

IHS TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE

c/o Self-Governance Communication and Education

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Submitted via: www.regulations.gov

March 7, 2017

The Honorable Patrick Conway
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9929-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Comments on Market Stabilization Proposed Rule (CMS-9929-P)

Dear Acting Administrator Conway:

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 February 17, 2017, and titled "Patient Protection and Affordable Care Act; Market Stabilization," CMS-9929-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 offers changes designed to help stabilize the individual and small group health insurance markets. Specifically, the Proposed Rule would amend standards relating to special enrollment periods, guaranteed availability, and the timing of the annual open enrollment period in the individual market for the 2018 plan year; standards related to network adequacy and essential community providers for qualified health plans; and the rules around actuarial value requirements. The TSGAC seeks to draw attention to a number of items in the Proposed Rule and has provided discussion and recommendations on these concerns 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):

¹ 82 Fed. Reg. 10980.

- Special Enrollment Periods (§ 155.420)
- Levels of Coverage (Actuarial Value) (§ 156.140)
- Network Adequacy (§ 156.230)
- Essential Community Providers (§ 156.235)

Discussion and Recommendations

1. Special Enrollment Periods (§ 155.420)

a. Exclusion of AI/ANs from Prohibition on Changing Plan Metal Levels During Coverage Year

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 qualified health plan (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 (ICHIA)) 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).² At the request of Tribes, CMS 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.³

In the Proposed Rule, CMS notes that it has heard concerns about some individuals using SEPs to change plan metal levels based on ongoing health needs during the coverage year, causing a negative impact on the risk pool. In response, CMS proposes to establish at § 155.420 a new paragraph (a)(4), which would impose restrictions on the ability of existing Marketplace enrollees to change plan metal levels during the coverage year. The Proposed Rule, however, would exclude from these restrictions Marketplace enrollees who qualify for the SEP for AI/ANs and their dependents (and certain other enrollees who qualify for SEPs). The TSGAC supports this exemption.

RECOMMENDATION 1a:

In the final rule, CMS should retain the proposal to exclude from the new restrictions at § 155.420(a)(4) Marketplace enrollees who qualify for the SEP for AI/ANs and their dependents.

b. Applicability of Continuous Coverage Requirements to AI/ANs

DISCUSSION: In section III.B.3. of the Proposed Rule, CMS cites the need to adopt policies that promote continuous enrollment in health insurance and discourage individuals from waiting until illness occurs to enroll in coverage as a means of addressing concerns about adverse selection. CMS discusses several examples of proposals designed to promote continuous coverage and requests comments on these and other potential policies. At this time, however, the Proposed Rule would not implement any of the proposals in section III.B.3.

² See § 155.420(d)(8).

³ See § 155.420(d)(8)(ii).

The ACA and implementing regulations at § 155.420(d)(8) explicitly provide that an individual who gains or maintains status as an Indian under section 4 of the IHCA (or who is or becomes a dependent of an Indian and is enrolled or is enrolling in a QHP on the same application as the Indian) can enroll in a QHP or change from one QHP to another one time per month. In part, this provision was provided to assist AI/ANs who relocate from an area with IHS and Tribal health programs to one in which the Indian health system is not available, creating a greater need for these individuals to secure health insurance coverage. In addition, the provision facilitates the transition of a Tribe to using comprehensive health insurance coverage as a vehicle for ensuring the availability of funding to support access to the full range of medically necessary health care services. Imposing a requirement for (prior) continuous coverage would run counter to the purpose of the M-SEPs.

RECOMMENDATION 1b:

If CMS decides to move forward with the proposals discussed in section III.B.3. (or other policies designed to promote continuous coverage), either in the final rule or in future rulemaking, it should exempt AI/ANs and not impose a new requirement that would override the purpose and function of M-SEPs.

2. Levels of Coverage (Actuarial Value) (§ 156.140)

DISCUSSION: Section 1302(d)(1) of the ACA requires the level of coverage for bronze, standard silver, gold, and platinum plans to have actuarial values (AVs) of 60%, 70%, 80%, and 90%, respectively. 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 for most plans, with the exception of certain bronze plans. In the HHS Notice of Benefit and Payment Parameters for 2018 (2018 Notice), CMS finalized a proposal 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.⁴

In the Proposed Rule, CMS cites a need for further flexibility in the *de minimis* variation range for all metal levels to help issuers design new plans for future years and to allow more plans to keep their cost-sharing the same from year to year. CMS proposes to allow most Marketplace plans to have an allowable variance in AV of -4 percentage points and +2 percentage points; bronze plans affected by previous change in the 2018 Notice could have an allowable variance in AV of -4 percentage points and +5 percentage points.

In comments on the proposed 2018 Notice, the TSGAC raised concerns that the revised policy on the allowable variance in AV for bronze plans would have the effect of increasing premiums for

⁴ See 81 Fed. Reg. 94058.

consumers.⁵ 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. The TSGAC also highlighted the particularly negative impact that the revised policy would have on AI/ANs, who do not pay any cost-sharing for Marketplace plans.⁶ When enrolled in a bronze plan, premium payments made by AI/ANs are responsible for covering 60% of the cost of coverage under the plan, and the federal cost-sharing protections cover the remaining 40% of the cost. However, as noted by the TSGAC, the revised policy could result in higher premiums, shifting as much as 5% of the cost of health insurance coverage under a bronze plan from the federal government's cost-sharing protections to the AI/AN enrollees.

The Proposed Rule would worsen the potential detrimental effects on AI/ANs discussed above. Under the proposal to expand further the allowable *de minimis* variation for Marketplace plans, the AV for the "reference plan" (second-lowest-cost silver plan) could fall by as much as 4 percentage points from the 70% standard under the ACA, while the AV for the lowest-cost bronze plan could increase by as much as 5 percentage points from the 60% standard. This situation could result in a 9 percentage point net increase in the effective cost of bronze-level coverage for an AI/AN enrollee, amounting to a 15% increase in net costs to a bronze plan enrollee.

In fact, depending on the household income of the AI/AN enrollee and the resulting net premium costs after consideration of the value of the available premium tax credits, the increase in the net premium costs to the AI/AN enrollee could be substantially greater than 15% when purchasing a bronze plan. For example, if premium tax credits reduced the net premium for an AI/AN Marketplace enrollee by half, the Proposed Rule would have the effect of increasing health insurance coverage costs for the enrollee by 30%.

An illustration appears below.

- The Marketplace reference plan has a \$5,000 annual premium at 70% AV, decreasing to 4,713 [$(\$7,142 * .66 = \$4,713)$] at 66% AV, a \$287 reduction (resulting in a \$287 decrease in the potential value of any available premium tax credit).
- The lowest-cost bronze plan has an annual premium of \$4,285 [$(\$5,000 / .70 = \$7,142) * .60 = \$4,285$] at 60% AV, rising to \$4,642 [$(\$7,142 * .65 = \$4,642)$] at 65% AV, a \$357 increase.
- The overall impact is a potential increase in net premium costs of \$644 ($-\287 in the value of the premium tax credit and $+\$357$ in the bronze plan premium).
- The \$644 increase in the net premium costs is at least a 15% increase in the net premium costs for the lowest-cost bronze plan [$\$644 / \$4,285 = .15$].

⁵ See TSGAC, Comments on HHS Notice of Benefit and Payment Parameters for 2018 (CMS-9934-P), October 5, 2016.

⁶ 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).

- Using the above scenario, if an AI/AN bronze plan enrollee had a household income of about \$32,500, making the enrollee eligible for a premium tax credit that reduced net premium costs by half (to \$2,143) under current regulations, the net impact to the enrollee under the proposed change would be an increase of 30% [$\$644 / \$2,143 = .30$].

The Merriam-Webster dictionary defines *de minimus* as “lacking significance or importance: so minor as to merit disregard.”⁷ A change in the net premium costs for an AI/AN enrollee of 15%, 30%, or an even greater amount would not seem on its face to fit the definition of *de minimis*, as these potential increases would not lack significance to the enrollee.

RECOMMENDATION 2:

In the final rule, CMS should (a) retain its current policy of restricting silver-level Marketplace plans to an allowable variance in AV of –2 percentage points and +2 percentage points; and, (b) impose a similar requirement on all bronze-level plans; if the agency intends to move forward with the proposed changes, it should (c) ensure that, for the purposes of calculating premium tax credits, the reference plan premium is adjusted to reflect no less than a 70% AV.

3. Network Adequacy (§ 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. In the Proposed Rule, CMS proposes to rely on state network adequacy reviews in all states—including states with a Federally-Facilitated Marketplace (FFM)—provided that the state has a sufficient network adequacy review process, rather than have federal regulators perform a time and distance evaluation.⁸ CMS currently conducts network adequacy reviews using the time and distance evaluation for QHPs in states that have an FFM, regardless of whether the agency or the state performs plan management functions.⁹

Under the Proposed Rule, CMS would defer to state network adequacy reviews in all states “with the authority at least equal to the ‘reasonable access standard’ defined in § 156.230 and means to assess issuer network adequacy,” regardless whether the state has an FFM or State-Based Marketplace (SBM).¹⁰ In states that lack the authority and means to conduct sufficient reviews, CMS would rely on issuer accreditation (commercial or Medicaid) from an accrediting entity recognized by HHS for ensuring network adequacy, again rather than having federal officials perform a time and distance evaluation.

⁷ See <https://www.merriam-webster.com/dictionary/de%20minimis>.

⁸ Under the time and distance evaluation, CMS reviews data submitted by issuers to ensure that plans provide access to at least one provider in each of 10 provider types for at least 90% of enrollees. See CCHIO, Addendum to 2018 Letter to Issuers in the Federally-Facilitated Marketplaces, February 17, 2017, 24-5.

⁹ States that operate SBMs can use a similar approach but are not required to apply these standards.

¹⁰ 82 Fed. Reg. 10990.

The Proposed Rule appears to seek to replace a relatively straightforward standard for determining the network adequacy of QHPs offered through FFMs with a nebulous standard or set of standards that likely would create uncertainty and could vary significantly from state to state. For potential enrollees, including many AI/ANs, this change would exacerbate existing concerns over whether the plans offered through the Marketplace include an adequate number and range of providers in their networks.

RECOMMENDATION 3:

In the final rule, CMS should retain its current policy of conducting reviews using the time and distance evaluation to determine the network adequacy of QHPs offered through FFMs.

Alternatively, if the agency intends to move forward with the proposal to rely on state reviews (and issuer accreditation), it should, at a minimum, take steps toward ensuring that states (and accrediting entities) use the time and distance evaluation in their reviews, where possible.

4. Essential Community Providers (§ 156.235)

a. Reduction in Essential Community Providers (ECP) Standard

DISCUSSION: CMS at § 156.235 established requirements for inclusion of ECPs in QHP provider networks in states that have FFMs and do not conduct plan management activities.¹¹ CMS uses a general enforcement standard under which it considers issuers to have met federal regulations if they demonstrate satisfaction of several criteria. Issuers must:

- Contract with at least 30% of available ECPs in the service area of each of their plans to participate the provider network for the plans;
- Offer contracts in good faith¹² to all available Indian Health Care Providers (IHCPs) in the plan service area, applying the special terms and conditions necessitated by federal law and regulations as referenced in the recommended model QHP Addendum; and
- Offer contracts in good faith to at least one ECP in each ECP category in each county in the service area, where an ECP in that category is available and provides medical or dental services covered by the issuer plan type.

If issuers do not satisfy the general enforcement standard, they must submit, as part of their QHP application, a satisfactory narrative justification describing how their plan network(s), as presently constituted, provide an adequate level of service for low-income and medically underserved individuals and how they plan to increase ECP participation in their network(s) in future years.

In the Proposed Rule, CMS proposes to allow issuers to contract with only 20%, rather than 30%, of available ECPs in the service area of each of their plans to meet the general enforcement standard.

¹¹ States with FFMs in which the state performs plan management functions, as well as states that operate SBMs, can use a similar approach but are not required to apply these standards.

¹² Issuers must “offer contract terms comparable to terms that it offers to a similarly-situated non-ECP provider.” See CCIIO, Addendum to 2018 Letter to Issuers in the Federally-Facilitated Marketplaces, February 17, 2017, 31.

CMS maintains that the relaxed standard, which the agency previously used in 2014, would substantially lessen the regulatory burden on issuers because fewer issuers would have to submit a narrative justification. In addition, CMS indicates that the relaxed standard would preserve adequate access to care. Both of these arguments appear tenuous at best.

The ACA granted the HHS Secretary broad authority to require issuers to include ECPs in their plan networks.¹³ The current 30% ECP standard imposed by CMS falls far short of requiring issuers to contract with all ECPs in the service areas of their plans—a permissible alternative under the law—and eroding this standard has the real potential to limit access to care for Marketplace enrollees, including AI/ANs, living in medically underserved areas. For example, in a plan service area with five ECPs, an issuer currently must contract with at least two of these providers; under the relaxed standard, the issuer could contract with only a single ECP. Given the breadth of a plan’s service area and the range of provider types under the ECP category, the reduction in the percentage of ECPs under contract could very likely negatively impact access to critical health care services.

For the relaxed standard not to diminish access to care, issuers would have to continue to offer contracts to at least 30% of ECPs in the service areas of their plans, even though they are no longer obligated to do so. This seems an unlikely scenario.

In regard to reducing the regulatory burden on issuers, at the time CMS initially increased the ECP standard from 20% to 30%, it anticipated that issuers “will readily be able to contract with at least 30 percent of ECPs in a service area and that issuers will largely be able to satisfy this without having to submit written justification.”¹⁴ That assumption has proven correct. In the Proposed Rule, CMS indicated that 94% of issuers met the 30% standard without having to submit a narrative justification in 2017. As such, the potential loss of access to care for low-income, medically underserved individuals seems a high price to pay so that a small fraction of issuers no longer have to include a narrative justification as part of their QHP application.

RECOMMENDATION 4a:

In the final rule, CMS should drop the proposal to allow issuers to contract with only 20%, rather than 30%, of available ECPs in the service area of each of their plans to meet the general enforcement standard.

b. Identification of ECPs in Plan Networks

DISCUSSION: Under current CMS guidance, beginning in 2018, issuers can identify as ECPs in their plan networks only providers that appear on the list of ECPs maintained by HHS (HHS ECP List). The HHS ECP List for 2018 includes providers that submitted a petition by the October 15, 2016, deadline and meet the definition of an ECP. In 2017 and previous years, issuers had the ability to identify ECPs that did not appear on the HHS ECP List through a “write-in” process.

¹³ See ACA § 1311(c)(1)(C).

¹⁴ See CCHIO, 2015 Letter to Issuers in the Federally-Facilitated Marketplaces, March 14, 2014, 20.

In the Proposed Rule, CMS indicates its awareness that not all qualified ECPs have submitted a petition for inclusion on the HHS ECP List. In response, the Proposed Rule would allow issuers to continue to use the write-in process to identify ECPs in 2018, provided that issuers arrange for these providers to submit an ECP petition to HHS by no later than the deadline for issuer submission of changes to their QHP application. This provision would benefit the IHCPs that currently do not appear on the HHS ECP List for 2018, as well as the AI/ANs served by these providers.

RECOMMENDATION 4b:

In the final rule, CMS should retain the proposal to allow issuers to continue to use the “write-in” process to identify ECPs in 2018.

Conclusion

Thank you for the opportunity to provide these comments on the Proposed Rule. 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.

Sincerely,



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

cc: Kitty Marx, Director, Division of Tribal Affairs/IEAG/CMCS
Jennifer Cooper, Acting Director, Office of Tribal Self-Governance, IHS
TSGAC Members and Technical Workgroup