

Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

c/o National Indian Health Board 926 Pennsylvania Avenue, SE Washington, DC 20003 (202) 507-4070 (202) 507-4071 fax

Submitted via e-mail: Kevin.Counihan@cms.hhs.gov

June 26, 2015

Mr. Kevin Counihan
Chief Executive Officer
Center on Consumer Information and Insurance Oversight
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7501 Wisconsin Avenue
Bethesda, MD 20814

Re: Request for Confirmation that Eligibility Determinations for Indian-Specific Cost-Sharing Protections Are Being Made Consistent with ACA and Implementing Regulations

Dear Mr. Counihan:

I write on behalf of the Tribal Technical Advisory Group (TTAG) of the Centers for Medicare and Medicaid Services (CMS) regarding a matter of critical importance to American Indians and Alaska Natives (AI/ANs).^{1,2} In this letter, we request that CMS engage with the TTAG to review the regulations implementing the Indian-specific cost-sharing benefits and protections established pursuant to the Patient Protection and Affordable Care Act (Affordable Care Act, or ACA) and confirm that these benefits and protections are, in fact, being implemented in the computer programs and guidance documents for the Federally-Facilitated Marketplace (FFM) pursuant to the relevant regulations. A similar effort focused on State-Based Marketplaces (SBMs) might be needed as well.

In brief, serious and systemic problems related to eligibility determinations for the Indian-specific cost-sharing protections are being experienced by Indian Marketplace enrollees and by the providers—both Indian health care providers (IHCPs) and non-IHCPs—that are serving

¹ TTAG advises CMS on Indian health policy issues involving Medicare, Medicaid, the Children's Health Insurance Program, and any other health care programs funded (in whole or part) by CMS. In particular, TTAG focuses on providing policy advice to CMS regarding improving the availability of health care services to AI/ANs under these Federal health care programs, including through providers operating health programs of the Indian Health Service (IHS), Indian Tribes, tribal organizations, and urban Indian organizations (referred to as I/T/Us, Indian health care providers, or IHCPs).

² In this letter, the term "American Indians and Alaska Natives" is used to describe all persons eligible for services from an Indian health care provider. The term "Indian" is used to describe individuals who meet the definition of Indian as found in the Affordable Care Act. The Affordable Care Act defines "Indian" as an individual who is a member of a federally-recognized Tribe or a shareholder in an Alaska Native regional or village corporation.

them.

- Indian Marketplace enrollees have had deductibles and co-payments improperly applied, with some enrollees having up to \$6,300 in cost-sharing charges imposed when attempting to access essential health benefits (EHBs), despite being eligible for comprehensive cost-sharing protections.
- One IHCP alone experienced over \$506,000 in waived cost-sharing incorrectly withheld from their payments.
- An analysis was conducted on a set of claims filed for services provided to Indians who have household income under 100 percent of the federal poverty level (FPL) or over 400 percent FPL and found that 69 percent of the enrollees who had a claim had a deductible applied inappropriately.

The problems experienced with eligibility determinations for Indian-specific cost-sharing protections might be leading to dramatically lower enrollment of Indians in Marketplace coverage.

- According to CMS-supplied data, 125,822 Indians submitted applications through an FFM for the 2015 coverage year, and of these applicants, only 21 percent (or 26,256 individuals) ultimately enrolled and selected a QHP.
- A chief reason for the great disparity between the number of applicants and actual QHP enrollees—125,822 initial Indian applicants vs. 26,256 enrollees—is that 42,028 Indian applicants were determined to be QHP-eligible but without any cost-sharing protections. Most or all of these individuals should have been determined eligible for one of the two Indian-specific cost-sharing protections.

Background

The Affordable Care Act established two Indian-specific cost-sharing protections for persons enrolled in health plans through a Health Insurance Exchange (Exchange or Marketplace). These protections are found at sections 1402(d)(1) and 1402(d)(2) of the ACA.

The regulations implementing these two ACA provisions were finalized by CMS on March 11, 2013, in the HHS Notice of Benefit and Payment Parameters for 2014.³

The first Indian-specific cost-sharing provision (under ACA section 1402(d)(1)) prohibits cost sharing under a QHP for eligible and Marketplace-enrolled Indians when receiving EHBs. These protections are referred to as the “zero cost-sharing variation” or the “02” cost-sharing variation (CSV). The second Indian-specific cost-sharing provision (under ACA section 1402(d)(2))

³ 78 Federal Register 15410, March 11, 2013.

prohibits cost sharing under a QHP for eligible and Marketplace-enrolled Indians when receiving EHBs directly from an Indian health care provider or through referral under contract health services⁴ to a non-Indian health care provider. These protections are referred to as the “limited cost-sharing variation” or the “03” CSV.

According to law and regulations, people who have Indian status, are enrolled in a qualified health plan (QHP) through a Marketplace, have household income between 100 percent and 300 percent FPL, and qualify for premium tax credits are eligible for the zero cost-sharing variation.⁵ All other persons who have Indian status and are enrolled in a QHP through a Marketplace, regardless of income or whether they qualify for premium tax credits, are eligible for the limited cost-sharing variation.

Descriptions of these provisions have been provided in a number of documents issued by CMS, but these descriptions are not always consistent with the law and regulations. For instance, the Center for Consumer Information and Insurance Oversight (CCIIO) summarized the range of cost-sharing protections available for QHP enrollees through a Marketplace in the “834 Companion Guide for FFE Enrollment Transactions, v. 15.” This document assigned two-digit codes for the cost-sharing protections and provided an abbreviated description, as follows:⁶

“The Variant Component ID is 2 characters (Numeric) with the following values and description:

- 00 - Non-Exchange variant
- 01 - Exchange variant (no CSR)
- 02 - Open to Indians below 300% FPL**
- 03 - Open to Indians above 300% FPL**
- 04 - 73% AV Level Silver Plan CSR
- 05 - 87% AV Level Silver Plan CSR
- 06 - 94% AV Level Silver Plan CSR”

Several other CMS documents also use this shorthand of the Indian-specific cost-sharing variations (CSVs), indicating the availability of protections under section 1402(d)(1) of the

⁴ The term “contract health services” was renamed “Purchased/Referred Care” in the Consolidated Appropriations Act of 2014. <http://www.ihs.gov/california/index.cfm/tribal-resources/letters-to-tribal-leaders11/2014/february/email-acting-ihs-directors-blog-on-february-19-2014-contract-health-service-name-change/>

⁵ The Affordable Care Act states that the zero CSV is available for persons “whose household income is not more than 300% of the [FPL]”. But because eligibility for the zero CSV also is tied to premium tax credit eligibility and premium tax credit eligibility requires household income to be at or above 100 percent FPL, eligibility for the zero CSV is limited to persons with household income between 100 percent and 300 percent FPL.

⁶ <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/companion-guide-for-ffe-enrollment-transaction-v15.pdf>, page 36.

Affordable Care Act to Indians “below 300% FPL” and the availability of the Indian-specific CSV under ACA section 1402(d)(2) to Indians “above 300% FPL.”⁷

We understand that this shorthand summary is a convenient way to highlight a general distinction between the two protections—that the “02” CSV is not available above 300 percent FPL and the “03” CSV is available above 300 percent FPL—but read literally, this description is not a fully accurate characterization of the provisions. In fact, this shorthand communicates a misunderstanding of the cost-sharing protections available to Indians. For example, the “03” CSV protections are available to Indians of any income level, whether under or over 300 percent FPL, or persons with no income determination. And as clearly stated in CMS regulations and companion documents, eligibility for the “03” CSV is not dependent on eligibility for premium tax credits.⁸

Even more importantly, we are concerned that some QHP issuers, and quite possibly the FFM as well as SBMs, might be implementing eligibility for the Indian-specific CSV provisions in a manner that reflects the limitations of the shorthand descriptions, and not fully as provided for in the Affordable Care Act and the CMS-promulgated regulations. To the extent the Indian-specific cost-sharing protections are not implemented according to the ACA and existing CMS implementing regulations, AI/ANs likely are experiencing unnecessary and damaging barriers to needed health care services.

Although there are a range of related issues that require additional CCIIO attention—some of which are discussed below—this letter is for the purpose of ensuring that *eligibility determinations* for the Indian-specific cost-sharing protections are being made consistent with the ACA and its implementing regulations.

Statutory and Regulatory Citations for Indian-Specific CSVs

The core provisions in the Affordable Care Act establishing the Indian-specific CSVs appear in sections 1402(d)(1) and 1402(2). These provisions read:

“[Section] 1402 (d) SPECIAL RULES FOR INDIANS.—

(1) INDIANS UNDER 300 PERCENT OF POVERTY.—If an individual enrolled in any qualified health plan in the individual market through an Exchange is an Indian (as defined in section 4(d) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(d))) whose

⁷ See <http://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/AIANs-SpecialProtections-Fact-Sheet.pdf>, page 1.

⁸ Discussion in CMS-9964-F at 78 Fed Reg 15492, March 11, 2013, which reads: “[C]ost-sharing reductions under section 1402(d)(2) of the Affordable Care Act would be available to Indians regardless of their eligibility for premium tax credits.”

household income is not more than 300 percent of the poverty line for a family of the size involved, then, for purposes of this section—

- (A) such individual shall be treated as an eligible insured; and
- (B) the issuer of the plan shall eliminate any cost-sharing under the plan.

(2) ITEMS OR SERVICES FURNISHED THROUGH INDIAN HEALTH PROVIDERS.—If an Indian (as so defined) enrolled in a qualified health plan is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services—

- (A) no cost-sharing under the plan shall be imposed under the plan for such item or service; and
- (B) the issuer of the plan shall not reduce the payment to any such entity for such item or service by the amount of any cost-sharing that would be due from the Indian but for subparagraph (A).”

The core CMS regulations implementing the eligibility standards for ACA sections 1402(d)(1) and (d)(2) are found at 45 CFR §§ 155.350(a) and (b). These regulatory provisions read as follows:

“§155.350 Special eligibility standards and process for Indians.

(a) Eligibility for cost-sharing reductions.

(1) The Exchange must determine an applicant who is an Indian eligible for cost-sharing reductions if he or she—

- (i) Meets the requirements specified in §155.305(a)⁹ and §155.305(f);¹⁰
- (ii) Is expected to have a household income, as defined in 26 CFR 1.36B-1(e) that does not exceed 300 percent of the FPL for the benefit year for which coverage is requested.

(2) The Exchange may only provide cost-sharing reductions to an individual who is an Indian if he or she is enrolled in a QHP through the Exchange.

⁹ 45 CFR § 155.305(a) refers to “*Eligibility for enrollment in a QHP through the Exchange*” for the general population.

¹⁰ 45 CFR § 155.305(f) refers to “*Eligibility for advance payments of the premium tax credit*” for the general population.

(b) *Special cost-sharing rule for Indians regardless of income.* The Exchange must determine an applicant eligible for the special cost-sharing rule described in section 1402(d)(2) of the Affordable Care Act¹¹ if he or she is an Indian, without requiring the applicant to request an eligibility determination for insurance affordability programs in accordance with §155.310(b)¹² in order to qualify for this rule.”

In the preamble to the final rule for the HHS Notice of Benefit and Payment Parameters for 2014, CMS provided an explanation of the CMS regulations implementing ACA section 1402(d)(1) and ACA section 1402(d)(2).¹³ The discussion provided in the preamble is as follows:

“Interpretation of section 1402(d)(2) of the Affordable Care Act: In the proposed rule, we discussed in detail our interpretation of sections 1402(d)(1), 1402(d)(2), and 1402(f)(2) of the Affordable Care Act. The implication of these interpretations is that cost-sharing reductions under sections 1402(a) and 1402(d)(1) of the Affordable Care Act are only available to individuals who are eligible for premium tax credits. However, we stated that under our interpretation, cost-sharing reductions under section 1402(d)(2) of the Affordable Care Act would be available to Indians regardless of their eligibility for premium tax credits.”

As noted above, further explanations of the Indian-specific cost-sharing protections were provided in the preamble to the proposed rule on the HHS Notice of Benefit and Payment Parameters for 2014. In the preamble to this proposed rule, CMS provided the following explanation of the CMS interpretation of the Indian-specific cost-sharing reductions under ACA section 1402(d)(1) and section 1402(d)(2).¹⁴

“i. Special Cost-Sharing Reduction Rules for Indians. We discuss in greater detail below a number of provisions throughout this proposed subpart E implementing section 1402(d) of the Affordable Care Act, which governs cost-sharing reductions for Indians.

Interpretation of section 1402(d)(2) of the Affordable Care Act:
Section 1402(d)(1) of the Affordable Care Act directs a QHP issuer to treat

¹¹ As shown above, ACA section 1402(d)(2) refers to services being received through an Indian health care provider or through referral under contract health services.

¹² 45 CFR §155.310 reads: “Eligibility process. (b) *Applicant choice for Exchange to determine eligibility for insurance affordability programs.* The Exchange must permit an applicant to request only an eligibility determination for enrollment in a QHP through the Exchange; however, the Exchange may not permit an applicant to request an eligibility determination for less than all insurance affordability programs.”

¹³ HHS Notice of Benefit and Payment Parameters for 2014, Final Rule, 77 Fed Reg 15492, March 11, 2013.

¹⁴ HHS Notice of Benefit and Payment Parameters for 2014, Proposed Rule, 77 Fed Reg 73178, December 7, 2012.

an Indian with household income not more than 300 percent of the FPL as an ‘eligible insured’—a defined term in the statute triggering cost-sharing reductions for non-Indians—and to eliminate all cost sharing for those Indians.¹⁵ Conversely, section 1402(d)(2) of the Affordable Care Act, which prohibits cost-sharing under a plan for items or services to an Indian enrolled in a QHP provided directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or through referral under contract health services, does not direct the issuer to treat the Indian as an ‘eligible insured.’ Section 1402(f)(2) of the Affordable Care Act permits cost-sharing reductions only for months in which the ‘insured’—which we interpret to be synonymous with the term ‘eligible insured’—is allowed a premium tax credit. The implications of this interpretation are that cost-sharing reductions under sections 1402(a) and 1402(d)(1) of the Affordable Care Act are only available to individuals eligible for premium tax credits. However, cost-sharing reductions under section 1402(d)(2) of the Affordable Care Act would be available to Indians regardless of their eligibility for premium tax credits. This approach aligns with the typical practice today, under which cost sharing is not required with respect to services provided to an Indian by the IHS, an Indian Tribe, Tribal Organization, or Urban Indian Organization. Furthermore, as described in § 155.350(b), an Exchange may determine an Indian eligible for cost-sharing reductions under section 1402(d)(2) of the Affordable Care Act without requiring the applicant to request an eligibility determination for insurance affordability programs.”

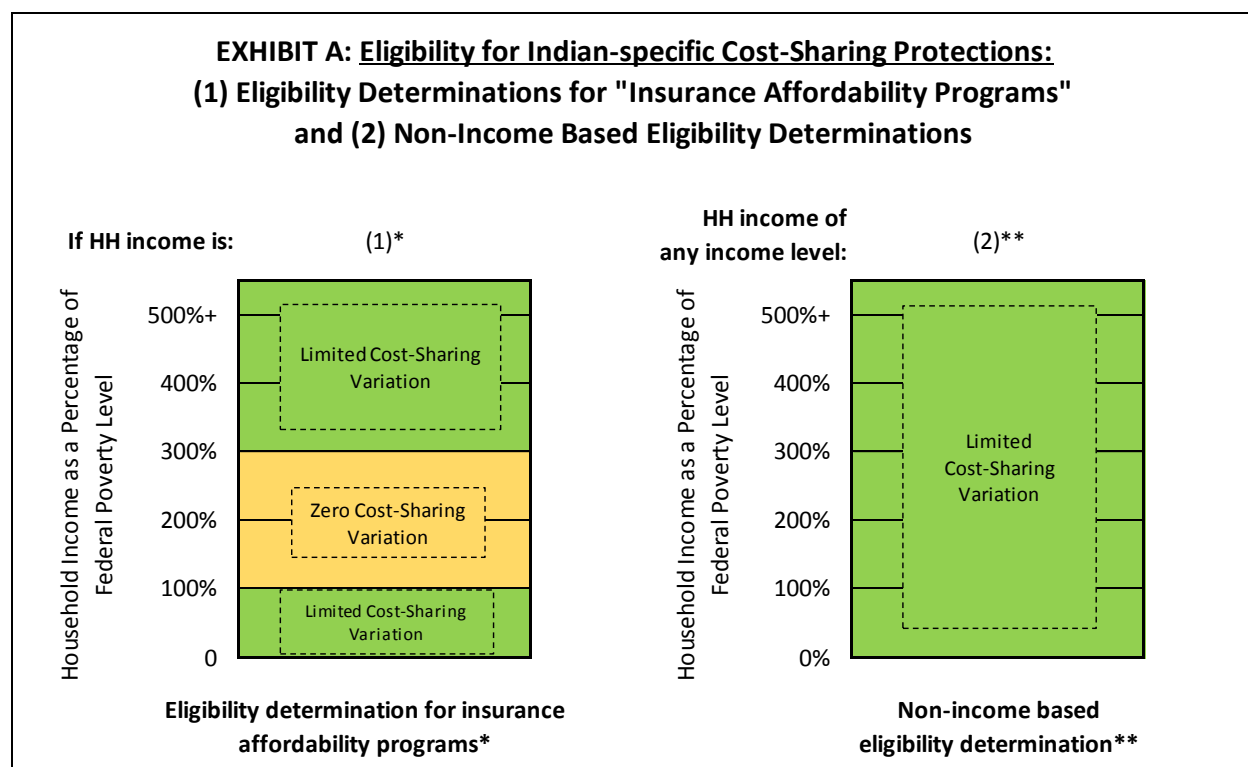
A critical distinction emphasized by CMS in implementation of the Indian-specific cost-sharing protections under ACA sections 1402(d)(1) and 1402(d)(2) is that Congress explicitly included persons meeting the criteria under 1402(d)(1) as “eligible insureds” and did not include persons meeting the criteria under 1402(d)(2) as “eligible insureds.” A key result of this distinction is that the restriction under ACA section 1402(f)(2) applies only to “eligible insureds.” Section 1402(f)(2) generally limits eligibility for cost-sharing protections under a QHP, such as the section 1402(d)(1) protections, to persons who also are eligible for premium tax credits.¹⁶

¹⁵ It is important to note that, in addition to having a projected income of not more than 300 percent of the federal poverty level, individuals in this category must also (and first) meet the requirements for enrollment in a Marketplace (under 45 CFR §155.305(a)) and meet the requirements for eligibility for premium tax credits (under 45 CFR §155.305(f)). Persons not meeting each of these requirements would not be eligible for the cost-sharing protections under section 1402(d)(1).

¹⁶ ACA section 1402(f)(2) reads: “(2) LIMITATIONS ON REDUCTION.—No cost-sharing reduction shall be allowed under this section with respect to coverage for any month unless the month is a coverage month with respect to which a credit is allowed to the insured (or an applicable taxpayer on behalf of the insured) under section 36B of such Code.”

Indians who are enrolled through a Marketplace and meet the criteria under section 1402(d)(2) are not subject to the (f)(2) restriction.

As such, Indians enrolled through a Marketplace who: (1) are eligible for premium tax credits under 45 CFR § 155.305(f), including meeting the expected household income requirements for premium tax credits of being at or above 100 percent FPL and not greater than 400 percent FPL; (2) have expected household income under 300 percent FPL (the upper limit in § 1402(d)(1)); and (3) meet the general requirements for enrolling in coverage through a Marketplace under 45 CFR § 155.305(a), such as not being incarcerated, are eligible for the zero CSV cost-sharing protections under section 1402(d)(1). In contrast, Indians who are enrolled through a Marketplace but do not meet each of these requirements are eligible for the limited CSV cost-sharing reductions under § 1402(d)(2). These Indians do not have to be eligible for premium tax credits to receive the limited CSVs.¹⁷



45 CFR § 155.350(a) Special eligibility standards and process for Indians.

* 45 CFR § 155.350(a) Eligibility for cost-sharing reductions.

** 45 CFR § 155.350(b) Special cost-sharing rule for Indians regardless of income.

Exhibit A above provides a graphic depiction of eligibility for the two Indian-specific cost-sharing protections.¹⁸ In the bar graph on the left, a Marketplace applicant requests an eligibility

¹⁷ HHS Notice of Benefit and Payment Parameters for 2014, Final Rule, 77 Fed Reg 15492, March 11, 2013.

¹⁸ CMS noted in the preamble to the proposed rule on the HHS Benefit and Payment Parameters for 2014 that the ACA did not limit the availability of the § 1402(d)(2) Indian-specific cost-sharing protections to the individual

determination for insurance affordability programs. In the bar graph on the right, a Marketplace enrollee elects to not have an income-based eligibility determination for insurance affordability programs.¹⁹

Labeling of Indian-Specific CSVs

The Indian-specific cost-sharing protections under ACA sections 1402(d)(1) and (d)(2) were labeled as the “zero cost-sharing plan variation” and the “limited cost-sharing plan variation” in other sections of the CMS-issued federal regulations. As shown below, the “zero cost-sharing plan variation” was labeled as such in §156.410(b)(2).²⁰ The “limited cost-sharing plan variation” was labeled as such in §156.410(b)(3).

“§156.410 Cost-sharing reductions for enrollees.

(a) *General requirement.* A QHP issuer must ensure that an individual eligible for cost-sharing reductions, as demonstrated by assignment to a particular plan variation, pays only the cost sharing required of an eligible individual for the applicable covered service under the plan variation. The cost-sharing reduction for which an individual is eligible must be applied when the cost sharing is collected.

(b) *Assignment to applicable plan variation.* If an individual is determined to be eligible to enroll in a QHP in the individual market offered through an Exchange and elects to do so, the QHP issuer must assign the individual under enrollment and eligibility information submitted by the Exchange as follows—

(2) If the individual is determined eligible by the Exchange for cost-sharing reductions for Indians with lower household income under §155.350(a) of this subchapter (subject to the special rule for family policies set forth in §155.305(g)(3) of this subchapter), and chooses to enroll in a QHP, the QHP issuer must assign the individual to the **zero cost sharing plan variation** of the selected QHP with all cost sharing eliminated described in §156.420(b)(1).

(3) If the individual is determined by the Exchange to be eligible for cost-sharing reductions for Indians regardless of household income under §155.350(b) of this subchapter (subject to the special rule for family policies set forth in §155.305(g)(3) of this

market of a Marketplace (77 Fed Reg 73178, December 7, 2012). Nonetheless, CMS issued regulations limiting the Indian-specific cost-sharing reductions to the individual market of a Marketplace.

¹⁹ 45 CFR §155.350(b).

²⁰ Emphasis added.

subchapter), and chooses to enroll in a QHP, the QHP issuer must assign the individual to the **limited cost sharing plan variation** of the selected QHP with the prohibition on cost sharing for benefits received from the Indian Health Service and certain other providers described in §156.420(b)(2).”

In the regulatory citation under 45 CFR § 156.410 referenced above, it is indicated that the zero and limited cost-sharing plan variations are further defined in 45 CFR § 156.420(b)(1) and (2), which indicate the scope of the cost-sharing protections to be provided by QHP issuers under each Indian-specific CSV. 45 CFR § 156.420(b)(1) and (2) read as follows:²¹

“(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.”

Marketplace Eligibility Determination Letters

One area causing confusion with the Indian-specific cost-sharing variations involves the eligibility determination that is indicated (or not) on the Marketplace eligibility determination letter provided to applicants, at least under the FFM.

When an Indian applicant seeks coverage through a Marketplace and qualifies for the zero cost-sharing variation, a designation of “02” is provided on the determination letter for the applicant when the applicant has been determined eligible for the Indian-specific cost-sharing protections under ACA § 1402(d)(1) (and 45 CFR §155.350(a)). This occurs whether the supporting documentation for meeting the definition of Indian under the Affordable Care Act is provided at the time of application or not. The specific language of a determination letter reads:

²¹ Emphasis added.

“Can choose a health plan with lower co-payments, coinsurance and deductibles (02).”²²

However, the determination letter for an applicant who is eligible for a limited cost-sharing variation does *not* include an “03” designation, despite the applicant meeting the requirements under ACA § 1402(d)(2) (and 45 CFR §155.350(b)).

The specific language of a determination letter for someone who should be eligible for the “03” CSV instead reads:

“Can choose a health plan with lower co-payments, coinsurance and deductibles”; or

“Will not have to pay any cost-sharing for covered services that are received from the Indian health system, but more information is needed.”

In the first response-type received and shown above, no “03” indicator is included. In the second response-type received and shown above, this language seems to describe general (pre-ACA) eligibility for American Indians and Alaska Natives who qualify for services from Indian health care providers. It does not mention that there is no cost sharing when receiving services through referral from an Indian health care provider; it does not provide the “03” designation; and it does not indicate whether there are any cost-sharing protections being afforded by way of the Marketplace-facilitated coverage.

Sample determination letters were reviewed from Indian applicants who should have been determined eligible for the “03” CSV, as the applicants had household income either (a) under 100 percent FPL, (b) between 300 and 400 percent FPL, or (c) over 400 percent FPL. To date, not a single determination letter has been identified with a “03” designation.²³

The absence of the “03” designation in determination letters leads us to question whether the “03” designation is being applied properly through the application and determination process. It is certainly not being indicated clearly in the determination letters or other Marketplace communications with individual Indian applicants for coverage. The differences in determination letters for the “02” and “03” CSVs appears to be a problem across FFM states, and it might also be a problem in SBMs.

Experience with Application of Cost-Sharing Protections by QHPs

The Affordable Care Act established in law not only cost-sharing protections for Indians but also related protections for providers serving Indians enrolled in a QHP through a Marketplace. When people with Indian-specific cost-sharing protections receive services from an Indian health

²² Language drawn from a Marketplace application determination letter issued by the FFM.

²³ If useful to CCIIO in the auditing of its eligibility determination process, specific examples of applications at each of these income levels can be provided to CCIIO. These cases involve individuals in several of the FFM states.

care provider or through referral to non-Indian health care providers, the provider is expected to be paid the entire amount of the claim by the QHP issuer with *no* reduction for deductibles or co-pays waived for the patient. The federal government reimburses the QHP issuer for the amount of cost sharing that is waived for the patient and paid by the QHP issuer to the provider.

Specifically, 45 CFR 156.420(g) reads:

“Prohibition on reduction in payments to Indian health providers. If an Indian is enrolled in a QHP in the individual market through an Exchange and is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or through referral under contract health services, the QHP issuer may not reduce the payment to any such entity for such item or service by the amount of any cost sharing that would be due from the Indian but for the prohibitions on cost sharing set forth in §156.410(b)(2) and (3).”

We have found numerous instances involving Indian health care providers in which QHP issuers have not been in compliance with this payment provision.²⁴ It has been documented that as much as \$6,300 in payments has been withheld for care provided to an individual QHP enrollee. In the aggregate, one Indian health care provider alone has experienced over \$506,000 in payments being withheld by one QHP issuer. We suspect similar withholding of payments is likely to be occurring with non-Indian health care providers that are serving Indians.

Some QHP issuers tend to apply protections properly; others do not. As might be imagined, this is causing great confusion among Indian health care providers, as well as among Indian enrollees in the Marketplace and Tribal sponsors of Indian enrollees. Adding to the confusion over these cost-sharing protections is that there are great variances across QHPs in the application of the Indian-specific CSVs.

Although this is a problem deserving resolution on its own merits, we raise this issue in this letter because it seems to exemplify the problems caused by the potential absence of the “03” CSV *eligibility determination* for eligible Indians who are enrolled in a QHP through a Marketplace. Rather than being a simple failure to comply with 45 CFR § 156.420(g) (although this is definitely occurring in some cases), we believe the lack of full payments to Indian health care providers might result from QHP issuers not being informed of the Indian enrollees’ eligibility for a limited cost-sharing plan variation. An analysis of payments made by QHP issuers for Marketplace enrollees at varying income levels supports this concern.

An analysis was conducted on a set of claims filed for services provided to Indian enrollees in Marketplace coverage. The enrollees and findings were grouped by income level. As shown in

²⁴ If useful to CCIIO in the auditing of its eligibility determination process and related activities, specific examples of improper withholding of payments to providers by QHP issuers can be made available to CCIIO.

Exhibit B, for each enrollee with at least one claim filed, a determination was made as to whether the proper deductible was applied to the claim by the QHP issuer.

The data indicate that there is a measurable pattern of a greater misapplication of cost-sharing protections for “03”-eligible persons when compared with “02”-eligible persons. As shown in Exhibit B, 6 percent of enrollees with household income between 100 percent and 300 percent FPL had a deductible improperly applied (these individuals likely would have the “02” CSV). In contrast, 29 percent of Indian enrollees with household income between 300 percent and 400 percent FPL had a deductible improperly applied (these individuals likely should be eligible for the “03” CSV). And finally, 69 percent of enrollees with household income under 100 percent or over 400 percent FPL had a deductible improperly applied (these individuals likely should be eligible for the “03” CSV).

If the cost-sharing protections were misapplied in a random fashion, the percentages with deductibles improperly applied should be fairly similar across the FPL groupings. They are not. It appears that protections are generally being applied correctly for “02” enrollees. For “03” enrollees, however, the experience is mixed. Those with household income between 300 percent and 400 percent FPL (which is the income range that matches the shorthand summary distributed by CMS) are much more likely to have the protections applied correctly than are likely “03” enrollees with household income above 400 percent or below 100 percent FPL.

EXHIBIT B: Summary of Findings: Is there a relationship between household income level -- measured by federal poverty level (FPL) percentage -- and application of deductibles?	
Household Income as a % of FPL	Percentage of Enrollees with Claims that Have Deductibles Improperly Applied
Under 100% FPL and Over 400% FPL	69%
100% - 300% FPL	6%
300-400% FPL	29%

The lack of proper application of the “03” cost-sharing protections raises the question of whether the root cause is that the eligibility determinations for the limited CSV are being done incorrectly by the FFM.²⁵

Impact on Access to Services from Incorrect Application of Indian-Specific CSVs

People with Indian status are able to access cost-sharing protections when enrolled at any metal level.²⁶ Indians enrolling in coverage through a Marketplace are counseled to enroll in bronze-

²⁵ Again, similar issues might be occurring in State-Based Marketplaces.

²⁶ The cost-sharing protections available to the general populations are only available to persons enrolled in silver-level coverage.

level coverage. This enables the Indian enrollees (or their sponsor) to purchase coverage with lower premiums and to maximize the comprehensive cost-sharing protections available through the Indian-specific CSVs. These bronze-level plans typically have deductibles of \$5,000-\$6,300 per year, absent the application of the Indian-specific cost-sharing protections.

Indian enrollees in Marketplace coverage are experiencing significant barriers to care because of the incorrect application of Indian-specific cost-sharing protections. For example, if the Indian enrollees had enrolled in silver-level coverage, the loss of cost-sharing protections might result in a \$250 deductible, or a \$25 co-payment, or some other relatively modest amount. But when enrolled in bronze-level coverage, if the Indian-specific cost-sharing protections are not applied correctly, Indian enrollees in Marketplace coverage can be confronted with deductibles reaching \$6,000 or more when seen by non-Indian health care providers. When visiting an emergency room or seeking a costly prescription medication at a non-Indian health care provider, an Indian patient might decline a needed health care service for fear of incurring a huge financial obligation or be prevented from receiving the service if the health care provider demands payment of the cost sharing prior to providing the service.

Rapid resolution of these issues is critical to ensuring access to needed health care services for current and future Indian Marketplace enrollees.

Impact on Payment to Indian Health Care Providers

As indicated above, the problems related to eligibility determinations for Indian-specific cost-sharing protections are resulting in significant delays, if not outright reductions, in payments to Indian health care providers.

There are numerous, documented instances whereby QHP issuers have deducted from payments to Indian health care providers the amounts of the cost sharing that should have been waived for Indian enrollees.²⁷ To secure these incorrectly withheld amounts, providers (both Indian health care providers and non-Indian health care providers) must convince QHP issuers that the amounts were erroneously withheld and, if successful, resubmit claims to QHP issuers. This is a time-consuming and burdensome process. And providers that are not familiar with the requirements of the Affordable Care Act might never receive these inappropriately withheld amounts.

These payment problems for Indian health care providers confound the financial pressures experienced by the approximately one-half of Tribes located in states that have yet to expand Medicaid using the new section 2001 authority established pursuant to the Affordable Care Act. To provide health insurance coverage for those who are barred from Medicaid coverage as a result of the state's decision, Tribes and tribal health organizations are sponsoring individuals who have household income under 100 percent FPL in Marketplace coverage. Because premium

²⁷ If useful to CCIIO in the auditing of its eligibility determination process and related activities, specific examples of improper withholding of payments to providers by QHP issuers can be made available to CCIIO.

tax credits are not available for individuals at this income level, the tribal sponsors are paying the full premium amount for the Marketplace coverage. Tribes are deciding to undertake sponsorship for these individuals with the understanding that the Affordable Care Act and the CMS-promulgated implementing regulations enable access to the comprehensive Indian-specific “03” CSV for these low-income individuals. The withholding of hundreds of thousands of dollars in waived cost sharing is violating this understanding. And these recent experiences are causing tribal sponsors to reconsider whether to continue sponsoring tribal members.

Recommendations

The TTAG offers the following recommendations to address at least some of the issues identified above. We also encourage CCIIO to offer additional, and possibly more effective, recommendations, as well as to engage with tribal representatives to consider these concerns.

Eligibility

- Audit the eligibility determination algorithm used by the FFM to confirm that eligibility determinations for the two Indian-specific CSVs are being implemented in the application computer program and the determination process according to the CMS regulations. Engage CCIIO policy and information technology staff in the audit. Present and discuss the findings with the TTAG.
- Indicate on the FFM determination letters the specific cost-sharing variation an Indian applicant has been determined eligible to receive (*i.e.*, “02” or “03”). Provide on the determination letter a summary description of the Indian-specific CSV.

General Protections

- Increase education of QHP issuers on Indian-specific cost-sharing protections
 - Provide language from CCIIO to QHP issuers on the Indian-specific CSVs for inclusion in the QHP’s Summary of Benefits and Coverage documents due by October 2015.
 - Require QHP issuers to indicate on QHP insurance cards what type of CSV in which the enrollee is enrolled.
- Communicate availability of the Health Insurance Complaint System (HICS). Permit tribal sponsors of enrollees to submit multiple (repeat) cases involving a single QHP but multiple QHP enrollees in one HICS submission.
- Ensure QHP issuers are applying the Indian-specific CSVs correctly. Draw upon filings through the HICS to identify erroneous application of Indian-specific CSVs by QHP issuers and prioritize conducting broader audits of the application of Indian-specific CSVs by QHP issuers.

Payments to Indian Health Care Providers

- Ensure QHP issuers are making full payment to Indian health care providers, without deducting waived cost-sharing amounts.
- Communicate availability of the HICS. Permit providers to submit multiple (repeat) cases involving a single QHP in one submission.

Shorthand Descriptions of Indian-Specific Cost-Sharing Variations

Consider adopting one or more of the following abbreviated descriptions for use by CMS when a shorthand version of the explanation of the Indian-specific CSVs is required.

OPTION 1:

- “00 - Non-Exchange variant
- 01 - Exchange variant (no CSR)
- 02 - Open to Indians between 100% and 300% FPL**
- 03 - Open to Indians of any income level, or income not determined**
- 04 - 73% AV Level Silver Plan CSR
- 05 - 87% AV Level Silver Plan CSR
- 06 - 94% AV Level Silver Plan CSR”

OPTION 2:

- “02” or “Zero cost-sharing variation” protections are available to persons who meet the ACA’s definition of Indian, have household income between 100 and 300 percent FPL, are eligible for premium tax credits, and enroll in coverage through a Marketplace.
- “03” or “Limited cost-sharing variation” protections are available to persons who meet the ACA’s definition of Indian, have any household income level, and enroll in coverage through a Marketplace.
 - o Persons eligible for the limited cost-sharing variation do not have to be eligible for premium tax credits and can decide to not request an eligibility determination for insurance affordability programs (*e.g.*, premium tax credits).

OPTION 3:

- ◇ “Zero cost-sharing variation” (“02”)

Protections available to persons enrolled in coverage through a Marketplace who:

- Meet the ACA’s definition of Indian
- Have household income between 100 and 300 percent FPL

- Qualify for premium tax credits
- ◇ “Limited cost-sharing variation” (“03”)

Protections available to persons enrolled in coverage through a Marketplace who:

- Meet the ACA’s definition of Indian
- Have household income of any level
- Do or do not qualify for premium tax credits

To receive the “02” or “03” protections, an individual cannot be enrolled in a family plan with individuals who are not eligible for the “02” or “03” protections.²⁸

Conclusion

We would like to communicate a sense of urgency with resolving the matters described above. We request a rapid and in-depth review and engagement for the purpose of confirming that eligibility determinations for Indian-specific cost-sharing protections are being made correctly and being implemented consistently.

We thank you for engaging with Tribes and tribal health organizations to ensure that the benefits and protections afforded to AI/ANs in the Affordable Care Act are fully and accurately implemented.

Sincerely,



W. Ron Allen
Tribal Chairman and CEO, Jamestown S’Klallam Tribe
Chair, TTAG

Cc: Andy Slavitt, Acting Administrator, CMS
Vikki Wachino, Director, CMCS
Kitty Marx, Director, CMS Division of Tribal Affairs

²⁸ The TTAG has made prior recommendations on approaches to eliminate the problem of mixed eligibility for CSVs under family plan enrollment. We encourage CCIIO to consider the recommendations made by the TTAG with regard to CMS-9964-P (December 2013) and CMS-9944-P (December 2014).