

# 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 [regulations.gov](http://regulations.gov)

December 31, 2012

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-9964-P  
P.O. Box 8016  
Baltimore, MD 21244-8016.

**RE: Comments on CMS-9964-P; Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014**

I write on behalf of the Technical Tribal Advisory Group (“TTAG”) to the Centers for Medicare and Medicaid Services (“CMS”) regarding the request for comments on CMS-9964-P, the proposed rule entitled “Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014.” 77 Fed. Reg. 73118 (Dec. 7, 2012) (“Proposed Rule”).

The TTAG advises CMS on Indian health policy issues involving Medicare, Medicaid, the Children’s Health Insurance Program, and any other health care program funded (in whole or part) by CMS. In particular, the TTAG focuses on providing policy advice to CMS regarding improving the availability of health care services to American Indians and Alaska Natives (AI/ANs) under these Federal health care programs, including through providers operating under the health programs of the Indian Health Service, Indian Tribes, tribal organizations and urban Indian organizations (I/T/U). The TTAG offers the following comments on the Proposed Rule.

**I. Premiums and Cost-Sharing**

**a. Background and Cost-Sharing Plan Variations Approach**

Section 1402(d) of the Patient Protection and Affordable Care Act (“Affordable Care Act” or “ACA”) provides critically important cost-sharing reductions for AI/ANs who purchase insurance through an Exchange. These special cost-sharing reductions for AI/ANs were added to implement the federal trust responsibility and ensure that AI/ANs are able to participate in the Exchange plans at no cost to them. Section 1402(d) creates two cost-sharing reduction rules for AI/ANs. Under Section 1402(d)(1), all AI/ANs with incomes less than 300 percent of the federal poverty level (FPL) who purchase insurance through an Exchange are exempt from cost-sharing no matter where or how they receive their care. Under Section 1402(d)(2) of the ACA, all AI/ANs (no matter what their income level) are exempt from cost-sharing when they receive care through the IHS, a tribe or tribal organization or an urban Indian organization, or through contract health services. Under Section 1402(d)(3) of the ACA, the Secretary of HHS is tasked with paying issuers the amount necessary to offset any increase in the actuarial value of the

Qualified Health Plan (QHP) by reason of these Indian cost-sharing exemptions.

The Proposed Rule would implement these requirements by requiring the QHP issuers to offer two separate Indian-specific QHP variations for each QHP offered on the Exchange. The first plan variation is called the “zero cost-sharing plan variation,” and applies to AI/ANs whose incomes are below 300 percent of the FPL and who qualify for no cost-sharing to be imposed no matter where they receive their care. AI/ANs in this group would also be eligible for premium tax credits as their income falls below 300 percent of the FPL. The second plan variation is called the “limited cost-sharing plan variation,” and provides that AI/ANs are entitled to no cost-sharing if they receive care through IHS, a tribe or/tribal organization, urban Indian organization, or elsewhere if referred through CHS.<sup>1</sup>

The TTAG supports this approach. However, Tribes would like the opportunity to work with CCIIO on some of the more specific guidance that is needed to make it workable. During the All Tribes Call held by CMS on December 14, 2012, CCIIO presenters said that individuals would be given a card that would tell providers the cost-sharing protections to which they are entitled. We hope that the computerized information for plan enrollment would also contain this information and make it available to providers electronically in the event that individuals do not have the card with them when they are seeking healthcare services. Furthermore, there is likely to be confusion when AI/ANs are referred through Contract Health Service (CHS) to providers who are out-of-network for the QHP in which the individual is enrolled. Those out-of-network providers may not understand the payment amount that they can expect from the QHP inclusive of the waived cost-sharing.<sup>2</sup>

**b. The Cost-Sharing Exemptions for AI/AN Are Not Limited to the EHB**

Under the ACA, the QHPs must offer at least an “essential health benefit,” which is being defined under a separate notice of proposed rulemaking. In the preamble to the Proposed Rule, CMS states that the no cost-sharing and limited cost-sharing plan variations for AI/ANs must offer the same benefits package as the standard plan, and require the same out-of-pocket spending for benefits *other than essential health benefits*. Similarly, proposed section 156.420(d) provides that a ““QHP and each zero cost-sharing plan variation or limited cost-sharing plan variation thereof must cover the same benefits and providers, and require the same out-of-pocket limit spending for benefits, *other than essential health benefits*.”“ Proposed section 156.420(b)(2) characterizes the limited cost-sharing plan as one where there is “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... .”

This interpretation is incorrect and contrary to plain language of the Affordable Care Act.

---

<sup>1</sup>We note, however, that there are cost-sharing protections for non-Indians who have incomes below 400 percent FPL. As a result, AI/ANs in the limited cost-sharing variation whose incomes are above 300 percent FPL, and below 400 percent FPL who receive services outside the IHS/tribal system not through CHS, would qualify for cost-sharing protections to the same extent as any non-Indian.

<sup>2</sup> To further complicate this matter, some CHS referrals for AI/ANs who are not enrolled in QHPs will require the provider to use Medicare-like rates for billing, while those AI/ANs who are enrolled in QHPs for whom CHS does not bear any financial responsibility for payment would be subject to the QHPs payment rates for off-plan providers.

There is nothing in the Affordable Care Act that limits Section 1402(d)'s AI/AN cost-exemption rules to only the minimum essential health benefit. Rather, the plain language of Section 1402(d) clearly applies the cost-exemption rules for AI/ANs to all “plans.” Section 1402(d)(1) provides that “the issuer of the plan shall eliminate any cost-sharing under the plan.” Section 1402(d)(2) provides that “no cost-sharing under the plan shall be imposed under the plan for such item or service....” Accordingly, all cost-sharing under a QHP (regardless of whether the benefit at issue goes beyond the EHB) is eliminated for AI/ANs who meet the criteria under Section 1402(d)(1) and 1402(d)(2).

On the All Tribe's Call held by CMS on December 14, 2012, a CMS representative justified limiting the AI/AN cost-sharing reductions to the essential health benefit by stating that doing so is mandated by the definition of cost-sharing in Section 1302(c) of the Affordable Care Act. Such an interpretation is contrary to the plain language of the statute, and if implemented would be contrary to law. Section 1302(c) of the Affordable Care Act, 42 U.S.C. § 18071, defines “cost-sharing” for the purpose of the Affordable Care Act as follows:

**(3) Cost-sharing.** In this title—

**(A) In general.** The term “cost-sharing” includes—

(i) deductibles, coinsurance, copayments, or similar charges; and

(ii) any other expenditure required of an insured individual which is a qualified medical expense (within the meaning of section 223(d)(2) of title 26) with respect to essential health benefits covered under the plan.

**(B) Exceptions.** Such term does not include premiums, balance billing amounts for non-network providers, or spending for non-covered services.

The limiting language in subparagraph (ii) above, “with respect to essential health benefits covered under the plan,” applies *only* to the category of cost-sharing listed in that same subparagraph (“any other expenditures of an insured individual which is a qualified medical expense ...”). It does not, by any means of statutory construction, apply to modify the categories of cost-sharing listed in subparagraph (i) (“deductibles, coinsurance, copayments, or similar charges”).

Under common and traditional rules of statutory construction, “[r]eferential and qualifying words and phrases, where no contrary intention appears, refer solely to the last antecedent.” Singer & Singer, *Statutes & Statutory Construction* § 47.33 (7th ed. 2007). As the Supreme Court has made clear, “a limiting clause or phrase ... should ordinarily be read as modifying only the noun or phrase that it immediately follows.” *Jama v. Immigration & Customs Enforcement*, 543 U.S. 335, 343 (2005). In section 1302(c)(3), the phrase “any other expenditure required of an insured individual ...” is the last antecedent to the limiting language “with respect

to essential health benefits covered under the plan.” As there is no evidence of Congressional intent to the contrary (for example, a comma setting limiting language apart from subparagraph (ii)), the limiting language only reaches to such “other expenditure[s]” and does not reach back to subparagraph (i), “deductibles, coinsurance, copayments, or similar charges[.]” The last antecedent rule is strongest when, as here, the limiting phrase appears in “a structurally discrete statutory provision” rather than a “single, integrated list.”*Id.* at 344 n.4 (also noting that, in such cases, “the structure refutes the premise of fellowship”). Here, the limiting language is entirely contained within subparagraph (ii) and no punctuation sets it apart from the rest of that subparagraph.

Accordingly, there is nothing in Section 1302 alone that mandates that cost-sharing be limited to EHB. The general rules on cost-sharing exemptions for non-Indians do impose such a limitation, however. Section 1402(c)(4) of the Act provides that for non-Indians, “[i]f a qualified health plan ... offers benefits in addition to the essential health benefits required to be provided by the plan, or a State requires a qualified health plan ... to cover benefits in addition to the essential health benefits required to be provided by the plan, the reductions in cost-sharing under this section shall not apply to such additional benefits.” The definition of “cost-sharing” already promulgated by CMS at 45 C.F.R. § 155.20 is consistent with these two provisions, read together, only as they apply to non-Indian cost-sharing in the Act. It is not consistent with, nor should it be applied to, the specific cost-sharing protections afforded to AI/AN under the Act.

The cost-sharing exemptions in Section 1402(d) were enacted as distinct, special provisions for AI/ANs, and are not subject to the general rules on cost-sharing exemptions that apply to the general population in Section 1402(c). Section 1402(d) broadly requires that the plan issuer “eliminate any cost-sharing under the plan” for an Indian whose household income is not more than 300 percent of the poverty line, and states that “no cost sharing under the plan shall be imposed under the plan” for items or services furnished through Indian health providers.

To the extent that there is any potential conflict between these two sections, it is a well settled rule of statutory construction that the more specific provision trumps the more general provision. *See, e.g., Bloate v. United States*, 130 S. Ct. 1345, 1354 (2010) (“general language of a statutory provision, although broad enough to include it, will not be held to apply to a matter specifically dealt with in another part of the same enactment”). As the Joint Committee on Taxation noted in its report on these provisions, Section 1402(d) was enacted to impose special rules for Indians that do not apply to the general population. *Technical Explanation of the Revenue Provisions of the “Reconciliation Act of 2010,” As Amended, In Combination With The “Patient Protection and Affordable Care Act”* (“[t]he [cost-sharing subsidy] provision implements special rules for Indians[.]”) JCX-18-10 at 22 (Mar. 21, 2010).

Imposing cost-sharing on QHP benefits that are in addition to the EHB would be contrary to the intent of Congress that AI/AN be protected from cost-sharing under Section 1402(d) with regard to any “plan.”<sup>3</sup> Such a result is clearly at odds with Congress' intent that, consistent with

---

<sup>3</sup> We recognize that AI/ANs whose incomes are above 300 percent FPL and who do not receive care through the IHS, a Tribe or Tribal organization, an Urban Indian Organization, or through contract health services, would nonetheless be eligible for the cost-sharing reductions available to the general population under Section 1402(c) of

its trust responsibility, that AI/ANs be able to access the significant federal benefits provided only through the Exchanges without being assessed a cost to do so.

**c. Family Rule and Premiums**

Under the Proposed Rule, all the members of a family that includes Indian and non-Indian members could not enroll in the same QHP if the AI/AN member(s) of the family wish to receive the Indian-specific cost-sharing protections.<sup>4</sup>The Proposed Rule identifies this proposed requirement – that *members of a family must enroll in separate plans if one or more of the family members are AI/AN and the AI/AN family member(s) wish to receive the Indian-specific cost-sharing protections* – but seems to dismiss concerns that this approach may result in higher aggregated premiums being paid. The Proposed Rule states, “*in many instances, a family made up of Indians and non-Indians would lose no premium savings from enrolling in different policies to obtain the maximum cost-sharing reductions for which each family member is eligible.*”<sup>5</sup> (Emphasis added.) However, clearly, in some instances a family made up of Indians and non-Indians would incur higher total premium costs if the members of the family are required to enroll in different policies in order to obtain the maximum cost-sharing reductions for which each AI/AN family member is eligible.

The Proposed Rule and the Proposed Market Reform Rules propose including a family cap which counts the premiums of only the oldest three individuals under the age of 21.<sup>6</sup> As a result, a family plan with four or more covered individuals under 21 would have the same premium as a family plan with three covered individuals under 21. As such, for a family with four or more individuals under the age of 21 in which at least one but not all of the individuals under 21 are AI/AN, an additional premium amount would be charged to this family *if the AI/AN individuals are to receive the protections under section 1402(d)(1) or (2) of the Affordable Care Act*. The additional premium amount would result from the additional person or persons under the age of 21 who would be included in the aggregate premium calculation under separate insurance plans as compared to the aggregate premium calculation under a single (family) plan. For each individual under age 21, the additional premium amount is likely to be in excess of \$2,300.<sup>7</sup> And the additional premium costs could be multiples of \$2,300 to the extent the family contains more than four children.<sup>8</sup> For a family with six persons under 21, the additional premium amount could be as much \$6,900.

---

the Act if their incomes were below 400 percent of the FPL. Because such cost-sharing reductions would be governed by the general rules for cost-sharing, they would only apply to the EHB.

<sup>4</sup> See § 156.410. Cost-sharing reductions for enrollees.

<sup>5</sup> See 77 FR 73179.

<sup>6</sup>This Proposed Rule, as well as the pending proposed market rules, described the proposed build-up of family premiums, and indicating that there will be no difference in premiums under a family plan versus a combination of individual and/or family plans. See 77 FR 73143 as well as CMS-9972, published November 26, 2012 (77 FR 70591). (“Proposed Market Reform Rules”)

<sup>7</sup> According to the Kaiser Family Foundation, in 2009, the average Medicaid payments per covered child nationally were \$2,305. <http://www.statehealthfacts.org/comparemaptable.jsp?ind=183&cat=4>

<sup>8</sup>It is recognized that Federal premium assistance will limit how much of the additional premium amounts the family would be required to pay, but these additional premium costs – incurred solely to gain access to the Indian-specific benefits authorized in federal law – could be substantial.

If a family with AI/AN family members is not able to purchase a single family policy (as this would block the AI/AN family members from accessing the Indian-specific cost-sharing exemptions), and as a result is required to purchase separate health insurance coverage, the additional premium costs could greatly reduce the effective value of the section 1402(d) cost-sharing protections for AI/ANs.

For example, for a middle income family at 250% of FPL, the *maximum* out-of-pocket costs under the standard ACA cost-sharing protections are \$5,200 for an individual and \$10,400 for a family.<sup>9</sup> An AI/AN-only family at the 250% of FPL income level would be protected from this full liability, with the *average* cost-sharing savings to the AI/AN family being a portion of the maximum liability, while mixed families would not. If a mixed family had to pay one or more extra child premiums (at \$2,300 each) because one or more of the family members are non-AI/AN, the added premium costs from enrolling in multiple plans could substantially reduce – and possibly negate – the average benefit of the “zero cost-sharing plan variation”. For higher income AI/AN families, one extra child premium of \$2,300 could easily exceed the savings under the “limited cost-sharing plan variation.”

Requiring AI/ANs to pay additional health insurance premiums in order to access the Congressionally-established Indian-specific cost-sharing protections available through an Exchange is not a reasonable approach to structuring this program. We request that CMS adjust the Proposed Rule to protect AI/ANs from being required to pay additional premiums in order for AI/AN family members to access the ACA section 1402(d) cost-sharing protections. In Section I.e. of this Comment, we offer one potential approach to remedy this problem. We believe this approach would remedy a significant downside to the premium and cost-sharing structure proposed by CMS, and do so in a way that does not disrupt the overall program structure being proposed by CMS.

**d. Family Rule and Cost-Sharing**

As detailed above, the Proposed Rule and the Proposed Market Reform Rules would require families with AI/AN and non-AI/AN members to enroll in different plans if the AI/AN family members are to access the section 1402(d)(1) and (2) cost-sharing protections. For some AI/AN families, this will result in increased aggregate premium payments.

There is a parallel concern that the effective cost-sharing protections for AI/ANs also may not be fully realized by families with AI/AN and non-AI/AN family members under the approach proposed by CMS.

For example, a family with income at 250% of the FPL enrolled in a single family policy would have a maximum out-of-pocket liability for the family of \$10,400. If the family were comprised of six individuals, this would equate to an average liability of \$1,733 per person.<sup>10</sup> In contrast, if a family with the same income level and the same family size were comprised of

---

<sup>9</sup> See Table 15, 77 FR 73173 for the CMS proposed maximum annual limitations on cost-sharing for 2014. The statutory maximum out-of-pocket amounts were adjusted upward by CMS to accommodate the actuarial value limitations for this income level.

<sup>10</sup> Calculated by dividing the maximum out-of-pocket costs of \$10,400 by the six family members enrolled in the family plan.

three family members who are AI/ANs and three family members who are not AI/ANs, they would be required to enroll in two family policies in order for the AI/AN family members to secure the Indian-specific cost-sharing protections. (See, discussion above for impact on aggregate premiums paid by the family.) *Under the proposed CMS policy, the combined maximum out-of-pocket liability for the family, after accounting for the comprehensive cost-sharing protections for the AI/AN family members, would not be reduced and would remain \$10,400.* This is because the family would be subject to two out-of-pocket maximums of \$10,400, with only one of these eliminated by the AI/AN-specific cost-sharing protections.

*In addition, under the proposed CMS policy, the average per person liability for the non-AI/AN family members would actually increase, from \$1,733 to \$3,467.<sup>11</sup>*

The point is made in the Proposed Rule that Federal cost-sharing reductions cannot be provided to individuals who are not eligible for these benefits.<sup>12</sup> However, people who are eligible for AI/AN benefits should not have the cost savings negated by shifting the liability to other family members. Under the Proposed Rule, the effective cost of the health insurance premiums for a family that has both AI/AN and non-AI/AN would actually increase when the section 1402(d)(1) and (2) provisions are operationalized. We request that CMS amend the Proposed Rule to ensure that AI/ANs receive the intended benefit of the Indian-specific cost-sharing protections under ACA section 1402(d) and that any liability relieved from AI/ANs is not shifted to non-AI/AN family members.

As noted above, in the next section of our Comment, we offer a recommended approach to address the shortcomings in the Proposed Rule. We believe this approach would remedy a significant downside to the premium and cost-sharing structure proposed by CMS, and do so in a way that does not disrupt the overall program structure being proposed by CMS.

e. **Recommended Approach to Remedy Family Rule for Families with AI/AN and Non-AI/AN Members**

To address the potential increase in aggregate premiums to be paid by families with AI/AN and non-AI/AN members and to ensure AI/ANs receive the full benefit of the cost-sharing protections afforded them in the Affordable Care Act without shifting cost-sharing liabilities to non-AI/AN family members, we recommend CMS adjust the Proposed Rule by adopting the three discrete policies (or some version of these policies.)

For families applying for family coverage wherein one or more of the family members are AI/ANs and one or more of the family members are not AI/ANs:

- 1. Calculate the aggregate family premium by calculating the premium for each family member as if they were all enrolled in a single family policy at the silver metal level.**
- 2. Enroll the family members in two separate plans that may be different in only the family type (family or individual, as appropriate), cost-sharing variation**

---

<sup>11</sup>Calculated by dividing the maximum out-of-pocket costs of \$10,400 by the three family members enrolled in the second family plan.

<sup>12</sup> See 77 FR 73165.

**(silver level plan, zero cost-sharing plan variation of the silver level plan, or limited cost-sharing plan variation of the silver level plan, as appropriate), and metal level (bronze or silver, as appropriate) with no increase in the aggregate premium paid.<sup>13</sup>**

**3. Establish the maximum out-of-pocket liability for the “non-AI/AN plan” as a proportion of the maximum liability of a single family plan.**

The adoption of these policies would facilitate the efficient and accurate administration of the AI/AN-specific cost-sharing policies and benefits in the Affordable Care Act, and they would do so without extending the cost-sharing protections to persons not eligible for these benefits. More specifically, we are recommending:

- 1. Premium for single family plan is aggregate premium for family:** Pricing the aggregate premium from multiple plans at no more than the premium of a single family plan (if all members of the family were able to be enrolled in a single family plan) would ensure that the aggregate premium is no more expensive than the baseline premium prior to consideration of the AI/AN-specific cost-sharing provisions.<sup>14</sup>
- 2. Enroll family members in appropriate and allowable separate policies:** If a family with AI/AN and non-AI/AN family members indicates it intends to enroll in a single family plan, the family would be notified of the relevant policies and enrolled in two versions of the selected plan, one with AI/AN-only members and one with non-AI/AN members. Because the general cost-sharing protections under § 1402(b) of the Affordable Care Act are available only to persons enrolled in a silver level of coverage in the individual market offered through an Exchange, the non-AI/AN family members would enroll at the silver metal level plan variation in order for the non-AI/AN family members to access the § 1402(b) protections, and the AI/AN family members would likely enroll at the bronze level.
- 3. Establish proportional maximum out-of-pocket liability:** To remedy the unintended cost-shift to non-AI/AN family members under the Proposed Rule (as discussed in I.d. above), we recommend applying a version of the principle CMS applied under the “Fair Health Insurance Premiums” section of the Proposed Market Reform Rules.<sup>15</sup> In the Proposed Market Reform Rules, the policy was applied with respect to determining the premium for family coverage in which one or more

---

<sup>13</sup> Alternatively, and possibly more simply, a cap on the *number* of premiums calculated for the family as a whole could be capped at the number of premiums counted under the single family plan.

<sup>14</sup> In the Proposed Market Reform Rules, CMS described the policy as follows: “The rule proposes that issuers add up the rate of each family member to arrive at a family premium. However, we propose that the rates of no more than the three oldest family members who are under age 21 would be taken into account in computing the family premium. This policy is intended to mitigate the premium disruption for larger families accustomed to family tier structures, which typically cap the number of children taken into consideration in setting premiums. We propose a cut-off age of 21 for this cap so that it is consistent with the cut-off age used in the proposed rule on age rating, as well as the requirement that child-only policies be available to those under age 21. (77 FR 70591; CMS-9972-P)

<sup>15</sup> CMS-9972, published November 26, 2012 (77 FR 70591).

members of the family use tobacco. In the application of that principle here, to the extent practicable, the adjustment made to the cost-sharing liability of one individual in the family would not impact the cost-sharing liability for other individuals in the family.

In the Proposed Market Reform Rules, CMS notes that “PHS Act section 2701(a)(4) provides that, with respect to family coverage, the rating variation permitted for age and tobacco use must be applied **based on the portion of the premium attributable to each family member covered under a plan.**”<sup>16</sup> (Emphasis added.) In applying this principle to the effective aggregate out-of-pocket cap of a family plan, the result would be to lower the out-of-pocket cap in proportion to the percentage of family members subject to the cost-sharing protections under section 1402(d)(1).<sup>17</sup>

As an example, for a family of six with three AI/AN family members subject to the section 1402(d)(1) protections, the aggregate out-of-pocket cap would be reduced by one half. The remaining proportion of the aggregate out-of-pocket cap would be then applied to the QHP enrolling the non-AI/AN family members. For the family of six at 250% of the FPL, the out-of-pocket liability for the QHP enrolling the non-AI/AN family members would be capped at 50 percent of \$10,400, or \$5,200.

In the example above, the out-of-pocket cap for the plan enrolling the AI/AN family members would be zero as these individuals are subject to the full section 1402(d)(1) cost-sharing exemptions (“zero cost-sharing plan variation”). If the three AI/AN family members are eligible only for the section 1402(d)(2) cost-sharing protections (“limited cost-sharing plan variation”), the aggregate out-of-pocket cap would not be reduced by half (or any other amount), but the out-of-pocket cap applicable in the single family plan (\$10,400) would be divided between the two silver-level family plans the AI/AN and non-AI/AN family members would be enrolled (with the AI/AN family members enrolled in a limited cost-sharing plan variation of the silver level family plan.)<sup>18</sup>

In proposing the Family Rule, CMS identified a number of constraints or goals that led to the proposed program structure. For example, CMS made the following observation in the Proposed Rule in relation to the application of the Family Rule policy to the general cost-sharing protections –

HHS recognizes that this policy may limit the cost-sharing reductions that members of a family could receive if the family chooses to enroll in a family policy; however, section 1402 of the Affordable Care Act does not permit an individual to receive benefits under the Federal cost-sharing reductions program for which the individual is ineligible.

---

<sup>16</sup> See 45 CFR § 147.102 in the proposed rule published on November 26, 2012 (77 FR 70591).

<sup>17</sup> Persons eligible for the cost-sharing protections under § 1402(d)(1) have no cost-sharing liabilities and, as such, have a maximum out-of-pocket liability of zero.

<sup>18</sup> It is recognized that, to maintain an equivalent aggregate actuarial value when the family is grouped into two (family) plans, but before consideration of the § 1402(d) protections, the aggregate out-of-pocket cap may need to be adjusted.

In addition, because deductibles and out-of-pocket limits are calculated at the policy level, as opposed to the individual level, it would be operationally difficult to establish separate cost-sharing requirements for different enrollees within the same policy. We discuss this policy further with regard to Indians in section III.E.4.i. of this proposed rule. We welcome comments on this proposal and its effect on families.<sup>19</sup>

We believe each of the concerns and goals identified above would be addressed in the adjustments to the proposed policy that we are recommending.<sup>20</sup> First, in the remedy offered here, persons not eligible for benefits under the Federal cost-sharing reductions would not receive these additional benefits. Conversely, AI/AN persons who are eligible would be able to receive these benefits without a requirement for the family to pay additional premiums, and non-AI/AN family members would not experience an effective increase in their potential out-of-pocket liability. Second, to accommodate the position of CMS that “it would be operationally difficult to establish separate cost-sharing requirements for different enrollees within the same policy,” this proposed approach would allow for individuals with the same cost-sharing protections to continue to be grouped in the same QHP(s). While the determination of the aggregate premium costs and the applicable cost-sharing caps would be made on a combined family basis, the individuals would be enrolled in plans that are differentiated by cost-sharing requirements (i.e., AI/AN individuals would be in zero or limited cost-sharing variations, as appropriate, and non-AI/AN family members would be in standard policies with adjusted out-of-pocket caps.)

Further, at 77 FR 73179, CMS states “we believe that the use of plan variations will permit issuers to efficiently and effectively provide to all enrollees eligible for cost-sharing reductions, especially Indians, their appropriate level of cost-sharing reductions.” We do not challenge the position of CMS to want to provide an approach that allows issuers to efficiently administer the cost-sharing exemptions for AI/ANs, but we do not believe it is acceptable to institute an approach that effectively shifts liability for health care costs to non-AI/AN family members. Again, we believe our suggested approach would enable the efficiency and effectiveness sought by CMS for issuers while still addressing the concerns of AI/ANs. For example, the approach recommended here would not “lead many issuers to implement cost-sharing waivers manually, which could lead to fewer cost-sharing reductions being available to Indians.”<sup>21</sup> Determined by an Exchange at the time of enrollment through an Exchange, the applicable out-of-pocket cap would be clearly indicated for each plan and done so electronically.

Finally, we reject the suggestion implicit in the statement in the Proposed Rule that “we seek comment on which approach HHS should adopt beginning January 1, 2016” that we need to wait until 2016 to adjust the proposed Family Rule policy as it applies to AI/AN

---

<sup>19</sup>77 FR 73165.

<sup>20</sup> We also believe that CMS may be able to propose other approaches that would address the shortcomings in the Proposed Rule we have identified on this issue and do so in a way that also addresses the concerns and goals articulated by CMS.

<sup>21</sup>77 FR 73179.

provisions.<sup>22</sup> Numerous instances are contained in this and other proposed rules in which adjustments in policies are being made, if determined to be warranted, effective October 1, 2013. This issue should be no different.

## II. Uniform Operational Guidance for Identification of Indians

In the presentation above on application of the Family Rule, the added complexity of administering the Indian-specific cost-sharing protections in families comprised of AI/ANs and non-AI/ANs was discussed. This issue is further complicated by the existence of multiple statutory references to the definition of Indian in federal law referenced in the Affordable Care Act and other health programs. In short, the concern we have expressed previously and do so again here is we believe a substantial number of American Indians and Alaska Natives will not be identified as AI/AN for ACA-related purposes because of confusion regarding implementation of the definition of Indian. The result of which “could lead to fewer cost-sharing reductions being available to [eligible] Indians.”<sup>23</sup>

We believe that uniform operational guidance is needed to ensure those eligible for the Indian-specific benefits and protections under the Affordable Care Act, as well as under the Medicaid program and through the Indian Health Service, actually receive these benefits. For purposes of administering the Affordable Care Act’s Indian-specific provisions, we request CMS issue uniform operational guidance for use by Exchanges and by the Internal Revenue Service that is consistent with the existing CMS regulations under 42 CFR 447.50.<sup>24</sup> The 42 CFR 447.50 regulations provide clear operational guidance in determining eligibility for Indian-specific benefits and protections under Medicaid.

CMS has opined in previous regulations that the eligibility standard for the Indian-specific provisions under the ACA are “slightly different” from the AI/AN eligibility standards for IHS services and Indian-specific benefits under Medicaid.<sup>25</sup> However, if the Indian-specific benefits under these various health programs are implemented in a way that attempts to capture the “slight differences” in eligibility, the overall accuracy in determining eligibility for the Indian-specific benefits and protections will be *lower* than if uniform operational guidance were followed.

Failure to issue uniform operational guidance will impede Exchange, Medicaid and IRS staff in efficiently making accurate and consistent determinations of eligibility as well as delay or completely deny access for some AI/ANs to the Indian-specific benefits and protections established under the Affordable Care Act. Four such examples of this potential result are:

- Delayed eligibility for some AI/AN children: An AI/AN child who is not allowed to enroll as a tribal member until her 18<sup>th</sup> birthday may not be considered eligible for

---

<sup>22</sup>77 FR 73179.

<sup>23</sup> This language was drawn from the preamble to the Proposed Rule (page 73179) and described a core rationale of CMS for not implementing alternative approaches to the proposed family rule.

<sup>24</sup> If necessary, the uniform operational guidance could be issued on a temporary basis to provide sufficient time to secure legislative changes that would make the definitional references in federal law fully consistent across the health care programs.

<sup>25</sup>Exchange Establishment Final Rule, 77 Fed. Reg. 18383.

Exchange-related Indian-specific cost-sharing and enrollment protections, despite being considered an AI/AN for purposes of IHS, Medicaid and CHIP coverage.

- Members of Alaska Native regional and village corporations: An Alaska Native individual whose parent or grandparent may have been enrolled in an Alaska Native regional or village corporation in the 1970s may not be determined to be an Alaska Native for the purposes of the Exchanges simply because the individual's parents or grandparents are still living and there (blessedly) has been no opportunity to inherit stock, despite the fact that as soon as the individual does inherit the stock his or her status as an Alaska Native under the Exchange plans would be clear.
- Unwarranted application of tax penalties: If an AI/AN who is eligible and, in fact, is accessing IHS services decides not to secure health insurance coverage, but is not (ultimately) determined to be eligible as an "Indian" for the exemption from the requirement to secure minimum essential coverage, this individual could be subject to significant tax penalties imposed under the ACA by the Internal Revenue Service.
- Reduced involvement of AI/AN in insurance options: Even if the instances of an individual being determined to be "Indian" for one Indian-specific provision and not for another represent a relatively small percentage of the total population (which we anticipate), this outcome would likely cast a shadow over AI/ANs involvement with ACA implementation more generally. AI/ANs are likely to be reluctant to supplement their IHS funded health access if there is a risk of ending-up subject to significant cost-sharing requirements under a different, potentially unknown application of a definition of Indian.

As established under the ACA-related regulation at 45 CFR § 155.315(h) *Flexibility in information collection and verification*, the Secretary of HHS has discretionary authority to approve modifications to the methods used for the collection and verification of information related to eligibility for enrollment through an Exchange and for eligibility for Exchange insurance affordability programs. This authority may be exercised by the Secretary "provided that HHS finds that such modification would reduce the administrative costs and burdens on individuals while maintaining accuracy and minimizing delay, [and] that it would not undermine coordination with Medicaid and CHIP..." Each of these criteria – which require increased accuracy and efficiency and reduced burden on enrollees in order for an alternative eligibility verification process to be implemented– would be met through the issuance and reliance on uniform operational guidance, as we are recommending.

### **III. Comments on Definition of "Commercial Book of Business"**

Section 1341(b)(3)(B)(i) sets contribution amounts for the reinsurance program. In the Proposed Rule, CMS states that contribution amounts must reflect, in part, "an issuer's fully insured commercial book of business for all major medical products." CMS proposes to interpret this requirement by excluding all coverage that is (1) not major medical coverage, (2) not part of a "commercial book of business," and (3) not regulated by a state department of insurance and written on a form filed with the State (although self-insurance plans would not be exempt by virtue of this exclusion even though they are not regulated by the states). 77 Fed. Reg. 73152.

CMS proposes to exclude plans or coverage offered by Indian Tribes to their members and their spouses and descendants, and other persons of Indian descent closely affiliated with the Tribe because such plans are not part of a “commercial book of business.” The TTAG strongly supports this interpretation, as plans offered by Tribes for their members and their spouses and descendants and other Indians are inherently governmental in nature, and are not any part of a “commercial book of business.”

#### **IV. Comments and Recommendations on Other Provisions**

##### **a. Ensuring Full Payment to I/T/U and Other Providers of Care to AI/ANs**

Regulatory language is needed to assure there is no reduction in payments to Indian health care programs and other providers due to reduced cost-sharing from patients.

Section 1402(d)(2)(B) imposes an important restriction on the Qualified Health Plans. It provides that the QHPs cannot reduce reimbursements otherwise due by the amount of cost-sharing they could otherwise impose but for the Indian cost-sharing exclusion. The proposed regulations are silent on this issue. In the preamble to the Proposed Rule, CMS states that it believes this provision is clear and self-implementing, and as a result does not propose to spell out this requirement in the actual rule.<sup>26</sup> In other NPRMs issued to implement the Affordable Care Act, HHS restates the law in regulation, so we are mystified by the explanation here that there is no need to restate the law in regulation because it is “self-enforcing.” To the contrary, we believe that there will be many instances where providers will look only to the final codified version of the regulations and not the Statute. If the regulations do not spell out this requirement, providers may well be unaware of it and attempt to charge AI/AN for cost sharing at the time of service. Moreover, QHPs are likely to use regulations, rather than the underlying law, as the basis for developing their own internal policies and procedures. A clear statement in the regulations would be helpful to all participants.

In addition, in the December 14, 2012 All Tribes Call a CMS representative indicated that CMS will require health plans to compensate providers for the value of cost-sharing waived for a patient under the limited cost-sharing plan variation (section 1402(d)(2)) as well as the zero cost-sharing plan variation (section 1402(d)(1)), and the representative indicated this requirement is stated and will be enforced through § 156.430. In contrast, § 156.430 does not explicitly address this point, and given that the requirement under section 1402(d)(2) is explicitly stated in the Affordable Care Act and the requirement under section 1402(d)(1), as well as under section 1402(a) generally, is implicitly stated, it seems to be unwarranted to state, as is done on page 73179 in the preamble to the Proposed Rule, that these requirements are “clear and self-enforcing”. Again, we request CMS to insert regulatory language on this matter in § 156.430.

We also note that there is a statement in Section 156.410 (a) that: “[t]he cost-sharing reduction for which an individual is eligible must be applied when the cost sharing is collected.” This statement may be confusing for those in a zero or limited cost sharing variation plan because in most cases there will be no cost-sharing collected from the individual at all. As a result, it could be assumed that the reduction will only be applied when the provider collects the portion of the cost sharing that is reimbursed by the QHP, either before or after the QHP collects

---

<sup>26</sup> See 77 FR 73179.

the reimbursement from HHS. We propose the following language be substituted:

A provider must apply the cost-sharing reduction for which an individual is eligible prior to collecting cost-sharing, if any, from the individual.

In addition, we are concerned that this general requirement does not provide adequate protection to the provider in the billing process. Therefore, we recommend inserting the following language into the regulation at the end of Section 156.410(a):

The QHPs cannot reduce or delay reimbursements to providers, regardless of whether the providers are in-network or out-of-network, by the amount of cost-sharing it could otherwise impose but for the Indian cost-sharing exclusion.

The intent of this language is to prohibit the QHP from waiting until it collects reimbursement from HHS for the cost sharing reductions to reimburse providers, and to prohibit providers from charging individuals for cost sharing and then refunding the charges after it receives reimbursement from QHPs for the amount of cost sharing that has been waived for the individual.

**b. The Proposed Rule Should Include a Definition of Contract Health Services**

One key aspects of the cost-sharing reductions for AI/AN under Section 1402(d)(2) is that AI/AN are exempt from any cost sharing when they receive care at any provider through “contract health services.” We are concerned that QHPs may not be familiar with contract health services, and how that term is used or defined. Although the preamble to the Proposed Rule notes that the term “contract health services” is already defined at 25 U.S.C. § 1603, there is no corresponding definition for contract health services in the actual regulation. We propose adding a definition to Section 156.400 which would define the term “contract health services” by reference to the statutory definition at 25 U.S.C. § 1603.

**c. Clarification of Formula for Actuarial Value Calculation for Impact of Induced Demand from Section 1402(d)**

As noted in the preamble to the Proposed Rule, the proposed risk adjustment methodology compensates issuers for a number of factors (including health status, diagnosis and other demographic characteristics of enrollees) to protect plans against adverse selection and to reduce incentives for health plans to avoid higher-risk enrollees. Included in the risk adjustment methodology is a factor for induced demand that may result from the general cost-sharing protections provided under section 1402(b) to individuals and families with income under 250% of the FPL. Under the proposed risk adjustment methodology, health issuers are compensated for the additional services that may be received by some plan enrollees as a consequence of these plan enrollees paying lower cost-sharing amounts due to the Federal cost-sharing assistance for low-to-moderate income enrollees. It appears that a similar factor for induced demand from the ACA section 1402(d)(1) and (2) provisions is not included in the risk adjustment methodology. Rather, compensation for induced demand resulting from application of section 1402(d)(1) and (2) is to be provided directly to issuers through the payments to plans for cost-sharing reductions.

Proposed Section 156.430 details the mechanism and methodology for making such payments, but it is unclear how the “induced utilization factor for advance payments for cost-sharing reductions for Indians” identified in Table 1 of the Proposed Rule (77 FR 73180) applies to the final reconciliation of related costs to issuers and ultimately to determining the net payments to issuers to compensate for the impact of the cost-sharing reductions.

Providing full compensation to issuers, and subsequently from plans to providers, for the value of the lost cost-sharing revenues from patients is an important component to reducing the likelihood that providers and health plans may discriminate against serving AI/ANs. For this reason, we encourage CMS to ensure that providers and issuers are “made whole” under the Indian-specific cost-sharing protections, as is required under section 1402(d)(3). Please clarify how issuers are compensated for the anticipated induced demand for services resulting from section 1402(d)(1) and (2) beyond the compensation provided to issuers for the reduced cost-sharing payments themselves.

**d. Inclusion of Payments to Issuers for Cost-Sharing Reductions Made pursuant to Section 1402(d) in Minimum Loss Ratio Calculations**

Under § 158.221, *Formula for calculating an issuer’s medical loss ratio*, revenues to issuers that are to be included in the medical loss ratio calculation are identified. In § 158.221, reference is made to § 158.130(b)(5) which incorporates net payments or receipts related to risk adjustment, risk corridors, and reinsurance programs under sections 1341, 1342, and 1343 of the Affordable Care Act.

The minimum medical loss ratio provisions are designed to create incentives for plans to provide needed services to plan enrollees or to reduce plan premiums, either upfront when setting plan premium rates or through a subsequent rebate. We recommend that payments to issuers to compensate for Federal cost-sharing reductions made pursuant to ACA section 1402(d)(3) be included in the total amount of plan premium revenue, along with the payments provided pursuant to the general risk adjustment mechanisms established under ACA section 1343. This will help ensure that the payments for cost-sharing reductions made to issuers are in fact used to subsequently compensate providers for the loss of cost-sharing payments. Please confirm that these payments are included in the medical loss ratio calculation or adjust the medical loss ratio formula to do so.

Again, we appreciate the opportunity to provide comments on the Proposed Rule, and we look forward to your consideration of these comments and adoption of the recommendations.

Sincerely Yours,



Valerie Davidson  
Chair, CMS Tribal Technical Advisory Group