Tables on Referrals and Payment Rates for Services For American Indians and Alaska Natives Enrolled in Marketplace Plans

Medicare, Medicaid and Health Reform Policy Committee (MMPC)
National Indian Health Board (NIHB)

May 23, 2014

This paper was prepared with technical assistance from the Centers for Medicare and Medicaid Services (CMS) and the Indian Health Service (IHS), but this is not an official document issued by the federal government. **For the purposes of these tables, all statutory and regulatory citations and descriptions of the legal status quo *reflect MMPC understanding of the current CMS interpretation* of the rules under discussion.**

Introduction

These tables on Referrals and Payment Rates for Services provided to people enrolled in Marketplace plans are intended for use by Indian health providers, including the Indian Health Service, Tribally-operated programs, and urban Indian clinics (I/T/U). To make the Affordable Care Act (ACA) sustainable for American Indians and Alaska Natives (AI/AN), it is important that they have access to the cost-sharing reductions for which they are eligible if they enroll in Qualified Health Plans (QHPs) through the Marketplace. It is also important for the I/T/U to receive the payment to which they are entitled if they provide services to people who are enrolled in Marketplace plans.

The tables explain some differences between types of plans offered on the Marketplaces set up by the Affordable Care Act.[1] The tables may be used in the following ways:

- Enrollment Assisters may use Tables 1 and 2 to help explain to patients what they need to do to avoid cost sharing for the Marketplace plan in which they are enrolled. For example, people who are enrolled in a limited cost sharing plan would need to have a Contract Health Service (CHS) referral for a non-I/T/U provider to avoid cost sharing.

- Contract Health Services (CHS) personnel may use Tables 1 and 2 to help figure out the type of document that is needed for patients to avoid cost sharing, and Table 3 to help explain the payment process to provider organizations that receive a referral or authorization. For example, to assure that the people served by the I/T/U who have QHP coverage incur no out-of-pocket costs, CHS would issue a referral to a person with a limit cost sharing plan or an authorization to a person with a standard plan.

- Business Office staff may use Table 3 to understand how the I/T/U may expect to be paid by insurance companies for services provided to people enrolled in specific types of plans through the Marketplace. For example, the Business Office may review payment of claims to assure that there is no deduction of an amount for cost sharing for people who are in zero cost sharing or limited cost sharing plans.

After the tables, there are explanations of terms that are used and excerpts from relevant documents. References within this document are provided as endnotes.

Essential Health Benefits and Cost-sharing

Cost-sharing reduction rules are different for services that are considered Essential Health Benefits (EHB) and services that are not EHBs. Both the ACA (42 U.S.C. § 18022(c)(3)(B)) and CMS regulations (45 C.F.R. § 155.20) define "cost-sharing" for the purposes of the AI/AN cost-sharing protections as being limited to deductibles, coinsurance, copayments, or similar charges *specifically* "with respect to essential health benefits." CMS has interpreted the language "with respect to essential health benefits" as meaning that AI/AN cost-sharing provisions under the ACA only apply to services that are considered "essential health benefits," meaning that CMS interprets the AI/AN cost-sharing protections as being limited to EHBs.

The first table applies to EHB services in various types of plans. The second table is only for non-EHBs and it applies to all types of plans. The third table explains payments to the I/T/U and to non-I/T/U providers for all types of plans, except plans that do not cover out-of network services, such as closed panel plans. More information is provided about this after the tables in CCIIO QHP Webinar Series Frequently Asked Questions, A27 (Apr. 11, 2013); CCIIO QHP Webinar Series Frequently Asked Questions, A84 (Apr. 25, 2013).

Organization of Tables

Table 1 covers EHB services, and it is organized by type of plan available in the Marketplace for IHS beneficiaries (column 1), including zero cost sharing and limited cost sharing plan variations (for members of Indian tribes and ANCSA shareholders), other plans for AI/ANs who are not members of tribes or ANCSA shareholders (including both the silver plan with cost sharing reductions for people under 250 percent of the Federal Poverty Level and the standard plans). The special case of plans that do not cover out-of-network services (including closed panel plans) is still under discussion between Tribes and CMS. This table presents the information that CMS has provided to issuers of such plans; however, Tribes strongly disagree with this guidance which was developed without Tribal Consultation. Table 2, which covers non-EHB services, combines all types of plans in column 1.

Column 2 for Tables 1 and 2 has the type of provider in the plan, starting with I/T/U providers. The other types of providers are non-I/TU, and include in-network providers and out-of-network providers. The providers in Column 2 are the ones that are providing the service, and the question that the table seeks to answer is whether the consumer needs a CHS referral or authorization to see the provider in Column 2 without incurring out-of-pocket expenditures. The provider in Column 2 is not necessarily the source of the referral or authorization, but rather the recipient of the referral or authorization.

Column 3 in Tables 1 and 2 shows the type of referral or authorization needed from CHS, if any, in order for the patient to avoid cost sharing.

Table 3 identifies the payment to providers for providing essential health benefits (EHBs). Information in Table 3 is intended to apply to all types of Qualified Health Plans (QHPs) offered in the Marketplace, including zero cost sharing plans, limited cost sharing plans, silver plans with cost sharing reductions (CSR) based on income, and standard plans. However, it does not cover the case of plans that do not cover out-of-network services, including closed panel plans.

In Table 3, Column 1 identifies whether the provider is an I/T/U provider or a non-I/T/U provider. Column 2 specifies whether the provider is in-network or out-of-network. Column 3 indicates the payment rate that the particular provider may expect. And Column 4 indicates how cost sharing reductions are treated in the payment to the specific providers.

Table 1. CHS Referrals or CHS Authorization Needed
For Patients to Avoid Cost-Sharing for Essential Health Benefits (EHB)

Type of Plan	Type of Provider of Service	CHS Referral or CHS Authorization Needed for Patient to Avoid Cost Sharing
Zero Cost Sharing Plan[2] (excluding closed panel HMOs)[3] [Note: Limited to those who are tribal members or ANCSA shareholders and are between 100- 300% FPL][4]	I/T/U Provider	None needed.[5]
	Non-I/T/U In-network Provider	None needed. (AI/AN patient may need a plan referral from an in-network provider pursuant to the terms and conditions of the plan to see non-I/T/U in-network providers who are not primary care providers.)
	Non-I/T/U Out-of-network Provider	CHS authorization needed to cover any balance billing amounts.
Limited Cost Sharing Plan (excluding closed panel HMOs)[6] [Note: Limited to those who are tribal members or ANCSA shareholders with any level of income]	I/T/U Provider	None needed.
	Non-I/T/U In-network Provider	CHS referral required to avoid cost-sharing. (AI/AN patient may also need a plan referral from an in-network provider pursuant to the terms and conditions of the plan to see in-network providers who are not primary care providers.)
	Non-I/T/U Out-of-network Provider	CHS referral is required for patient to avoid cost-sharing and CHS authorization is required to pay any balance billing charges.
Silver Plan with Cost Sharing Reductions (CSR) based on income (excluding closed panel HMOs) [Note: for IHS beneficiaries who are not members of federally recognized tribes or ANSCA shareholders and whose income is between 100% and 250% FPL.]	I/T/U Provider	Indian health beneficiaries do not need a referral to see an I/T/U provider. To get the CSR, a plan referral may be needed if the I/T/U provider is out-of-network.
	Non-I/T/U In-network Provider	CHS authorization is needed for the IHS beneficiary to avoid paying any cost sharing. A referral requirement from network provider depends on plan.
	Non-I/T/U Out-of-network Provider	CHS authorization is needed for the IHS beneficiary to avoid paying any cost sharing or balance billing.

Type of Plan	Type of Provider of Service	CHS Referral or CHS Authorization Needed for Patient to Avoid Cost Sharing
Standard Plan (excluding closed panel HMOs) [Note: for IHS beneficiaries who are not members of federally recognized tribes or ANSCA shareholders and whose income is above 250% FPL.]	I/T/U Provider	Indian health beneficiaries do not need a referral to see an I/T/U provider. Cost sharing will be applied to visit, but I/T/U may choose not to collect cost sharing.
	Non-I/T/U In-network Provider	CHS authorization is needed for the IHS beneficiary to avoid paying any cost sharing or balance billing. In addition, patient should follow plan referral requirements to have the lowest cost sharing.
	Non-I/T/U Out-of-network Provider	CHS authorization is needed for the IHS beneficiary to avoid paying any cost sharing or balance billing. In addition, patient should follow plan referral requirements to have the lowest cost sharing.
HMOs that do not cover out-of-network services, including closed panel HMOs [Note: Tribes were not consulted on this and disagree with the guidance provided by CMS to issuers.]	I/T/U Provider	• No referral or authorization needed. • Benefits only apply to services delivered by in-network providers.[7] • If I/T/U is in-network, there is no cost sharing for zero cost sharing and limited cost sharing plans. For people in standard plans and silver plans with CSR, cost sharing will be applied to visit, but I/T/U may choose not to collect cost sharing from patient. • If I/T/U is out-of-network, insurance may expect patient to pay entire cost of visit (for all plan variations); however, I/T/U has a right to be paid by insurance company under Sec. 206.
	Non-I/T/U In-network Provider	• HMO rules apply. • No cost sharing for AI/AN enrolled in zero cost sharing plans (no CHS referral is needed). • CHS referral needed for people in limited cost sharing plans for all visits to avoid cost sharing.
	Non-I/T/U Out-of-Network Provider	• Benefits only apply to in-network providers. • CHS authorization is needed for entire cost of service.

Table 2. Referrals or Authorizations for AI/AN for Non-Essential Health Benefits (non-EHBs)

Type of Plan	Type of Provider	CHS Referral or Authorization to Avoid Cost Sharing
All QHPs offered through the Marketplace	I/T/U	None needed.
	Non-I/T/U	CHS authorization needed for patient to avoid paying for the total cost of the service.

Table 3. Payment to Providers for Providing Essential Health Benefits (EHBs) by All QHPs offered through the Marketplace (including Zero Cost Sharing Plans, Limited Cost Sharing Plans, Silver Plans with Cost Sharing Reductions based on income, and Standard Plans) except Closed Panel Plans

Type of Provider	Network Status	Payment Rate by QHP to Provider	Treatment of Cost Sharing in Payment to Providers
I/T/U Provider	In-network	Payment is at the rate specified in the contract between the issuer and the I/T/U provider.	• For people enrolled in zero cost sharing plans and limited cost sharing plans, the plan may not make any deduction from payments to the I/T/U for cost sharing which the AI/AN patient is exempt from paying.[8] • For people in silver plans with CSR and standard plans, the QHP may deduct cost sharing amounts that are owed by the patient. • IHS beneficiaries are not required to pay the I/T/U for the cost sharing amount.[9]
	Out-of-network	Payment is at "the reasonable charges billed" or if higher, the highest amount the plan would pay for care and services furnished by providers other than governmental entities.[10]	
Non-I/T/U Provider	In-network Provider Payment	• Payment is at whatever contractual rate the non-I/T/U in-network provider has negotiated with the plan. • With CHS authorization, CHS pays for any balance billing or cost sharing that would otherwise be charged to patient. • For hospital-based inpatient services and	• For zero cost sharing plans, the plan may not make any deduction for cost sharing that the AI/AN patient is exempt from paying.[11] • For limited cost sharing plans, if the patient has a CHS referral, the plan may not make any deduction for cost sharing that the AI/AN patient is exempt from paying. • For silver plan variations and standard plans, the rules that apply to treatment of cost sharing for non-I/T/U providers are different than for I/T/U. In a fee-for-service arrangement, the

Type of Provider	Network Status	Payment Rate by QHP to Provider	Treatment of Cost Sharing in Payment to Providers
		outpatient services with CHS authorization, and CHS pays only the balance between payment from the plan (and any other payers) and the Medicare-Like Rate for that service.	issuer will not be reimbursed by the federal government for the CSR unless they reimburse the provider. • A CHS authorization that covers the cost sharing amount would result in no out-of-pocket cost to consumer.
	Out-of-network Provider	• Payment is at whatever rate the plan pays out of network providers, if the plan pays at all. • With CHS authorization, CHS pays for any billed charges not covered by the plan and any cost sharing that would otherwise be charged to patient. • For hospital-based inpatient services and outpatient services with CHS authorization, CHS pays only the balance between payment from the plan (and any other payers) and the Medicare-Like Rate for that service.	• For zero cost sharing plans, to the extent the plan makes any payment to out-of-network providers it may not make any deduction for cost sharing that the AI/AN patient is exempt from paying. • For limited cost sharing plans, if the patient has a CHS referral, to the extent the plan makes any payment to out-of-network providers, the plan may not make any deduction for cost sharing that the AI/AN patient is exempt from paying. • For silver plan variations and standard plans, the rules that apply to treatment of cost sharing for non-I/T/U providers are different than for I/T/U. In a fee-for-service arrangement, the issuer will not be reimbursed by the federal government for the CSR unless they reimburse the provider. • A CHS authorization that covers the cost sharing amount would result in no out-of-pocket cost to consumer.

Reference Materials

1. Definitions

ACA: Patient Protection and Affordable Care Act (P.L. 111-148) enacted March 23, 2010.

ANSCA: Alaska Native Claims Settlement Act

CHS: Contract Health Services, also called Purchased/Referred Care in the 2014 Budget.[12]

CHS Authorization: Authorizes the provider to bill the CHS program as the last payer, issued only to people who live in CHSDA, and may be limited by budget and priority system for CHS program.

CHS Referral: Referral provided by I/T/U under ACA rules, does not obligate CHS to pay for services, is not restricted to people who live in CHSDA, is not limited by CHS budget or priorities.

Closed Panel Plan: Type of health maintenance organization (HMO) where all the providers in the network are employed by the HMO and do not see patients with other types of insurance, and where patients benefits are restricted to in-network providers.

CSR: Cost sharing reductions

EHB: Essential Health Benefits are defined by ACA as ten categories of services that all QHPs and MSPs must provide, including: 1) ambulatory patient services; 2) emergency services; 3) hospitalization; 4) maternity and newborn care; 5) behavioral health treatment; 6) prescription drugs; 7) rehabilitative and habilitative services; 8) laboratory services; 9) preventive and wellness services, chronic disease management; and 10) pediatric, including oral and vision.[13]

FPL: Federal Poverty Level

HMO: Health Maintenance Organization, a type of managed care plan. Some HMOs do not pay for out-of-network services.

I/T/U Provider: Any clinic, hospital or program provided by the Indian Health Service, a Tribe or Tribal Organization, or an urban Indian clinic. For purposes of this table, the I/T/U provider can be either in the plan network or out-of-network.

In-network Provider: For purposes of these tables, in-network providers are non-I/T/U providers who are part of the network of the QHP or MSP in which the patient is enrolled.

Limited Cost Sharing Plan: Available to members of federally-recognized Tribes and shareholders in Alaska Native Regional or Village Corporations with any level of income (including those with MAGI below 100 percent FPL, above 300 percent FPL, or no income determination). There is no cost sharing for EHB services provided by I/T/U or with referral from CHS.[14]

MSP: Multi-State Plan offered by Office of Personnel Management on Exchange/Marketplace[15]

Out-of-Network Provider: For purposes of these tables, out-of-network providers are non-I/T/U providers who are not part of the network of the QHP or MSP in which the patient is enrolled.

Plan Referral: Some plans require a referral from an in-network primary care provider to a specialist. This type of referral is different from the CHS referral.

QHP: Qualified Health Plan offered on Exchange/Marketplace

Silver Plan with CSR: Silver level QHP offered in the Marketplace with cost-sharing reductions on a sliding scale for people whose income is below 250 percent of the FPL. Indian health beneficiaries who are most likely to purchase this type plan are those who are not enrolled members of Tribes or ANSCA shareholders.

Standard Plan: QHP that is offered through the Marketplace without cost-sharing reductions. The most likely Indian health beneficiary to purchase is standard plan is a person whose income is over 250 percent of the FPL and who is not an enrolled Tribal member or a shareholder in an ANSCA corporation.

Zero Cost Sharing Plan: Available to members of federally-recognized Tribes and shareholders in Alaska Native Regional or Village Corporations with MAGI below 300 percent of the federal poverty level (FPL). There is no cost sharing for any EHB services.[16]

2. CHS referrals for AI/AN who are enrolled in Marketplace plans in another state

Frequently Asked Questions (FAQs) # 12
Date: June 28, 2013

Q50: For plan 03 (AI/AN above 300% FPL), are issuers required to only apply the $0 cost share to Tribal providers to the on exchange states?

A50: 45 CFR 156.420(b)(2), as described in the final Payment Notice (http://www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04902.pdf), requires QHP issuers to offer a limited cost sharing plan variation 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, or through referral under contract health services – regardless of the state in which the coverage is provided, or the state in which the provider is located. Please see Q84 of QHP FAQ #9 for additional information.

3. Section 206 of the Indian Health Care Improvement Act (IHCIA)

Under Section 206 of the IHCIA, plans must pay I/T/U providers for covered services delivered to people enrolled in the plan, both AI/AN and non-Indian, whether or not the I/T/U is in-network or out-of-network. However, closed panel HMOs define the covered services as only those services provided by the closed panel HMO providers. I/T/U providers cannot become providers in closed panel HMOs because those HMO providers only see people enrolled in the HMO and they must serve all people enrolled in the HMO. For this reason, the I/T/U should strongly encourage the people they serve not to enroll in a closed panel HMO and should assist people to change their enrollment to a different plan during the next monthly special enrollment period for AI/AN.

4. Guidance provided by CCIIO for closed panel HMOs

QHP Webinar Series Frequently Asked Questions
Selected Responses
Date: April 25, 2013
Page 24

Q84: For a limited cost sharing plan variation of a **QHP that does not cover services when furnished by an out-of-network provider,** does the cost sharing need to be eliminated for EHB out-of-network services furnished directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or through referral under contract health services?

A84: As discussed in Q&A 27 of QHP FAQ #3 (published on REGTAP on April 11, 2013) in relation to the zero cost sharing plan variation, **enrollee spending for non-covered services is not considered cost sharing**. As a result, if a QHP does not cover certain services (or all **services) furnished by a provider outside of the network, the spending for these non-covered services would not need to be eliminated for the zero cost sharing plan variation or the limited cost sharing plan variation, even if the service was furnished directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or through referral under contract health services.** QHP issuers, including HMOs, should note however, that reimbursement is required in compliance with **section 206** of the Indian Health Care Improvement Act. In general, QHP issuers should be aware that they can indicate that a service is not covered by marking the service as not covered on the Benefits Package Worksheet, or, if a service or no services are covered when furnished by an out-of-network provider, the QHP issuer can set the out-of-network coinsurance for the service(s) to 100%, set the out-of-network copay(s) to "no charge," and indicate that enrollee spending for those service(s) does not count towards any deductible or towards any maximum out-of-pocket limit. In addition, as discussed in Chapter 10 of the Plans and Benefits Application, QHP issuers should be aware that **the cost-sharing reductions under the limited cost sharing plan variation do not need to be recorded in the Plans and Benefits Template**.

Frequently Asked Questions (FAQs) # 3
Date: April 11, 2013

Q27: For the zero cost sharing plan variation of a closed-panel HMO QHP, does the cost sharing for out-of-network services need to be eliminated?

A27: A zero cost sharing plan variation, as defined at 45 CFR 156.420(b)(1), is a variation of a QHP with all cost sharing eliminated. However, cost sharing is defined at 45 CFR 155.20 to be any expenditure required by or on behalf of an enrollee with respect to Essential Health Benefits, including deductibles, coinsurance, copayments, or similar charges, but excluding premiums, balance billing amounts for non-network providers, and spending for non-covered services. Therefore, **if the QHP is a closed-panel HMO that does not cover services furnished by a provider outside of the network** (i.e. cost sharing for services provided by an out-of-network provider is 100%), the spending, or cost sharing, for these non-covered services would not need to be eliminated for the zero cost sharing plan variation associated with this QHP, and should be entered as it would be for non-covered out-of-network services under the corresponding standard plan. **For covered benefits that are not Essential Health Benefits, the coinsurance and copays must be the same as the associated standard plan** (despite the template auto-populating them with 0's). For additional information, please consult the final HHS Notice of Benefit and Payment Parameters, published March 11th 2013.

5. Emergency Services

Under ACA section 1001 (which established section 2719A of the Public Health Service Act), the "prudent layperson definition" is applied in defining an emergency medical condition that must be covered by a QHP.

> Section 2719A(b)(2) -- ''(2) DEFINITIONS.—In this subsection:
> ''(A) EMERGENCY MEDICAL CONDITION.—The term emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

A discussion of the provision and related regulations was published in a joint regulation by Treasury, Labor and HHS (OCIIO-9994) on June 28, 2010. The discussion can be found at
37194 Federal Register / Vol. 75, No. 123 / Monday, June 28, 2010 / Rules and Regulations

The emergency services must be paid for by the QHP without requirements for prior authorization or consideration to whether the provider is in-network or not. And, the cost-sharing amount cannot be more than the cost-sharing would be for in-network providers; however, for out-of-network providers, balance billing is allowable. (There is discussion in the preamble to the final rule on when and what is considered acceptable.)

6. Regulations

Final HHS Notice of Benefit and Payment Parameters
Date published: March 11, 2013
http://www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04902.pdf
CMS-9964-F
(A) ***In the Code of Federal Regulations, the requirement for QHP to offer zero cost-sharing and limited cost-sharing plan variations is established:***

45 CFR § 156.420 Plan variations.

> (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.

http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&SID=b6a391a763f25de161a38f22a2980dd1&rgn=div8&view=text&node=45:1.0.1.2.71.5.27.3&idno=45

(B) ***In the Federal Register / Vol. 78, No. 47 / Monday, March 11, 2013 / Rules and Regulations, page 15421***

An explanation of the zero cost-sharing plan variation and the limited cost-sharing plan variation is provided.

(C) In the CMS regulations titled, Notice of Benefit and Payment Parameters for 2014 (CMS-9964-F, dated 3-11-201), the following was included, in part:

"[A] QHP issuer must ensure that an individual assigned to a limited cost sharing plan variation must not be required to pay any cost sharing at the time when cost sharing would normally be collected if the individual receives services or items from IHS or a related provider." [78 FR 15493]

Endnotes

[1] Similar questions arise under Medicaid, especially when the State has contracted with managed care organizations (MCO) to administer part or all of the Medicaid program. Under ARRA Section 5006, AI/ANs are never subject to cost sharing requirements associated with services provided by an Indian health provider. They are also not subject to cost sharing when they use non-Indian program providers if they were referred by an Indian health provider. Different rules may also apply to the payments an Indian health provider will receive from Medicaid (or a Medicaid MCO).

[2] For each of the QHPs that an issuer offers at any level of coverage, or intends to offer in the individual market on an Exchange, the issuer must submit to the Exchange for certification the health plan as well as a "zero cost variation" of the health plan with all cost-sharing eliminated for any individual who (1) is American Indian or Alaska Native, as defined in 42 C.F.R. § 155.300(a); (2) is otherwise eligible for enrollment in a QHP under 45 C.F.R. § 155.305(a); (3) is eligible for an advance premium tax credit under 45 C.F.R. § 155.305(f); and (4) is expected to have a household income, as defined in 26 C.F.R. § 1.36B-1(e), that does not exceed 300% of the FPL for the benefit year for which coverage is requested. *See* 45 C.F.R. § 155.420(b)(1); 45 C.F.R. § 155.350(a)(1)(ii).

[3] With regard to the references exclusions for "closed panel HMOs" under the zero and limited cost-sharing plan descriptions, 42 U.S.C. § 18022(c)(3)(B) and 45 C.F.R. § 155.20 exclude "spending for non-covered services" from the definition of "cost-sharing." In a subsequent guidance, CCIIO stated that if a "QHP is a closed-panel HMO that does not cover services furnished by a provider outside of the network (i.e. cost sharing for services provided by an out-of-network provider is 100%), the spending, or cost sharing, for these non-covered services would not need to be eliminated for the zero cost sharing plan variation associated with this QHP, and should be entered as it would be for non-covered out-of-network services under the

corresponding standard plan." *See* CCIIO QHP Webinar Series Frequently Asked Questions, A27 (Apr. 11, 2013).

[4] 42 U.S.C. § 18071(d); 45 C.F.R. § 155.300(a), .350.

[5] For the purposes of all entries marked "None needed" in the column on whether CHS authorization is required to authorize cost-sharing reductions in the zero and limited cost-sharing plans, this is because CMS has clarified that QHP issuers must eliminate cost-sharing for both in network and out-of-network covered EHBs for the zero cost sharing plan variation, as well as for the limited cost-sharing plan variation when the service is furnished by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or through referral under contract health services, as described in 45 CFR 156.420(b), and thus no other authorization is required for the AI/AN to take advantage of these benefits. *See* Patient Protection and Affordable Care Act; Program Integrity: Exchange, Premium Stabilization Programs, and Market Standards; Amendments to the HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 65,046, 65,074 (Oct. 30, 2013).

[6] For each QHP that an issuer offers at any level of coverage, or intends to offer in the individual market on an Exchange, the issuer must submit to the Exchange for certification the health plan as well as a "limited cost-sharing variation" of the health plan with no cost sharing on any item or service that is an essential health benefit 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, to anyone who is an Indian, as defined by 45 C.F.R. § 155.300(a). *See* 45 C.F.R. § 155.420(b)(2).

[7] CMS has stated that if "the QHP is a closed-panel HMO that does not cover services furnished by a provider outside of the network (i.e. cost sharing for services provided by an out-of-network provider is 100%), the spending, or cost sharing, for these non-covered services would not need to be eliminated for the zero cost sharing plan variation associated with this QHP, and should be entered as it would be for non-covered out-of-network services under the corresponding standard plan." *See* CCIIO QHP Webinar Series Frequently Asked Questions, A27 (Apr. 11, 2013).

[8] CMS has clarified that QHP issuers must eliminate cost sharing for both in network and out-of-network covered EHB for the zero cost-sharing plan variation, as well as for the limited cost-sharing plan variation when the service is furnished by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or through referral under contract health services, as described in 45 CFR 156.420(b). *See* Patient Protection and Affordable Care Act; Program Integrity: Exchange, Premium Stabilization Programs, and Market Standards; Amendments to the HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 65,046, 65,074 (Oct. 30, 2013); CCIIO QHP Webinar Series Frequently Asked Questions, A27 (Apr. 11, 2013) (noting that under 45 C.F.R. § 155.20, the definition of "cost-sharing" for the purposes of the AI/AN protections include "any expenditure required by or on behalf of an enrollee with respect to Essential Health Benefits, including deductibles, coinsurance, copayments, or similar charges"). This reasoning applies for the purposes of all entries in the

"Payment Rate" column for zero and limited cost-sharing plans in which it is noted that the plan must pay the individual AI/AN's cost-sharing.

[9] Tribal health programs may elect to charge Indians for services provided by the Tribal health program. 25 U.S.C. § 1680r.

[10] 25 U.S.C. § 1621e. This right of recovery, which provides that tribes and tribal organizations the right to recover "from an insurance company, health maintenance organization, employee benefit plan, third-party tortfeasor, or any other responsible or liable third party (including a political subdivision or local governmental entity of a State) the reasonable charges billed . . . in providing health services . . . or, if higher, the highest amount the third party would pay for care and services furnished by providers other than governmental entities," applies to entries in the "Payment Rate" column referring to services provided by an out-of-network I/T/U under the zero and limited cost-sharing plans, as well as under the standard plan.

[11] 78 FR 15493 In the CMS regulations titled, Notice of Benefit and Payment Parameters for 2014 (CMS-9964-F, dated 3-11-201), the following was included, in part: "[A] QHP issuer must ensure that an individual assigned to a limited cost sharing plan variation must not be required to pay any cost sharing at the time when cost sharing would normally be collected if the individual receives services or items from IHS or a related provider."

[12] While the ACA and the regulations refer to "contract health services," according to the IHS Director's blog on February 9, 2014: "The Consolidated Appropriation Act of 2014 that was signed by the President in January included approval of a new name for IHS' Contract Health Service (CHS) Program, which funds referrals for care in the private sector when those services cannot be provided in the IHS facility. Congress requested that IHS propose a new name for the program since it was often confused for other budget items, and the FY 2014 President's Budget proposed that the name be changed to Purchased/Referred Care (PRC). The name change was official with passage of the FY 2014 appropriation, and IHS will transition the name from CHS to PRC during the next year."

[13] 42 U.S.C. § 18022(b); 45 C.F.R. § 440.347.

[14] *See generally* 45 C.F.R. § 155.420(b)(2).

[15] *See generally* 42 U.S.C. § 18054; 45 C.F.R. §§ 156.105; .420(g); 45 C.F.R. § 800 (establishing MSP program).

[16] *See generally* 45 C.F.R. § 155.420(b)(1).