

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 email to OIRA_submission@omb.eop.gov

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CMS Desk Officer

Fax Number (202) 395-5806

OIRA_submission@omb.eop.gov

RE: Comments on CMS-10320 (OCN: 0938-1086)

I write on behalf of the Tribal Technical Advisory Group (TTAG) of the Centers for Medicare & Medicaid Services (CMS) to comment on the Information Collection Request for CMS-10320, "Health Care Reform Insurance Portal Requirements." Through this opportunity for comment, we wish to request that the information requested of issuers through the Web portal include information on cost sharing exemptions and the Indian-specific zero and limited cost-sharing variations of qualified health plans (QHPs). American Indians and Alaska Natives (AI/ANs), with the assistance of Tribes and Tribal health organizations, have been working to enroll in QHPs offered through Marketplaces.

A significant impediment to achieving greater enrollment levels has been the limited and sometimes erroneous information made available through the Marketplace and/or from issuers on the QHP offerings available to AI/ANs. Requiring the issuers to provide information on the QHP offerings available to AI/ANs through the Marketplace Web portal, with both the Marketplaces and QHP issuers then required to post or link to this information on their respective Web sites, would go a long way to addressing a significant barrier to AI/AN enrollment in the QHPs. We also recommend that CMS provide a template for use by QHP issuers in providing the information in order to minimize the burden on QHP issuers as well as to increase the accuracy of the information provided.

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 in part) by CMS. In particular, the TTAG focuses on providing policy advice to CMS regarding the improvement 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 (referred to as Indian Health Care Providers or I/T/Us).

AI/ANs who meet the definition of Indian under the Patient Protection and Affordable Care Act (Affordable Care Act, or ACA), are eligible for either a “zero cost-sharing plan variation” or a “limited cost-sharing plan variation,” depending on their household income level.¹

Information on Indian-specific cost-sharing protections that is provided by QHP issuers to consumers, if any, is often confusing if not outright incorrect. AI/ANs looking to enroll in health insurance coverage through a Federally-facilitated Marketplace (FFM), as well as through State-based Marketplaces, have found it difficult to gain a clear understanding of the cost-sharing protections for AI/ANs under the various Qualified Health Plans (QHPs) offered. As a result, many AI/ANs have failed to complete the enrollment process due to their uncertainty as to whether they will be charged cost-sharing liability (and if so, how much).

The lack of information provided to AI/ANs by issuers on the Indian-specific cost-sharing plan variations is proving to be a significant barrier to AI/AN enrollment in the Exchanges. We propose the following recommendations to reduce these barriers by improving the information issuers must provide with regard to their plans on the Exchange and through the Web portal.

Background

QHPs offered on a Marketplace must have at least two Indian-specific plan variations: a zero cost-sharing plan variation and a limited cost-sharing plan variation.

- The zero cost-sharing variation is available to an Indian with income that does not exceed 300% of the federal poverty level (FPL). The limited cost-sharing variation is available to an Indian who does not seek a determination of eligibility based on income or who is not eligible for the zero cost-sharing variation.
- The zero cost-sharing plan variation requires no cost-sharing for essential health benefits (EHBs), whether provided by an in-network provider or not. The limited cost-sharing variation requires no cost-sharing for EHBs provided by an Indian Health Care Provider (IHCP) or through referral from contract health services to a non-IHCP.

The CMS regulations require the QHPs to submit zero and limited cost-sharing plan variations to the Exchanges:

¹ In this letter, the term “American Indians and Alaska Natives” is used to describe all persons eligible for services from an Indian Health Care Provider. The term “Indian” is used to describe individuals who meet the definition of Indian as found in the Affordable Care Act.

(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.

45 C.F.R. § 156.420(b). The same benefits and providers must be covered in each variation.

(d) *Benefit and network equivalence in zero and limited cost sharing plan variations.* A QHP and each zero cost sharing plan variation or limited cost sharing plan variation thereof must cover the same benefits and providers....

45 C.F.R. § 156.420(d).

These AI/AN cost sharing plan variations are critical to inducing AI/ANs to enroll in the QHPs. Because AI/ANs have a federal right to health care at no cost to the individual through the Indian health system, they will be reluctant to enroll in a QHP that does require them to pay cost-sharing amounts. The U.S. Congress recognized this in establishing these Indian-specific cost-sharing protections.

Lack of Information Hinders Enrollment

The CCIIO 2015 Issuer Letter (issued in final form on March 14, 2014) states that issuers are not required to prepare a Summary of Benefits and Coverage (SBC) for each health plan variation. The 2015 Issuer Letter states: “*While QHP issuers are not required to create separate SBCs to reflect different levels of cost-sharing reductions for each plan variation, QHP issuers should create an SBC that represents the base plan, consistent with the requirements set forth in §147.200.*”² QHPs may not combine information about multiple plan variations in one SBC. However, *QHP issuers are permitted, and encouraged, to create separate SBCs for each plan variation.*”³ (Emphasis added). As a result, unless an issuer goes

² 45 C.F.R. §147.200.

³ CCIIO Final 2015 Issuer Letter, page 45.

beyond the minimum requirements and provides SBCs for plan variations (and not just the base plan, as currently required), a QHP enrollee will not be able to determine from the SBC the actual cost-sharing protections and requirements under the particular QHP plan variation in which the individual is eligible to enroll.

But it does not appear that issuers are taking this extra, and crucial, step towards ensuring adequate dissemination of information. For example, QHPs listed on the FFM and/or on the issuer Web pages do not include a general description of the cost-sharing variations that apply to Indians. Nor do the QHPs shown for potential enrollment by an Indian contain a link to an SBC that describes the scope of the Indian-specific cost-sharing protections in greater detail. In addition, when searching for a QHP on a Marketplace, the information presented typically does not indicate: a) that the two Indian-specific cost-sharing variations apply to each QHP, b) which QHPs, if any, are considered part of a “set” and therefore the applicable premium for the lowest cost QHP in the set is not known, or c) which QHP plan variations apply to a particular applicant.

Without this information, potential AI/AN enrollees have been left with the impression that the plans available on a Marketplace require substantial cost-sharing, even though the applicant may be eligible for a zero or limited cost-sharing variation. Despite a Marketplace determination letter indicating that an applicant “can choose a health plan with lower copayment, coinsurance, and deductibles,” the SBCs on the QHPs offered on the Marketplace and/or on the issuer’s Web site do not present this information. Many potential AI/AN QHP applicants have therefore simply exited the QHP application process when the plan information presented on the Marketplace or on an issuer’s Web site identified substantial cost-sharing requirements.

Recommendations:

The TTAG recommends that in setting the parameters for the information issuers must submit to the Web portal, and the subsequent dissemination of this information, CCIO should consider requiring the following:

1. Require issuers to submit an explanation to the Marketplaces that AI/ANs are eligible to enroll in all QHPs offered, that each QHP is offered with a zero cost-sharing plan variation and a limited cost-sharing plan variation specifically for AI/ANs, and the distinctions between each.
2. Require Marketplaces to create a template SBC for the zero cost-sharing plan variation and the limited cost-sharing plan variation indicating what the cost-sharing protections are and how they generally apply to covered services.

3. Require issuers to populate the CMS-issued template with information on each QHP zero and limited cost-sharing variation and to provide access to the SBC to potential QHP enrollees by making the cost-sharing variation-specific SBC accessible on the issuer's Web site that displays the QHP options without requiring the use of passwords or other barriers. Marketplaces should also be required to similarly list this information on the Marketplace Web sites.
4. Require issuers to proactively provide the cost-sharing-specific SBC to enrollees within seven days of receiving an application from a potential enrollee.

We appreciate the opportunity to offer comments on this topic.

Sincerely,

A handwritten signature in black ink, appearing to read "Valerie Davidson", with a long, sweeping flourish extending to the right.

Valerie Davidson
Chair, TTAG

Cc: Kitty Marx, Director, CMS Division of Tribal Affairs
Dr. Yvette Roubideaux, Director, IHS
Lisa Wilson, CCIIO
Nancy Goetschius, CCIIO
Stacy Bohlen, Executive Director, NIHB