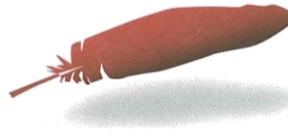


National Indian Health Board



Delivered via electronic submission to: <http://www.regulations.gov>

September 27, 2011

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9975-P
P.O. Box 8010
Baltimore, MD 21244-8010

RE: Comments on CMS-9975-P: Standards Related to Reinsurance, Risk Corridors and Risk Adjustment

The National Indian Health Board¹ (NIHB) is submitting analysis and comments to the Centers for Medicare and Medicaid Services (CMS), Department of Health and Human Services (HHS) in response to the request for comments published July 15, 2011 in the *Federal Register* involving “Standards Related to Reinsurance, Risk Corridors and Risk Adjustment” (CMS-9983-P or Proposed Rule). We appreciate the opportunity to comment on this Proposed Rule.

In October of 2010, NIHB provided written comments in response to the Request for Comments regarding Exchange-related provisions in Title I of the Patient Protection and Affordable Care Act (ACA) published in the *Federal Register* on August 3, 2010,² which included a discussion of the risk mitigation measures in this Proposed Rule. Those comprehensive comments, as well as subsequent comments we will be submitting in response to CMS-9989-P: Establishment of Exchanges and Qualified Health Plans, provide additional context to the comments offered below. The comments below are tailored directly to the provisions in the Proposed Rule.

The analysis and comments contained in the attached “Standards Related to Reinsurance, Risk Corridors and Risk Adjustment to Be Implemented Pursuant to Title I of the Patient Protection and Affordable Care Act; Analysis of Proposed Rule (CMS-9975-P) by

¹ Established nearly 40 years ago, NIHB is an inter-Tribal organization that advocates on behalf of Tribal governments for the provision of quality health care to all American Indians and Alaska Natives. NIHB is governed by a Board of Directors consisting of a representative from each of the twelve Indian Health Service (“IHS”) Areas. Each Area Health Board elects a representative to sit on the NIHB Board of Directors. In areas where there is no Area Health Board, Tribal governments choose a representative who communicates policy information and concerns of the Tribes in that area with NIHB. Whether Tribes operate their entire health care program through contracts or compacts with IHS under Public Law 93-638, the Indian Self-Determination and Education Assistance Act (“ISDEAA”), or continue to also rely on IHS for delivery of some, or even most, of their health care, NIHB is their advocate.

² See NIHB letter to the Office of Consumer Information and Insurance Oversight, dated October 4, 2010 submitted via electronic transmission via <http://www.regulations.gov>.



the National Indian Health Board” reference the specific section on which a comment is made, and the comments are presented in the order of the sections in the Proposed Rule.

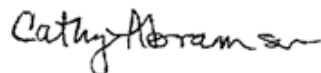
In summary, the NIHB concurs in large measure with the approaches taken in the Proposed Rule. Nonetheless, we believe the risk management approaches in these regulations are helpful, but not sufficient, to “mitigate the impact of potential adverse selection” and ensure access for American Indians and Alaska Natives to comprehensive and timely health care services, including access to the “I/T/U”³ health care providers and programs that traditionally have served American Indians and Alaska Natives (AI/AN). Through these comments and our comments on the proposed rule on Exchange Establishment (CMS-9989-P), we are recommending that health plans offered through an Exchange be required to offer to contract with I/T/U providers in their service area.

In addition, we are recommending that HHS include discussion and rulemaking in this Proposed Rule on an additional risk management mechanism that is specific to AI/AN. As are the three risk mitigation mechanisms in the Proposed Rule, this additional mechanism is also designed to mitigate the potential impact of adverse selection (by making payments to account for higher cost cases) and to stabilize premiums in the individual and small group markets.

Under “Special Rules for Indians” in section 1402(d) of the Affordable Care Act, AI/AN with family income at or below 300 percent of the federal poverty level who are enrolled in the individual market in an Exchange are protected from any cost-sharing requirements. In addition, any AI/AN (regardless of income) enrolled in a qualified health plan in an Exchange shall not have cost-sharing requirements for any item or service provided by an Indian health provider. The HHS Secretary is directed to make payments to health plans offered through an Exchange in an amount that is sufficient to offset the additional actuarial value of the plan as a result of these special protections for AI/AN. We refer to this payment as the “HHS Indian Offset”. Again, we recommend that HHS add a discussion and the necessary rulemaking in this Proposed Rule in order to ensure that timely and adequate payments are made under this provision of the Affordable Care Act.

Thank you in advance for consideration of these recommendations as we jointly work to advance the health status of American Indian and Alaska Native individuals and communities across the United States.

Sincerely,



Cathy Abramson
Chairman, National Indian Health Board

Cc: Valerie Davidson, Chair, Tribal Technical Advisory Group to CMS
Dr. Yvette Roubideaux, Director, Indian Health Service
Kitty Marx, Director, CMS Tribal Affairs Group
H. Sally Smith, Chair, NIHB Medicare, Medicaid and Health Reform Policy
Committee (MMPC)

³ “I/T/U”, or “Indian health provider”, means the Indian Health Service (IHS), an Indian Tribe, tribal organization or urban Indian organization provider.

Stacy Bohlen, Executive Director, NIHB
Jennifer Cooper, Legislative Director, NIHB

Attachment: Comments on CMS-9975-P: Standards Related to Reinsurance, Risk
Corridors and Risk Adjustment