DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DEC - 5 2012

Dear Tribal Leader:

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the release of three proposed rules under provisions of the Affordable Care Act. Because these rules may have tribal implications, we are seeking your advice and input through an opportunity to provide formal, written comments, and through a series of All Tribes Calls, pursuant to CMS's Tribal Consultation policy.

On November 26, 2012, we published two proposed rules with comments due December 26, 2012:

Essential Health Benefits (EHB), Actuarial Value, and Accreditation (77 FR 70644) (www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28362.pdf); and

Health Insurance Market Rules and Rate Review (77 FR 70584) (www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28428.pdf).

To facilitate consultation, CMS will be hosting an All Tribes Call on Tuesday, December 11, 2012, from 1:00pm to 3:00pm Eastern Standard Time. The purpose of this call will be to provide an overview of the proposed rules and to solicit advice and input regarding those provisions that have tribal implications. The All Tribes Call will provide further details about special provisions of the rules that have tribal implications.

The following is a brief summary of these two proposed rules:

The EHB, Actuarial Value, and Accreditation proposed rule outlines Exchange and issuer standards related to coverage of EHB, actuarial value, and accreditation. Consistent with prior information released about these topics, this rule proposes that EHB be defined by a state-specific benchmark plan. Also, the rule clarifies benefit substitution, state-required benefits, accreditation timelines for issuers in Federally-facilitated Exchanges (including State Partner Exchanges), and requirements for coverage of habilitative services. The rule also proposes an opportunity for accrediting entities that have not already been recognized to apply to be recognized to provide accreditation as part of qualified health plan certification.

The Health Insurance Market Rules and Rate Review proposed rule would bar insurers from denying coverage or charging higher premiums based on a number of factors, including health status, and gender. This rule implements the law's provisions regarding fair health insurance premiums, guaranteed availability, guaranteed renewability, statewide risk pools, and catastrophic plans. This proposed rule would also amend the requirements for health insurance

issuers and states regarding reporting, utilization, and collection of data under the current rate review rule.

On November 30, 2012, we published a proposed rule entitled, "HHS Notice of Benefit and Payment Parameters for 2014," (www.ofr.gov/OFRUpload/OFRData/2012-29184_PI.pdf) and comments are due December 31, 2012.

To facilitate consultation, CMS will be hosting an All Tribes Call on Friday, December 14, 2012, from 1:00pm to 3:00pm Eastern Standard Time. The purpose of this call will be to provide an overview of the proposed rule and to solicit advice and input regarding those provisions having tribal implications. The All Tribes' Call will provide further details about special provisions of the proposed rule that have tribal implications, such as:

- Cost-Sharing Reductions for Indians: Eliminating or reducing cost sharing for enrolled Indians through plan variations. These plan variations are not separate plans, but reflect the cost-sharing reductions provided under the Affordable Care for Indians who are enrolled in qualified health plans through the Exchange.
- Special Rules for Family Policies: Amending the currently titled "Special Rule for Multiple Tax Households" to address households where Indians and non-Indians enroll in a family policy.
- Risk adjustment and reinsurance: Indian cost-sharing reduction adjustments for risk adjustment calculations and exemptions for tribal plans from reinsurance contributions.

Additional details on these provisions are included in the enclosed appendix.

All Tribes Call on Notice of Proposed Rules (with comments due December 26, 2012):

Essential Health Benefits (EHB), Actuarial Value, and Accreditation (77 FR 70644) (www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28362.pdf); and

Health Insurance Market Rules and Rate Review (77 FR 70584) (www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28428.pdf).

DATE: Tuesday, December 11, 2012
TIME: 12:30pm-3:00pm Eastern Standard Time
CALL-IN NUMBER: 800-289-0436 and PASSCODE: 204535
Webinar Access: kauffmaninc.adobeconnect.com/r167xbc0h2r/

All Tribes Call on the Notice of Benefit and Payment Parameters for 2014 (with comments due December 31, 2012):

HHS Notice of Benefit and Payment Parameters for 2014 (www.ofr.gov/OFRUpload/OFRData/2012-29184_PI.pdf)

DATE: Friday, December 14, 2012
TIME: 1:00pm-3:00pm Eastern Standard Time
CALL-IN NUMBER: 888-778-9063 and PASSCODE: 315914
Webinar Access: kauffmaninc.adobeconnect.com/r410lh6lqs7/

Presentation slides will only be available during the call. To access the slides, please login to the website as a Guest.

Your input on the proposed rules is extremely valuable and we encourage you to provide comments and ask questions during the All Tribes Calls. We strongly encourage you to submit written comments during the 30-day comment period as outlined in the Federal Register notice. Written comments that are submitted during the comment period will be part of the official rulemaking record.

Please contact Kitty Marx, Director of CMS Tribal Affairs Group, with any questions or concerns regarding consultation of these proposed rules. She can be reached on 410-786-8619 or via email at kitty.marx@cms.hhs.gov.

We look forward to obtaining your advice and input on the proposed rules.

Sincerely,

Marilyn Tavenner

Marilyn Tavenner
Acting Administrator

Enclosure

Appendix

The proposed Department of Health and Human Services (HHS) Notice of Benefit, and Payment Parameters for 2014 would provide states and issuers with further details and parameters related to: the risk adjustment, reinsurance, and risk corridors programs (sections 1341-1343 of the Affordable Care Act), advance payments of the premium tax credit (sections 1401, 1411, and 1412 of the Affordable Care Act), cost-sharing reductions (sections 1402 and 1412 of the Affordable Care Act), user fees for the Federally-facilitated Exchange (section 1311 of the Affordable Care Act), the Small Business Health Option Program (section 1311 of the Affordable Care Act), and the medical loss ratio program (section 2718 of the Public Health Service Act).

Within this proposed rule, there are several provisions that have tribal implications or would apply specifically to American Indians and Alaska Natives (AI/ANs):

- Cost-Sharing Reductions: The Affordable Care Act requires health insurance issuers to eliminate cost sharing for Indians (as defined in 45 CFR155.300(a)) enrolled in a qualified health plan (QHP) in the individual market through an Exchange, with a household income at or below 300 percent of the Federal Poverty Level. The law also prohibits issuers from charging cost sharing when an Indian enrolled in a QHP in the individual market through an Exchange receives a service from an urban Indian organization (I/T/U) or through referral under contract health services.

    - We propose to implement these provisions by requiring issuers to develop variations of their QHPs with the appropriate cost-sharing structures. This approach mirrors the policy for non-Indians, and ensures that enrollees receive the appropriate cost-sharing reduction at the point of care. However, under this approach, Indians could not receive the cost-sharing reduction available to eligible Indians while enrolled in a family policy with a non-Indian.

    - We also considered an alternative approach to the provision of cost-sharing reductions for Indians. Rather than requiring QHP issuers to assign Indians to zero and limited cost sharing plan variations, QHP issuers would simply assign Indians to the standard plan, and would waive the cost-sharing requirements, as appropriate. This approach would permit an Indian and non-Indian to enroll in the same plan, and for each to receive the cost-sharing reductions to which they would be individually entitled. We are proposing the approach described above in part because 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. Because of technical constraints, we understand that complying with the alternative approach would be nearly impossible for many issuers for the 2014 benefit year. Due to these considerations, adopting the alternative approach could lead many issuers to implement cost-sharing waivers manually, which could lead to fewer cost-sharing reductions being available to Indians. In addition, we note that under the proposed Market Reform Rule at §147.102(c)(1), the total premium

for family coverage in a State that has not adopted community rating principles is to be determined by summing the premiums for each individual family member (but that premiums for no more than the three oldest family members who are under age 21 must be taken into account). Thus, 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. However, we seek comment on which approach HHS should adopt beginning January 1, 2016. We propose the approach first described above pending the adoption of any change in approach. We also seek comment on the burdens that may be imposed on individuals, providers and insurers under the proposed and alternative approaches.

- Reinsurance Program: Pursuant to section 1341(b)(3)(B)(i) of the Affordable Care Act, contribution amounts for reinsurance are to reflect an issuer's "fully insured commercial book of business for all major medical products." In the proposed HHS Notice of Benefit, and Payment Parameters for 2014, we propose to amend the Premium Stabilization Rule by adding § 153.400, clarifying that a contributing entity must make reinsurance contributions for its self-insured group health plans, and health insurance coverage except to the extent such plan, or coverage is not major medical coverage, or considered to be part of a commercial book of business, or in the case of health insurance coverage, is not issued and approved by a State department of insurance.

  Specifically, in § 153.400 (a)(2)(xi), we propose to exclude from the reinsurance contributions requirement, those plans or coverage (whether fully insured or self-insured) offered by an Indian tribe to tribal members and their spouses and dependents (and other persons of Indian descent closely affiliated with the tribe), in the tribal members' capacity as tribal members (and not in their capacity as current or former employees of the tribe or their dependents) because they would not be part of a commercial book of business. However, plans or coverage offered by a tribe to employees (or retirees or dependents) on account of a current or former employment relationship would not be excluded. Health care services operated by the Indian Health Service (IHS), a tribe or a tribal organization, or an urban Indian organization (I/T/U), as defined in Section 4 of the Indian Health Care Improvement Act, are similarly excluded from reinsurance contributions under proposed § 153.400 (a)(2)(xii).

- Risk Adjustment Program: The proposed rule also sets forth the risk adjustment methodology that HHS proposes to use when it operates risk adjustment on behalf of a state. That methodology includes a set of adjustments to account for individuals eligible for cost-sharing reductions, including AI/ANs so eligible.

- Medical Loss Ratio Program: Section 2718 of the Public Health Service Act requires issuers to rebate to enrollees, including AI/ANs, any excess premiums if issuers spend less than 80 percent (85 percent in the large group market) of premiums on medical care, and efforts to improve the quality of care. We propose to amend this medical loss ratio rule to include payments related to reinsurance, risk adjustment, and risk corridors beginning 2014, as required by statute. We also propose to change the way the rule treats

community benefit expenditures, which may include programs that benefit AI/ANs. This change would level the playing field between tax-exempt, not-for-profit, and for-profit issuers that invest in community benefit programs.