NPAIHB POLICY BRIEF

Summary of Proposed Rule: Establishment of Insurance Exchanges and Qualified Health Plans

PREPARED BY: NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

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Summary of Notice of Proposed Rule
Patient Protection and Affordable Care Act;
Establishment of Exchanges and Qualified Health Plans

On July 11, 2011, the U.S. Department of Health and Human Services (HHS) released proposed rules which provide the **framework for States to use in developing insurance Exchanges under the Affordable Care Act. The proposed rules** establish minimum standards for Exchanges, give states a lot of flexibility to design Exchanges to fit the unique requirements of their insurance markets. For example, each State can structure its Exchange in its own way: as a non-profit entity established by the State, as an independent public agency, or as part of an existing State agency. In addition, a State can choose to operate its Exchange in partnership with other States through a regional Exchange or it can operate subsidiary Exchanges that cover areas within the State. Any combination of these options can be approved.

HHS is accepting public comment on the proposed rules over the next 75 days to learn from States, consumers, and other stakeholders how the rules can be improved. To facilitate that public comment process, HHS will convene a series of regional listening sessions and meetings. The details of these sessions are not available yet. The deadline for comments is September 26, 2011. You may submit comments electronically, by regular mail, express mail, or by hand/courier.

Summary and Tribal Implication

This notice of proposed rule (NPR) will implement the Affordable Insurance Exchanges, consistent with Title I of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), more commonly referred to collectively as the Affordable Care Act. The insurance exchanges will provide marketplaces for individuals and small employers to compare available private health insurance options on the basis of price, quality, and other factors. The Exchanges become operational by January 1, 2014.

Generally, the NPR includes a number of requirements that Tribes and NPAIHB recommended be adopted in order to make insurance exchanges work for the Indian health system. Highlights from the NPR are as follows:

- The NPR explains special benefits and protections for Indians including limits on cost sharing and payer of last resort requirements and that these requirements are covered through-out the NPR;
- The NPR clarifies that cost sharing exemptions for Indians do not apply to insurance premiums;
- There are requirements for Tribal consultation to develop exchanges;
- Indian tribes, tribal organizations, and urban Indian organizations are eligible to serve as Navigators in the exchange;
- The NPR permits exchanges to allow tribes, tribal organizations, and urban Indian organizations premiums on behalf of qualified individuals, subject to the terms and conditions set by an Exchange;

- A special monthly special enrollment period for Indians will allow for an Indian to join or change plans one time per month;
- There are at least three different Indian definition requirements explained in the NPR that could pose challenges for Indians, and
- The NPR explains that IHS programs have the right to recover from insurance companies reasonable charges for providing health services or a higher amount an insurer would pay others and that exchange requirements shall not hinder or prohibit this requirement.

While the rule clarifies key Indian aspects in developing insurance exchanges it also requests comment on several important items that will impact Tribal participation in insurance exchanges. A short summary of some of these important items include:

- How to distinguish between individuals eligible for assistance under the Affordable Care Act and those who are not in light of the different definitions of "Indian" that apply for other Exchange provisions;
- Potential implications on the process for verifying Indian status for the purpose of special monthly enrollment periods;
- Recommendations to establish requirements regarding reimbursement of Indian health providers as qualified health plans and on contracting issues with Tribes.

A detailed Preliminary Regulatory Impact Analysis associated with this proposed rule is available at http://cciio.cms.gov under "Regulations and Guidance." The following is a cut/paste summary of the key Indian provisions that are included in the NPR and is not intended to be a detailed analysis:

Special benefits & protections for AI/ANs

The NPR explains the special benefits and protections to Indians including limits on cost sharing and payer of last resort requirements for health programs operated by the Indian Health Service (IHS), Indian tribes, tribal organizations, and urban Indian organizations. CCIIO explains that issue is covered in other parts of the NPR and that they expect to address this in future rulemaking.

Consultation with Key Stakeholders include Federally-recognized Tribes

According to section 1311(d)(6) of the Affordable Care Act, Exchanges are required to consult with certain groups of stakeholders as they establish their programs and throughout ongoing operations. CCIIO proposes that the Exchange consult on an ongoing basis with key stakeholders that include Federally-recognized tribe(s) as defined in the Federally Recognized Indian Tribe List Act of 1994, 25 U.S.C. §479a, located within the Exchange's geographic area.

The NPR further clarifies that each Exchange that has one or more Federally-recognized tribes, as defined in the Federally Recognized Indian Tribe List Act of 1994, 25 U.S.C. §479a, located within the Exchange's geographic area must engage in regular and meaningful consultation and collaboration with such tribes and their tribal officials on all Exchange policies that have tribal implications. Exchanges are encouraged to also seek input from all tribal organizations and urban Indian organizations. While the Exchanges will be charged with the consultation, tribal consultation is a government-to-government process, and therefore the State should have a role in the process. CMS encourages States to develop a tribal consultation policy that is approved by the State, the Exchange, and tribe(s). CMS also anticipates providing additional guidance to both the tribes and States on how the governments may collaborate and build a strong working relationship.

Tribes are eligible to serve as Navigators

The Affordable Care Act (Section 1311(i)(2)(B)) identifies entities which may be eligible to serve as Navigators, including "other entities" pursuant to section 1311(i)(2)(B) insofar as they meet the requirements of section 1311(i)(4).

In paragraph (b)(2), CMS proposes that the Exchange include at least two of the types of entities listed in Section 1311(i)(2)(B) as Navigators. CMS seeks comment as to whether it should require that at least one of the two types of entities serving as Navigators include a community and consumer-focused non-profit organization, or whether we should require that Navigator grantees reflect a cross section of stakeholders. CMS notes that Indian tribes, tribal organizations, and urban Indian organizations may be eligible, along with State or local human service agencies.

Payment of Premiums

The NPR discusses the payment of insurance premiums through Exchanges with three possible options as follows: (1) take no part in payment of premiums, which means that enrollees must pay premiums directly to a Qualified Health Plans (QHPs); (2) facilitate the payment of premiums by enrollees by creating an electronic "pass-through" of premiums without directly retaining any of the payments; or (3) establish a payment option where the Exchange collects premiums from enrollees and pays an aggregated sum to the QHP issuers.

CMS proposes that an Exchange may permit Indian tribes, tribal organizations and urban Indian organizations to pay the QHP premiums on behalf of qualified individuals, subject to the terms and conditions determined by the Exchange. CMS describes that consultation has indicated premiums may present an obstacle for Indians and Tribes have suggested that CMS consider implementation of a process for a tribe to pay premiums on behalf of its members since "premiums cannot be waived for Indians."

This last statement is very important because it is the first time that CMS/CCIIO has indicated that the cost sharing exemptions do not apply to insurance premiums. This policy implication is that the cost sharing exemptions for AI/ANs will apply only to point of purchase services.

Group Pay Arrangements

The NPR makes clear that an Exchange may consider setting-up an upfront group payment mechanism similar to the mechanism currently used by some tribes to enroll members in the Medicare Prescription Drug Program. Under that program, tribes offer a selection of plans from which their members may choose, thus limiting the members' options. CMS requests comments on whether this approach would work in an Exchange and how such an approach might be tailored to fit the Exchange.

CMS notes that section 402 of the Indian Health Care Improvement Act (IHCIA) permits Indian tribes, tribal organizations, and urban Indian organizations to purchase health benefits coverage for HIS beneficiaries. As a result, the payment of premiums proposed under this section is more inclusive than other Exchange provisions (special enrollment periods and cost-sharing rules) that pertain to Indians.

CMS invites comment on how to distinguish between individuals eligible for assistance under the Affordable Care Act and those who are not in light of the different definitions of "Indian" that apply for other Exchange provisions.

Special Enrollment Periods

In accordance with section 1311(c)(6)(C), the Secretary must establish special enrollment periods. CMS proposes to codify the statutory special enrollment period that Indians receive a monthly special enrollment period as specified in section 1311(c)(6)(D). CMS has interpreted the monthly special enrollment period to allow for an Indian to join or change plans one time per month. For purposes of this special enrollment period, section 1311(c)(6)(D) defines an Indian as specified in section 4 of the Indian Health Care Improvement Act (IHCIA). Section 4 of the IHCIA defines "Indian" as a member of a Federally-recognized tribe. CMS seeks comment on the potential implications on the process for verifying Indian status.

Standards for Establishing SHOP

CMS proposes that an Exchange must provide for the establishment of a Small Business Health Option Program (SHOP) that will be designed to assist qualified employers and facilitate the enrollment of qualified employees into qualified health plans. CMS clarifies that the payment of premiums by individuals, Indian tribes, tribal organizations and urban Indian organizations do not apply to the SHOP.

Establishment of Exchange network adequacy standards

The Exchanges will make health insurance available to a variety of consumers, including those who reside or work in rural or urban areas where it may be challenging to access health care providers. Network adequacy requirements will help ensure that QHP enrollees can readily obtain services. Under section 1311(c)(1)(B) of the Affordable Care Act, HHS is required to establish network adequacy requirements for health insurance issuers seeking certification of QHPs.

CMS seeks comment on an additional standards that the Exchange ensure that QHPs' provider networks provide sufficient access to care for all enrollees, including those in medically underserved areas. CMS further elaborates that this standard would allow an Exchange to set standards appropriate to local patterns of care. CMS further urges Exchanges to consider the needs of enrollees in isolated
geographic areas, such as "meeting the needs of American Indians and Alaska Natives residing in remote locations, given that they may often have a limited choice of providers from which to select. "

CMS clarifies that a QHP issuer's provider network must ensure reasonable access to care for all enrollees enrolled through the Exchange regardless of an enrollee's medical condition.

Essential community providers

CMS will codify section 1311I(1)I of the Affordable Care Act, which requires that a health plan's network include essential community providers who provide care to predominantly low-income and medically-underserved populations to be certified as a QHP. CMS invites comment on establishing requirements regarding reimbursement of Indian health providers qualifying under 340B(a)(4) of the PHS Act. Section 206 of the Indian Health Care Improvement Act (IHCIA) provides that all Indian health providers have the right to recover from third party payers, including insurance companies up to the reasonable charges billed for providing health services or, if higher, the highest amount the insurer would pay to other providers to the extent that the patient or another provider would be eligible for such recoveries.

This section also states that no law of any State or provision of any contract shall prevent or hinder this right of recovery. Therefore, this requirement applies whether or not there is a contract between the insurance company and the Indian health provider. We believe that payment requirements under section 206 of IHCIA apply to QHP issuers, as well as to any insurer, employee benefit plan or other third party payer. CMS invites comment on the payment requirement under section 206 of IHCIA, and how it might be reconciled with the essential community provider payment requirement described in section 1311I(2) of the Affordable Care Act.

CMS is interested in special accommodations that must be made when contracting with Indian health providers. Indian health providers operate under or are governed by numerous federal authorities, including but not limited to the Anti-Deficiency Act, the Indian Self-Determination and Education Assistance Act, the Indian Health Care Improvement Act, the Federal Tort Claims Act, and the Federal Medical Care Recovery Act. Indian health providers serve a specific population in accordance to these and other federal laws. Some RFC commenters recommended that we consider developing a standard contract addendum containing all conditions that would apply to QHP issuers when contracting with Indian health providers. Such an addendum may be similar to the special Indian Health Addendum currently used in the Medicare Prescription Drug Program, which CMS requires all plans to use when contracting with Indian Health Service, tribal organization, and urban Indian organization (I/T/U) pharmacies and serve as a safe-harbor for all issuers contracting with Indian health providers, which would minimize potential disputes and legal challenges between Indian health providers and issuers. We invite comment on the applicability of these special requirements to QHP issuers, and the potential use of a standardized Indian heath provider contract addendum.

Definitions

Cost-sharing reductions means reductions in cost sharing for an eligible individual enrolled in a silver level plan in the Exchange or for an individual who is an Indian who is enrolled in a QHP in the Exchange.

Stake-holder consultation: Federally-recognized Tribes, as defined in the Federally Recognized Indian Tribe List Act of 1994, 25 USC §479a, that are located within such Exchange's geographic area.

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