2 percentage points; alternatively, if the agency intends to move forward with the proposed changes, it should ensure that an issuer that offers a bronze plan with an AV greater than 62% also offers a bronze plan with an AV that does not exceed 62%.

Network Adequacy Standards (§ 156.230)

DISCUSSION: CMS at § 156.230 established the minimum criteria for network adequacy that issuers must meet to have plans certified as QHPs, including the requirement that all issuers maintain a network sufficient in number and types of providers to ensure enrollees have access to all services without unreasonable delay. As set forth in the HHS Notice of Benefit and Payment Parameters for 2017, for the 2017 benefit year, CMS intends to pilot a network breadth indicator in certain states to denote the relative network coverage of QHPs.

In the Proposed Rule, CMS notes that it seeks to incorporate more specificity into the network breadth indicator—in particular, identifying for consumers whether a QHP is offered as part of an integrated delivery system—for the 2018 benefit year. According to CMS, for QHPs with an integrated delivery system, network breadth as calculated through the network breadth indicator methodology might not accurately describe the ability of consumers enrolled in these plans to access providers relative to consumers enrolled in plans without an integrated delivery system in the same county.

To define which plans utilize an integrated delivery system, CMS proposes to use the definition of a plan that qualifies for the alternate essential community provider (ECP) standard at 45 CFR 156.235(b): “A plan that provides a majority of covered professional services through physicians employed by the issuer or through a single contracted medical group.” CMS seeks comments on all aspect of this proposal, including whether it should make a differentiation between QHPs that use and do not use an integrated delivery system, whether it should use the alternate ECP standard to define plans with an integrated delivery system, and whether it should expand the definition to include other types of plans.

CMS notes that, through the proposal, it seeks to provide consumers with information to allow better comparison of QHPs based on relative network breadth. *However, conflating QHPs that are allowed to use the alternate ECP standard with those that utilize integrated delivery systems, and then indicating that these plans provide better access to providers, is not helpful or accurate.*

For AI/ANs, the proposal is especially concerning because QHPs that can use the alternate ECP standard do not have to offer contracts to participate as in-network providers to all available Indian health care providers (IHCPs) in their service area, as is required under the general ECP standard. And these so-called “alternative ECP standard” or “integrated delivery system” plans are permitted to make no payments for services provided by non-preferred or out-of-network providers.

In contrast to the CMS proposal, the TSGAC recommends that the agency reconsider which plans are permitted to utilize the “alternative ECP standard” as having an integrated delivery system. Simply having a closed-panel network and being labeled an “exclusive provider organization” (EPO) does *not*, in practice, mean the health plan has an integrated delivery system. In fact, the growing prevalence of closed-panel EPO health plan offerings on Marketplaces—and the risk that this type of plan might be the sole type of health plan offering on a particular Marketplace—threatens access to timely, culturally-competent care for many AI/ANs.

A health maintenance organization (HMO) with a truly integrated system of primary, preventive, and acute care services and providers might provide “integrated care” and, as such, meet the stated purpose of the “alternative ECP standard.” However, health plans—such as EPOs—that offer closed provider panels and no ability to access health care services from out-of-network providers, but do not operate in practice as truly integrated delivery system, should not be permitted to use the “alternative ECP standard,” which, again, permits the health plan from including IHCPs as in-network or (reimbursed) out-of-network providers.

As mentioned above, the growing prevalence—and potential dominance—of closed-panel plans creates a need for urgent action by CMS to restrict which plans are permitted to avail themselves of the “alternate ECP standard.”

RECOMMENDATION: In the final rule, CMS should create a definition for QHPs that utilize an integrated delivery system separate from the definition used for determining whether plans can use the alternate ECP standard; the agency also should clarify, in any related communication to consumers, that plans utilizing an integrated delivery system do not have to meet certain requirements with regard to ECPs, specifically the requirement to offer contracts to all IHCPs in their service area.

Finally, CMS should reconsider which plans are designated as integrated delivery systems and permitted to utilize the “alternative ECP standard,” which permits exclusion of IHCPs.

Conclusion

We appreciate the opportunity to comment on these issues and are available to address any inquiries you might have regarding our recommendations. If you have any questions or wish to discuss these comments further, please contact me at (860) 862-6192 or via email at lmalerba@moheganmail.com. Thank you.

Sincerely,



Chief Lynn Malerba, Mohegan Tribe of Connecticut
Chairwoman, IHS TSGAC

cc: Mary Smith, Principal Deputy Director, Indian Health Service (IHS)
P. Benjamin Smith, Director, Office of Tribal Self-Governance, IHS
TSGAC Members and Technical Workgroup