



# Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

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Submitted via: <http://www.regulations.gov>

March 7, 2017

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

**RE: Patient Protection and Affordable Care Act; Market Stabilization Proposed Rule (CMS-9929-P) Comment**

Dear Acting Administrator Conway:

On behalf of the Centers for Medicare and Medicaid Services (CMS) Tribal Technical Advisory Group (TTAG), I write to submit comments on the proposed rule with comment period, published in the Federal Register on February 17, 2017, titled “Patient Protection and Affordable Care Act; Market Stabilization,” (CMS-9929-P) (hereinafter Proposed Rule).<sup>1</sup>

The TTAG advises CMS on Indian health policy issues involving Medicare, Medicaid, the Children’s Health Insurance Program, and any other health care programs funded (in whole or part) by CMS. In particular, TTAG focuses on providing policy advice to CMS regarding improving the availability of health care services to 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 (IHS), Tribes, Tribal organizations, and Urban Indian organizations (I/T/Us or Indian health care providers).

We appreciate the opportunity to submit these comments, however Tribal consultation did not take place prior to the release of the Proposed Rule. Executive Order 13175 requires agencies to engage in widespread Tribal consultation through timely written notice before moving forward with new policies that have Tribal implications, “policies that have [T]ribal implications” refers to regulations, legislative comments or proposed legislation, and other policy statements or actions that have substantial direct effects on one or more Indian [T]ribes, on the relationship between the Federal Government and Indian [T]ribes, or on the distribution of power and responsibilities between the Federal Government and Indian [T]ribes.<sup>2</sup> Tribes and Tribal organizations are not merely stakeholders who may participate in the public comment processes. Tribes must be consulted prior to the rulemaking process to uphold the Nation-to-Nation political relationship

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<sup>1</sup> Patient Protection and Affordable Care Act; Market Stabilization, 82 Fed.Reg.10980.

<sup>2</sup> Executive Order 13175, Sec.2, 65 Fed.Reg. 67249 (November 9, 2000).

between Tribes and the United States that is enshrined in the U.S. Constitution. In addition, TTAG is significantly disappointed in the Administration's 18 day comment period. The 18 day comment period is not enough ample time to provide thoughtful consideration to all the potential impacts that this Proposed Rule might have on the Indian Health Care delivery system. TTAG is hopeful that not only will CMS provide early notice to Tribes on changes in policy and regulation, but that there will be ample time to provide meaningful and thorough input.

## **I. Special Enrollment Periods (§155.420)**

Section 1311(c)(6) of the Affordable Care Act (ACA) establishes enrollment periods, including special enrollment periods (SEP) for qualified individuals, for enrollment in the Qualified Health Plans (QHPs) through an Exchange. Special enrollment periods exist to ensure that individuals who lose health coverage during the year or who experience other qualifying life events such marriage or the birth or adoption of a child) can enroll in a QHP outside of the open enrollment period for 60 days (30 days for employment-based health plans). Special enrollment periods are an important consumer protection to ensure access to health insurance.

Under the ACA, AI/ANs (as defined in section 4 of the Indian Health Care Improvement Act (IHCIA)), are able to enroll in health coverage through the Marketplace any time of the year. AI/ANs qualify for monthly special enrollment periods (M-SEPs), therefore AI/ANs are able to enroll in health coverage through the Marketplace as often as once per month.<sup>3</sup> At the request of Tribes and Tribal organizations, the Centers for Medicare and Medicaid Services (CMS) extended the monthly special enrollment periods (M-SEP) to the family members of AI/ANs who meet the definition of Indian under the ACA, if the family members enroll in the Marketplace coverage along with the AI/AN individual.<sup>4</sup>

In the Proposed Rule, CMS highlights concerns about some individuals using the special enrollment periods (SEPs) to change plan metal levels based on ongoing health needs during the coverage year, which could cause a negative impact on the risk pool. CMS proposes to establish restrictions in § 155.420 on the ability of existing Marketplace enrollees to change plan metal levels during the coverage year. However, the Proposed Rule would exclude Marketplace enrollees who qualify for an SEP, such as AI/ANs and their dependents. **TTAG supports the exclusion of Marketplace enrollees who qualify for and SEP, including AI/ANs and their dependents from the proposed restrictions.**

## **II. Continuous Coverage**

CMS highlights the need to adopt policies that promote continuous enrollment in health insurance and discourage individuals from waiting to enroll in health coverage when an illness occurs. The ACA and the implementing regulations within § 155.420(d)(8) explicitly provide that an individual who gains or maintains status as an Indian or dependent of an Indian under section 4 of the Indian Health Care Improvement Act (IHCIA) can enroll in a qualified health plan (QHP) or change from one QHP to another once per month. This provision was provided to assist AI/ANs

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<sup>3</sup> See § 155.420(d)(8).

<sup>4</sup> See § 155.420(d)(8)(ii).

who relocate from an area with IHS and Tribal health programs to one in which the Indian health system is unavailable, creating a greater need for these individuals to secure health insurance coverage. In addition, the provision facilitates the transition of a Tribe to use comprehensive health insurance coverage as a vehicle for ensuring the available funding to support access to the full range of medically necessary health care services. The proposal to impose this requirement for (prior) continuous coverage would run counter to the purpose of the M-SEPs. Imposing waiting periods before effectuating enrollment, preexisting condition exclusions, and penalties for people who experience a gap in insurance coverage will harm enrollees, particularly those in Indian Country who may be living with chronic illnesses and disabilities needing consistent access to care to manage their conditions. AI/ANs who need care but are denied coverage due to such restrictions are likely to forgo early treatment and risk needing more expensive uncompensated care later on. **TTAG recommends that if CMS moves forward with the proposal to promote continuous coverage, American Indians and Alaska Natives (AI/ANs) should be exempt and CMS should not impose a new requirement that would disrupt the purpose and function of the monthly special enrollment periods (SEPs)**

### **III. Levels of Coverage (Actuarial Value) (§ 156.140)**

Section 1302(d)(1) of the ACA requires the level of coverage for bronze, standard silver, gold, and platinum plans to have actuarial values (AVs) to be 60percent, 70percent, 80percent, and 90percent, respectively. In addition, section 1302(d)(3) states that the Department of Health and Human Services (HHS) Secretary must develop guidelines to provide for a *de minimis* variation in the AV used in determining the level of coverage of a plan to account for differences in actuarial estimates. Currently, § 156.140(c) allows a *de minimis* variation of +/-2 percentage points for most plans, with the exception of certain bronze plans. In the HHS Notice of Benefit and Payment Parameters for 2018 (2018 Notice), CMS finalized a proposal to permit bronze plans that cover and pay for at least one major service before the deductible, other than preventive services, to have an allowable variance in AV of -2 percentage points and +5 percentage points.

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

#### **TTAG opposes the significant proposed expansion of the *de minimis* AV variations.**

Congress established firm actuarial valuations for each plan metal level and only permitted *de minimis* variation “to account for differences in actuarial estimates” in the ACA.<sup>5</sup> The proposal could reduce the value of health care for middle-income and low-income consumers. For example, if a bronze plan with an AV of 60percent has an annual premium of \$5,000, raising the AV to 65percent would increase the premium to \$5,416. In addition, the significant negative impact that the proposal would have on AI/ANs who do not pay any cost-sharing for

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<sup>5</sup> See 42 U.S.C. § 18022(d)(3)

Marketplace plans.<sup>6</sup> When enrolled in a bronze plan, premium payments made by AI/ANs are responsible for covering 60percent of the cost of coverage under the plan, and the federal cost-sharing protections cover the remaining 40percent of the cost. TTAG shares concerns that the 2018 revised policy would result in higher premiums, shifting as much as 5percent of the cost of health insurance coverage under a bronze plan from the federal government’s cost-sharing protections to the AI/AN enrollees.

The Proposed Rule would impose detrimental effects on AI/AN enrollees if the allowable *de minimis* variation for Marketplace plans is further expanded. The AV for the “reference plan” (second-lowest-cost silver plan) could fall by as much as 4 percentage points from the 70percent standard under the ACA, while the AV for the lowest-cost bronze plan could increase by as much as 5 percentage points from the 60percent standard. This would result in a 9 percentage point net increase in the effective cost of bronze-level coverage for an AI/AN enrollee, amounting to a 15percent increase in net costs to a bronze plan enrollee. In fact, depending on the household income of the AI/AN enrollee and the resulting net premium costs after consideration of the value of the available premium tax credits, the increase in the net premium costs to the AI/AN enrollee could be substantially greater than 15percent when purchasing a bronze plan. For example, if premium tax credits reduced the net premium for an AI/AN Marketplace enrollee by half, the Proposed Rule would have the effect of increasing health insurance coverage costs for the enrollee by 30percent. A scenario is illustrated below:

- The Marketplace reference plan has a \$5,000 annual premium at 70% AV, decreasing to 4,713 [ $(\$7,142 * .66 = \$4,713)$ ] at 66% AV, a \$287 reduction (resulting in a \$287 decrease in the potential value of any available premium tax credit).
- The lowest-cost bronze plan has an annual premium of \$4,285 [ $(\$5,000 / .70 = \$7,142) * .60 = \$4,285$ ] at 60% AV, rising to \$4,642 [ $(\$7,142 * .65 = \$4,642)$ ] at 65% AV, a \$357 increase.
- The overall impact is a potential increase in net premium costs of \$644 ( $-\$287$  in the value of the premium tax credit and  $+\$357$  in the bronze plan premium).
- The \$644 increase in the net premium costs is at least a 15% increase in the net premium costs for the lowest-cost bronze plan [ $\$644 / \$4,285 = .15$ ].
- Using the above scenario, if an AI/AN bronze plan enrollee had a household income of about \$32,500, making the enrollee eligible for a premium tax credit that reduced net premium costs by half (to \$2,143) under current regulations, the net impact to the enrollee under the proposed change would be an increase of 30% [ $\$644 / \$2,143 = .30$ ].

A change in the net premium costs for an AI/AN enrollee of 15percent or 30percent or a greater amount would not be categorized as *de minimus*. **TTAG recommends that CMS (a) retain its current policy of restricting silver level Marketplace plans to an allowable variance in**

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<sup>6</sup>Under sections 1402(d)(1) and (2) of the ACA, AI/ANs can enroll in either a zero or limited cost-sharing plan, depending on their income level; Indians with household income between 100percent and 300percent of the federal poverty level (FPL) qualify for zero cost-sharing plans, and all other Indians qualify for limited cost-sharing plans. Under both of these plan variations, enrollees pay no deductibles, co-insurance, or copayments when receiving essential health benefits (EHBs).

**actuarial value (AV) of -2 percentage points and +2 percentage points; (b) impose a similar requirement on all bronze level plans, if the agency intends to move forward with the proposed changes; and (c) ensure that for the purposes of calculating premium tax credits, the reference plan premium is adjusted to reflect no less than a 70percent actuarial value (AV).**

#### **IV. Network Adequacy (§ 156.230)**

CMS at § 156.230 established the minimum criteria for network adequacy that issuers must meet to have plans certified as qualified health plans (QHPs), including the requirement that all issuers maintain a network sufficient in number and types of providers to ensure enrollees have access to all services without unreasonable delay. In the Proposed Rule, CMS proposes to rely on state network adequacy reviews in all states—including states with a Federally-facilitated Marketplace (FFM)—provided that the state has a sufficient network adequacy review process, rather than have federal regulators perform a time and distance evaluation.<sup>7</sup> CMS currently conducts network adequacy reviews using the time and distance evaluation for QHPs in states that have an FFM, regardless of whether the agency or the state performs plan management functions.

Under the Proposed Rule, CMS will defer to state network adequacy reviews in all states “with the authority at least equal to the ‘reasonable access standard’ defined in § 156.230 and means to assess issuer network adequacy,” regardless whether the state has an FFM or State-Based Marketplace (SBM).<sup>8</sup> In states that lack the authority and means to conduct sufficient reviews, CMS would rely on issuer accreditation (commercial or Medicaid) from an accrediting entity recognized by HHS for ensuring network adequacy, rather than having federal officials perform a time and distance evaluation. For potential enrollees, including many AI/ANs this change would exacerbate existing concerns over whether the plans offered through the Marketplace include an adequate number and range of providers in their networks. **TTAG opposes any proposal that would jeopardize access to providers with the appropriate experience and expertise to treat individuals living with chronic illnesses and disabilities in Indian Country. TTAG recommends that CMS retain its current policy of conducting reviews using the time and distance evaluation to determine the network adequacy of qualified health plans (QHPs) offered through Federally-facilitated Marketplaces (FFMs); alternatively, if the agency intends to move forward with the proposal to rely on state reviews and issuer accreditation, at minimum steps must be taken toward ensuring that states (and accrediting entities) use the time and distance evaluation in their reviews.**

#### **V. Essential Community Providers (§ 156.235)**

Section 156.235(2)(i) of the ACA established the inclusion of 30percent of essential community providers (ECPs) in qualified health plan (QHP) provider networks. CMS used a general

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<sup>7</sup> Under the time and distance evaluation, CMS reviews data submitted by issuers to ensure that plans provide access to at least one provider in each of 10 provider types for at least 90% of enrollees. *See* CCIIO, Addendum to 2018 Letter to Issuers in the Federally-Facilitated Marketplaces, February 17, 2017, 24-5.

<sup>8</sup> *See* 82 Fed. Reg. 10990.

enforcement standard under which it considers issuers to have met federal regulations if they demonstrate satisfaction in the following criteria: (1) contract with at least 30percent of available ECPs in the service area of each of their plans to participate in the provider network; (2) offer contracts in good faith<sup>9</sup> to all available Indian Health Care Providers (IHCPs) in the plan service area, applying the special terms and conditions necessitated by federal law and regulations as referenced in the recommended model QHP Addendum; and (3) offer contracts in good faith to at least one ECP in each ECP category that is available and provides medical or dental services covered by the issuer plan type. If issuers do not satisfy the general enforcement standard, they must submit a satisfactory narrative justification as to how they provide an adequate level of service for low-income and medically underserved individuals as part of the QHP application. “Issuers that qualify for the alternate ECP standard articulated at 45 CFR 156.235(a)(2) and (b) are not reviewed for compliance with the additional general ECP standard requirement of offering contracts in good faith to all available Indian health care providers.<sup>10</sup> **TTAG recommends that issuers of medical QHPs and SADPs are held to a uniform ECP requirement to offer contracts in good faith to all available Indian health care providers.** This uniform medical and dental ECP enforcement standard would ensure that medically underserved AI/AN consumers experience equal access to covered benefits, regardless of whether they are enrolled in plans offered by issuers that qualify for the general or the alternate ECP standard.

In the Proposed Rule, CMS proposes to allow issuers to contract with only 20percent, rather than 30 percent, of available ECPs in the services area of each of their plans to meet the general enforcement standard. The current standard of 30percent falls short of requiring issuers to contract with all ECPs in the service area of their plans, and eroding this standard will lead to limiting access to care for Marketplace enrollees, including AI/ANs living in medically underserved areas. For example, in a plan service area with five ECPs, an issuer currently must contract with at least two of these providers; under the relaxed standard, the issuer could contract with only a single ECP. **TTAG strongly opposes the CMS indication that the relaxed standard would preserve adequate access to care because issuers will not be obliged to continue to offer contracts in the service areas of their plans, therefore impacting critical health care services.** The relaxed enforcement standard requirement for ECPs from 30percent to 20percent will decrease the availability of health care providers in crucial underserved areas, such as Indian Country. AI/ANs are designated as an underserved population exposed to an ongoing health professional shortage issue within rural and low-income communities. **TTAG recommends that CMS not diminish the current ECP standard requiring issuers to contract with 30percent of available ECPs in the service area of each of their plans.**

Under the current CMS guidance, beginning in 2018, issuers can identify as essential community providers (ECPs) in their plan networks, so long as only providers appear on the ECP list maintained by the Department of Health and Human Services (HHS). In the Proposed Rule, CMS states that not all qualified ECPs have submitted a petition for inclusion of the HHS ECP list. The Proposed Rule would allow issuers to continue to use the write-in process to identify ECPs in 2018, provided that issuers arrange for these provider to submit an ECP petition by no later than

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<sup>9</sup> Issuers must “offer contract terms comparable to terms that it offers to a similarly-situated non-ECP provider.” See CCIIO, Addendum to 2018 Letter to Issuers in the Federally-Facilitated Marketplaces, February 17, 2017, 31.

<sup>10</sup> CCIIO 2018 Letter to Issuers in the Federally-facilitated Marketplaces, 34.

the deadline for issuer submission of changes to the qualified health plan application. This provision would benefit the Indian Health Care Providers (IHCPs) that currently do not appear on the HHS ECP list for 2018, as well as the AI/AN patients that utilize these health care providers. **TTAG recommends that CMS retain the proposal to allow insurers to continue to use the “write-in” process to identify ECPs in 2018.**

## **VI. Conclusion**

TTAG hopes that CMS, in the spirit of its partnership and shared interest in improving AI/AN access to health care resources and services, will work with the Indian Health Service, Tribes, and Urban Indian health care providers to prevent harm to the Indian health care delivery system. We request that CMS consult with IHS, Tribes, and urban Indian health care programs during the regulatory process. We thank you for this opportunity to provide our comments and recommendations and look forward to further engagement with CMS. Please contact Devin Delrow at [ddelrow@nihb.org](mailto:ddelrow@nihb.org) or at (202) 507-4072 if there are any additional questions or comments on the issues addressed in these comments.

Sincerely,

A handwritten signature in black ink that reads "W. Ron Allen". The signature is written in a cursive style and is contained within a thin black rectangular border.

W. Ron Allen  
Chairman, Tribal Technical Advisory Group

Cc: Kitty Marx, Director, CMS Division of Tribal Affairs