National Indian Health Board

Via Email to www.regulations.gov

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RE: RIN 3206-AM47

Dear Mr. O'Brien:

I am writing on behalf of the National Indian Health Board (NIHB)[1] to submit comments on the draft rules regarding the Patient Protection and Affordable Care Act ("ACA"); Establishment of Multi-State Plan Program ("MSPP") for the Affordable Insurance Exchanges, published December 5, 2012, 77 Fed. Reg. 72582 *et seq*.

We appreciate the opportunity to comment on the proposed rules to implement the MSPP. Tribal advocates, including the Tribal Technical Advisory Group ("TTAG") to the Centers for Medicare and Medicaid Services ("CMS") and the National Indian Health Board ("NIHB"), as well as individual Tribes and Tribal organizations, have offered comment on most stages of the development of the health insurance exchanges required under the ACA. These comments have focused on those parts of the various proposed rules and processes that will most directly affect American Indians and Alaska Natives ("AI/ANs") to whom the United States owes a special

[1] Established 40 years ago, NIHB is an inter-Tribal organization that advocates on behalf of Tribal governments for the provision of quality health care to all American Indians and Alaska Natives. NIHB is governed by a Board of Directors consisting of a representative from each of the twelve Indian Health Service ("IHS") Areas. Each Area Health Board elects a representative to sit on the NIHB Board of Directors. In areas where there is no Area Health Board, Tribal governments choose a representative who communicates policy information and concerns of the Tribes in that area with NIHB. Whether Tribes operate their entire health care program through contracts or compacts with IHS under Public Law 93-638, the Indian Self-Determination and Education Assistance Act ("ISDEAA"), or continue to also rely on IHS for delivery of some, or even most, of their health care, NIHB is their advocate.

trust responsibility[2] and the Indian health providers who serve them. These include the Indian Health Service ("IHS"), health programs carried out by Tribes and Tribal organizations under the Indian Self-Determination and Education Assistance Act,[3] and urban Indian organizations ("UIOs") providing health services pursuant to Indian Health Care Improvement Act[4] (collectively referred to as "I/T/Us"). The I/T/Us have also participated in Tribal consultation with the Office of Personnel Management ("OPM") regarding its roles under the ACA, as well as other matters, such as implementation of access by Tribes, Tribal organizations, and UIOs to Federal Employee Health Benefit Plan ("FEHB") insurance coverage pursuant to 25 U.S.C. § 1647b.

We have been very pleased with the responsiveness of OPM and its efforts to learn more about the unique conditions that affect AI/ANs. Implementation of the MSPP in a way that fully achieves the special protections afforded AI/ANs under the ACA will be a new level of challenge for OPM. We hope these comments help OPM meet that challenge, but also encourage OPM to continue to meet directly with Tribal and UIO representatives and to engage in formal Tribal consultation as it proceeds. We discuss the request for Tribal consultation further at the end of these comments.

We have organized our comments into two sections. First, we address specific provisions of the proposed rule in largely the order in which they are presented in the proposed rule. Secondly, we address a number of issues related to the operation of the MSPP that should be addressed either in the rules or in other administrative procedures by OPM. We have attempted to cross-reference these in the comments, but request that all comments included in this letter be considered in relationship to these proposed rules.

SECTION SPECIFIC COMMENTS

§ 800.20 Definitions.

"Indian." In the proposed rule, the definition of "Indian" corresponds to that in proposed 45 C.F.R. § 155.300(a). We remain concerned about how that definition will be operationalized. CMS found when it tried to implement cost sharing protections for AI/ANs under the American Recovery and Reinvestment Act of 2009[5] that state Medicaid programs were unable to determine who was actually an Indian without further guidance from CMS. CMS responded to that need by adopting regulations found at 42 C.F.R. § 447.50. We believe the challenge will be even greater for health insurance issuers. Failure to provide guidance, either in the form of further regulation incorporating the CMS regulation or in some other form of communication from OPM, will almost surely result in some individuals who are AI/AN not being identified as such and, therefore, not receiving the cost-sharing benefits to which they are

[2] 42 U.S.C. § 1602.

[3] Pub. L. 93-638, as amended ("ISDEAA"), 25 U.S.C. § 450 *et seq.*

[4] Pub. L. 94-437, as amended ("IHCIA"), 25 U.S.C. § 1601 *et seq.*

[5] Pub. L. 111-5, as amended ("ARRA").

entitled. These misidentifications will trigger unnecessary disputes that have to be managed by OPM, but more importantly will deprive AI/ANs of benefits they were intended to receive and undermine confidence of AI/ANs and Tribes in the commitment of the United States to fulfilling its trust responsibility.

"**Indian plan variation."** The proposed definition of "Indian plan variation is "the meaning given that term in proposed 45 C.F.R. § 156.400." Unfortunately, that term does not appear in 45 C.F.R. § 400 as it is proposed in CMS's Notice of Benefit and Payment Parameters for 2014, CMS-9964-P,[6] in which definitions were provided. The CMS Proposed Parameters Rule proposes a "zero cost-sharing variation" and a "variable cost-sharing variation for AI/ANs. We urge that the definition be corrected so there is no confusion, particularly since we have many concerns about these "variations" as they will be implemented generally.

§ 800.101(i) General Requirements; Non-Discrimination.

We certainly understand and support in general requirements that there be no discrimination based "on race, color …." Such requirements are often misinterpreted as they apply to AI/ANs in two ways. First, many state and industry officials fail to recognize that being AI/AN is a political status and not a racial status. That leads to the second error: failing to recognize that I/T/Us providing health services may and, in fact, must in many instances, serve only AI/ANs, excluding non-AI/ANs except under limited circumstances. These circumstances for IHS and Tribal health programs are described in Section 813 of the IHCIA, 25 U.S.C. § 1680c, Health Services for Ineligible Persons. This has led to insurers taking the position, incorrectly that they cannot enter into provider contracts with an I/T/U because it generally limits its services to AI/ANs.

To address this, we advocate that OPM expressly clarify, in this section or in another part of the rule, that I/T/Us are not violating the non-discrimination requirements if they limit their services, in whole or part, to AI/ANs. We note that HHS regulations at 45 C.F.R. § 80.3(d) specifically provide that individuals shall not be deemed subjected to discrimination by reason of their exclusion from benefits limited by federal law to individuals eligible for services from I/T/U providers. We suggest that this exception to the non-discrimination requirements be specifically referenced by OPM in its Final Rule. This is one of several matters of federal Indian law that have been put forth in an "Indian Addendum" to be used in provider contracts between issuers and I/T/Us. The purpose of the Addendum, to facilitate beneficial arrangements between the parties, is further explained in another section of these comments.

§§ 800.102 Compliance with Federal law.

Non-Discrimination. The same issue as discussed regarding § 800.101(i) arises here under subsection (a), which requires compliance with applicable provisions of Part A of Title XXVII of the Public Health Service ("PHS") Act, as listed in Appendix A to the proposed rule. Among these is "Section 2706: Non-Discrimination in Health Care."[7] The remedy advocated

[6] 77 Fed. Reg. 73118 (Dec. 7, 2012).

[7] 77 Fed. Reg. 72608.

regarding § 800.101(i) should be extended to apply to this additional (and duplicative) requirement.

Other Federal Laws. The Federal laws referenced in this section are limited to those in the ACA. There are many other federal laws that also apply to insurance companies, including federal Indian law. For example, Section 221 of the IHCIA, 25 U.S.C. § 1621t, provides for an exemption from in-state licensing of health professionals who are licensed in some other state and are employed by a Tribal health program. Another example is Section 408, 25 U.S.C. § 1647a, which requires all federal health care programs to reimburse I/T/Us without regard to whether they have acquired state licenses that might otherwise be required so long as they meet generally applicable state or other requirements. The definition of "Federal health care program" is extremely broad, and we believe encompasses those carried out under MSPP.

> the term, "Federal health care program" has the meaning given that term in section 1128B(f) of the Social Security Act (42 U.S.C. 1320a-7b(f)), except that, for purposes of this subsection, such term shall include the health insurance program under chapter 89 of title 5, United States Code [5 USCS §§ 8901 et seq.]. [8]

There are also special rules that apply to payments by insurers (and other payers) to I/T/Us. *See*, IHCIA Section 106, 25 U.S.C. § 1621e.

These special rules, and others that effect I/T/Us and AI/ANs, need to be expressly incorporated into the regulations in order to avoid disputes. The Indian Addendum that we are recommending would also address these concerns.

§§ 104 Phased Expansion and 109 Network Adequacy. [9]

Phased Expansion. Proposed 45 C.F.R. § 800.104(b) states that OPM may enter into a contract with an MSPP issuer even if the issuer's MSP covers fewer than all the service areas specified for that State. In such circumstances, the issuer's application for participation must include a plan for offering coverage throughout the State, and the issuer's compliance with said plan will be a consideration during OPM's contract compliance review.[10] Proposed 45 C.F.R. § 800.109 then requires that the issuer ensure that its MSPs operate provider networks that are adequate to provide all services without unreasonable delay, are consistent with the network adequacy provisions of section 2702 of the Public Health Service Act,[11] and include essential

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[8] 25 U.S.C. § 1647a(b)(3); *also see* section 1139(c) of the Social Security Act (42 U.S.C. § 1320b-9(c)).

[9] *Also see*, comments below regarding a national plan.

[10] This is reiterated at proposed 45 C.F.R. § 800.110.

[11] Section 1201 of the ACA, codified as amended at 42 U.S.C. 300gg–1.

community providers in compliance with 45 C.F.R. § 156.235.[12] In fact, proposed 45 C.F.R. § 800.109 is taken nearly verbatim from the Exchange QHP network adequacy Final Rule, except that the letter makes specific reference to the inclusion of mental health services, while the Proposed Rule does not.[13]

We appreciate that issuers failing to offer statewide coverage must propose a plan for expanding coverage and that coverage may not be determined based on discriminatory factors or designed to avoid high utilizing, high cost, or medically underserved populations.[14] Without more specificity, however, these requirements are insufficient to ensure that AI/ANs will be able to access the MSPs in any meaningful way.

For example, these fairly vague protections do not change the fact that AI/ANs often live in extremely remote areas that OPM may deem permissibly excludable from MSP coverage based on low population density or extreme logistical difficulty in providing services. Anything other than a statewide coverage requirement will almost certainly place regions with high concentrations of AI/ANs at risk of coverage deficiencies.[15] Because of market conditions in areas with low population density, there is no way to assure access to care for many AI/ANs other than explicitly requiring the inclusion of I/T/U providers in MSP networks.

In those states where there are IHS and Tribal health providers, we believe that MSP proposals to limit coverage should not be accepted if inclusion of the IHS and Tribal health providers would be sufficient to assure that covered individuals would have access to health care services. Failure to impose this kind of requirement may encourage MSPs to delay adding areas principally served by IHS and Tribal health programs as long as they can, in order to avoid complying with the special conditions that apply to doing business with I/T/U providers, particularly the payment provisions of 25 U.S.C. § 1621e. Given the healthcare burdens borne by AI/ANs and the special trust responsibility owed to them, allowing such an outcome should be unacceptable.

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[12] In paragraph (c)(1) of this section, CMS held that "essential community providers" includes the providers defined in Section 340B(a)(4) of the PHS Act, which includes both "urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act" and "Federally qualified health care centers," as defined in Section 1905(l)(2)(B) of the Social Security Act. This latter definition includes both outpatient health programs and facilities operated by Tribes and Tribal organizations under the Indian Self-Determination Act or urban Indian organizations receiving funds under title V of the Indian Health Care Improvement Act.

[13] *See* 45 C.F.R. § 156.230(a).

[14] Proposed Rule, at 72,588.

[15] And although a statewideness requirement is preferable, even that does not guarantee adequate provision of services to AI/ANs. When States converted their Medicaid programs to managed care, some managed care organizations whose service area included the entire State assigned AI/AN enrollees to primary care providers in areas that required driving three to five hours to access care, while excluding providers from the Indian health services, Tribes and Tribal organizations, and urban Indian organizations (I/T/Us) their networks. Thus, defining a large service area is not sufficient to assure access to care.

Network Adequacy. In addition to requiring MSPs to cover geographic areas, as described above, MSPs should be required to offer network status to I/T/U providers. We believe this outcome is dictated by both the requirements of network adequacy and other federal law. As discussed above, IHCIA Section 408(a) requires health care programs that receive Federal funding to accept I/T/U providers. It requires any:

> Federal health care program to accept an entity that is operated by the Service, an Indian Tribe, Tribal organization, or urban Indian organization as a provider eligible to receive payment under the program for health care services furnished to an Indian on the same basis as any other provider qualified to participate as a provider of health care services under the program if the entity meets generally applicable State or other requirements for participation as a provider of health care services under the program.[16]

Under this broad definition, any "plan or program" that provides health benefits "through insurance or otherwise" that is funded directly "in whole or in part" by the United States clearly includes MSPs because they will receive federal funding through advanced payments of tax credits and through the cost-sharing provisions for AI/ANs. The language in section 408(a) of the IHCIA stating that I/T/Us must be accepted "on the same basis as any other provider qualified to participate as a provider of health care services under the program" means the I/T/U would function like other providers in the network for the MSP, except that federal Indian laws would also apply.

As was discussed in TTAG comments submitted to OPM on October 22, 2012, regarding the Draft Multi-State Plan Program Application, we are encouraged that the Draft 2014 Multi-State Plan Program Application (Application) requires MSPs to

> [d]escribe provisions for adequate choice for enrollees who are American Indians and for ensuring covered services from the Indian Health Service, as applicable

in demonstrating the adequacy of their provider networks. The Application also requires MSPs to

> [d]escribe your approach to ensuring compliance with 45 CFR 156.235, regarding Essential Community Providers in your network.

[16] We note that Section 408(a)(2) of the IHCIA makes it clear that any licensing requirement imposed by a state will be deemed to have been met by the I/T/U provider if it meets the standards required for licensing regardless of whether a license is obtained, and Section 221 of the IHCIA provides that licensed professionals at an I/T/U facility do not have to be licensed in the state in which they are located provided they are licensed in any state. *Also see*, the definition of "federal health care program" in our discussion of § 800.102.

As was discussed in those comments, it is very positive that OPM has proposed to ask potential MSPs to demonstrate their networks will provide adequate choice for AI/AN enrollees and to ensure continued coverage of services from the IHS.[17] For the purposes of these proposed rules, however, we wish to reiterate the most critical point, which is that AI/ANs should be able to choose to continue to obtain health care from an I/T/U. "Adequate choice" for many AI/AN people means the health care facility operated by their Tribe or Tribal organization or the IHS on their reservation or in their community.

Because the I/T/U is unique, contracts that are offered by MSPs need to be modified to achieve the two objectives of (1) allowing the I/T/U to participate as a provider in a MSP, and (2) upholding the Federal laws and regulations that govern the I/T/U. Based on experience with Medicare Part D implementation, the best way to accomplish these two objectives is for the Federal government to approve a standard amendment that MSPs can use with contracts that are offered to the I/T/U.

Requiring that MSP issuers offer all I/T/Us a contract with an approved Indian health addendum is one way to assure both network adequacy and compliance with the special rules applicable to I/T/Us. Sufficient choice of providers is not defined in the Proposed Rule, but OPM notes that it is basing its network adequacy provisions on those pertaining to Qualified Health Plans ("QHPs") within the Exchanges.[18] CMS recognized in the preamble to Exchange implementation Proposed Rule,[19] that there are several components to the concept of network adequacy, including geographic accessibility, ensuring that a provider is able to deliver the care needed by the insured, and the ability to offer culturally competent care.

I/T/U hospitals and clinics are located in some of the most isolated, sparsely populated and poverty-stricken areas of the United States, and are the sole source of health care for many AI/ANs.[20] The only way to ensure a "reasonable proximity of participating providers" is for MSPs to offer to contract with I/T/U providers. Unless the Federal government mandates that MSPs include I/T/U providers in their networks, the AI/ANs in these areas may have no in-network providers at all.[21]

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[17] We request that this favorable comment not be construed to undercut the proposed changes that were offered in the October 22, 2012, comments regarding the application. While the principle is right, there are implementation improvements needed.

[18] Proposed Rule at 72,590-91 ("With respect to network adequacy, OPM's proposed standard mirrors the HHS standard set forth in 45 CFR 156.230.")

[19] Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, 76 Fed. Reg. 41,866, 41,894 (July 15, 2011).

[20] The Bristol Bay Area Health Corporation, for example, is located 329 air miles from the nearest non-I/T/U facility in Anchorage, Alaska.

[21] Geography is not the only barrier to care for AI/ANs, however. In many cases, the I/T/U provider is the only facility with the capacity to serve AI/AN in a culturally competent manner even in areas where other providers may be available. Whether because of lack of trust, a history of abuse and discrimination, or because I/T/U providers are the only providers able to offer needed services to their AI/AN populations in

AI/ANs will benefit from inclusion of I/T/U providers in network in other ways. For example, including I/T/U providers in MSP networks will ensure network access to other providers, and make it more efficient to refer patients to other providers. It will also minimize duplication of services that may result from AI/ANs receiving services from in-network and out-of-network providers alike. Inclusion of I/T/U providers will also benefit the MSP. Under Section 206 of the IHCIA, I/T/U providers have a Federal right to receive reimbursement for the services they provide whether they are in-network or not. Under Section 206, I/T/U providers have the right to recover the "reasonable charges billed . . . or, if higher, the highest amount [a] third party would pay for care and services furnished by providers other than governmental entities . . . ." If I/T/U providers are not included in Exchange plan networks, there may be more expensive transaction costs incurred by both the I/T/U provider and the MSP when I/T/Us exercise their right to seek the highest possible payment rates rather than a negotiated network rate. [22]

In order to overcome these barriers, maximize AI/AN participation in the Exchanges, and minimize payment and enrollment disputes, the network adequacy criteria mandated for MSPs must include a requirement that MSPs offer to contract with I/T/U providers and include an Indian addendum.

In the alternative, we note that the OPM/MSPP contracting provisions proposed 45 C.F.R. § 800.303 and .304 indicate that OPM retains broad flexibility to determine the terms of such contracts, thus providing OPM with the opportunity to require I/T/U inclusion and the use of the Indian addendum via the contracting process, if not through regulation.

§§ 106 Cost-Sharing Limits and 107(d) Plan Variations for the Reduction or Elimination of Cost-Sharing.

The cost-sharing provisions of the proposed rule essentially require MSPs to ensure that cost-sharing provisions and cost-sharing reductions comply with the underlying provisions of law (ACA §§ 1302(c) and 1402, respectively) and "with any applicable standards set by OPM or HHS."[23] The standards of HHS were one of the subjects of proposed rules for which the comment period closed on December 31, 2012.[24] The TTAG (and others) commented on HHS/CMS proposed rule. We are very concerned that an error regarding the application of the

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a culturally appropriate and competent manner, many AI/ANs will not participate in an MSP plan unless they can use their I/T/U provider.

[22] Alternatively, if the requirement for I/T/U providers to be reimbursed by health plans is not effectively enforced, then the MSPs may realize a potential windfall by collecting premiums for AI/AN enrollees – most likely paid for with Federal dollars – and not making full payment for the health services their Indian enrollees receive from I/T/U providers.

[23] Proposed § 800.106(a) and (b).

[24] CMS-9964-P; ACA; HHS Notice of Benefit and Payment Parameters for 2014, 77 Fed. Reg. 73118 *et seq.* (Dec. 7, 2012) (hereafter "CMS Proposed Parameters Rule").

cost-sharing protections provided to AI/ANs under the rules applicable to QHPs will carry over to the MSSP, unless it is corrected. We believe that OPM has an obligation to participate in assuring that does not occur.

Cost-Sharing Variations. 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 QHP by reason of these Indian cost-sharing exemptions.

The CMS Proposed Parameters 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. [25] 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 because their income is below 300 percent of the FPL. The second plan variation, called the "limited cost-sharing plan variation," 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.[26]

The TTAG supports this approach. However, more specific regulation or guidance is needed to make it workable. During the All Tribes Call held by CMS on December 14, 2012, presenters from the Center for Consumer Information and Insurance Oversight ("CCIIO") said that individuals would be given a card that would tell providers the cost-sharing protections to

[25] We note that the OPM proposed rule used the singular when it attempted to define "Indian plan variation" in § 800.20. It is evident that consistency with the HHS rules will require at least two variations if OMP intends to require MSPs to rely principally on HHS rules.

[26] We note, however, that there are also cost-sharing protections for all Americans, including AI/ANs 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 also qualify for cost-sharing protections to the same extent as any non-AI/AN.

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 the Contract Health Service ("CHS") to providers who are out-of-network. Those out-of-network providers may not understand the payment amount that they can expect from the MSP inclusive of the waived cost-sharing,[27] and they may have difficulty obtaining payment from the MSP for the services they provide.

Limiting Application of Cost-Sharing Protections. There is currently a misunderstanding by CMS of the relationship between cost-sharing exemptions for AI/ANs and essential health benefits ("EHB"). Under the ACA, the QHPs (and, accordingly, the MSPs) must offer at least an "essential health benefit," which is being defined under a separate notice of proposed rulemaking. In the preamble to the CMS Proposed Parameters Rule, CMS states that the no cost-sharing plan variations 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 42 C.F.R. § 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 42 C.F.R. § 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… ."

On the December 14, 2012, CMS All Tribe's Call, 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.

[27] 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.

> **(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 <u>any cost-sharing under the plan</u>" for an Indian whose household income is not more than 300 percent of the poverty line, and states that "<u>no cost sharing under the plan</u> shall be imposed under the plan" for items or services furnished through Indian health providers.

In this instance, the "plan" includes any benefits offered by the plan, both those that are EHB and those that are not.

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).

In summary, the HHS interpretation is incorrect and contrary to plain language of the ACA. There is nothing in the ACA 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 or MSP (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).

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," which would certainly include the MSPs.[28] Such a result is clearly at odds with Congress' intent, consistent with 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. We have submitted comments on this subject to CMS in response to their NPRM on Benefit and Payment Parameters and we trust that this matter will be corrected in the final rule. Similarly, we urge OPM to assure that the MSPP does not implement cost-sharing protections for AI/ANs in a way that restricts their application to EHBs.

§ 107 Levels of Coverage.

Bronze Plan. Proposed 45 C.F.R. § 800.107(a)-(b) state that participating MSPP issuers must offer at least one plan at the silver level of coverage and one plan at the gold level of coverage. The choice of offering bronze or platinum plans is left to the issuer's discretion. OPM also notes that MSPP issuers must also comply with section 1334(c)(3)(B) of the Affordable

[28] 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 the Act if their incomes were below 400 percent of the FPL.

Care Act, which specifies that individuals enrolled in an MSP are eligible for the premium tax credits and cost-sharing reductions just as they would be if purchasing any other insurance product on the Exchange.[29] We have several comments on these provisions.

Section 1402(d) of the ACA contains a number of cost-sharing protections for AI/ANs. For example, cost-sharing is waived for AI/ANs with a household income up to 300% of the federal poverty level (FPL) and who enroll in a QHP through the Exchange, while cost-sharing is similarly waived for any AI/AN furnished an item or service at an I/T/U or through referral under contract health services. Any such AI/AN who chooses to enroll in an MSP will, in practice, end up paying premium costs and nothing else for their health care.[30]

The distinction between the metal-level plans is one of actuarial value rather than provided benefits; that is, the higher "level" of the plan, the higher the premiums and lower the deductible. The silver level plans (which are the lowest level that OPM proposes requiring an MSP to offer) will therefore have higher premiums and lower deductibles than that of a bronze level plan. Because, in practice, most AI/ANs will be required to pay premiums but not cost-sharing, it will make the most economic sense for these AI/ANs to enroll in a bronze plan, thus allowing them to minimize premium payments while remaining generally shielded from the bronze plans' higher cost-sharing. Not requiring MSPP issuers to offer bronze plans, and instead only mandating the comparatively more expensive (at least to AI/ANs) silver plans, will further dissuade AI/AN participation in the Exchanges. We therefore recommend that OPM require MSPP issuers to offer at least one plan at the bronze level in order to maximize AI/AN participation.

We note that CMS has proposed rules that offer plan variations for AI/ANs at each metallic level in Exchange statewide plan, while the cost-sharing reduction variations for the general population are only at the silver level. Similarly, OPM could consider addressing this issue by requiring MSPs to offer bronze level variations of plans for AI/AN only without requiring bronze level to be offered to the general population. There would be no negative consequence to the issuer since the actual amount of cost-sharing waived for AI/AN would be reimbursed by the federal government to the plan.

Premiums and Child-Only Plan. The concept of a child-only plan needs greater explanation to be able to understand the covered benefits and relative premiums of such a plan. Potentially, a child-only plan could be less costly than enrolling children in family plans or QHPs. Until there is resolution of the issue of identify AI/AN, it is entirely likely that families will have to be split between those who qualify as Indian and those who do not under the rules proposed by CMS. This has significant implications for both the cost of premiums and shifting the liability for cost-sharing from Indian to non-Indian family members.

[29] Proposed Rule, at 72,590.

[30] The AI/AN cost-sharing protections include a waiver of deductibles, coinsurance, copayments, or similar charges, but not premiums. *See* ACA § 1302(c)(3)(A), codified as amended at 42 U.S.C. § 18022(c)(3)(A).

We are very concerned about how the cost-sharing plan variations and premiums interact, as well as how the child-only plan may affect premiums. The CMS Proposed Parameters Rule asserts that the AI/AN cost-sharing variations are not available to non-AI/AN family members and that in order for the AI/AN family members to enjoy the benefits of cost-sharing protections to which they are entitled, the non-AI/AN family members must be enrolled separately. As the TTAG and others discussed in depth in comments to the CMS Proposed Parameters Rule, this has potential to substantially increase the premium costs for the AN family to the point that it eliminates the benefits of any reasonably likely cost-sharing savings, thus undermining the intent of the law. QHPs and MSPs must be required to adopt provisions to assure that the total premiums paid for the multiple plans that may be required for a family with both AI/AN and non-AI/AN members is no larger than the premium that would have been required if the entire family had been allowed to enroll in a single plan. We urge OPM to adopt such a rule.

OPM Plan and Variation Review. Subsection (e) of § 800.107 requires MSPP issuer to submit levels of coverage plans and plan variations to OPM for review and approval by OPM. We strongly endorse this. It will give OPM an opportunity to assure that among other things, all provisions of the law intended for the benefit of AI/ANs and I/T/Us are addressed correctly.

§ 800.110 Service Area

See, comments regarding § 800.104, phased expansion, above and the discussion of national plans below.

§ 800.113 Benefit Plan Material or Information.

We support the requirements set forth in § 800.113 of the proposed rule. In addition, we believe it is critical that the information about the special protections for AI/ANs be clearly stated in all plan materials so that AI/ANs are informed about the cost-sharing plan variations that may apply to them so they can enroll in the correct plan. Also, they should know whether a plan network includes their I/T/U provider.

§ 800.114 Compliance with Applicable State law.

With certain exceptions, 45 C.F.R. § 800.114 requires MSPP issuers to comply with State law with respect to each of its MSPs. However, federal Indian law supersedes state law and this should be acknowledged. Without this exception, MSPP issuers might require, for example, that providers be licensed in the State in which they provide services as a condition of reimbursement. Such a provision would conflict with section 221 of the IHCIA,[31] which exempts licensed health professionals employed at a Tribal health program from State licensing requirements so long as the professional is licensed in *any* State. Other provisions of the IHCIA discussed in other sections of these comments should be considered as well in relation to compliance with state laws.

800.401 Contract Performance.

[31] Codified as amended at 25 U.S.C. § 1621t.

Under § 800.401, OPM proposes rules regarding contract performance. We support these, and, in particular support the requirement of the escrow account in subsection (e). We urge OPM to ensure that subsection (d)(5) is administered to include failure by MSPs to properly pay I/T/Us in compliance with 25 U.S.C. § 1621e and all of the cost-sharing protections for AI/ANs and I/T/Us under the ACA section 1402, including full payment (without cost-sharing deductions) of payments to I/T/Us under subsection (d)(2). It is enormously inefficient to require each I/T/U to try to enforce these requirements individually, when OPM can accomplish the task easily by imposing and enforcing the requirements in these rules.

OTHER COMMENTS

Tribal Sponsorship

45 C.F.R. § 155.240(b) states that Exchanges may permit Indian Tribes, Tribal organizations, and urban Indian organizations to pay aggregated QHP premiums on behalf of qualified individuals. Although the OPM Proposed Rule does not discuss Tribal sponsorship, we suggest that OPM establish the rules and conditions that will facilitate Tribal sponsorship of individuals to enroll in MSPs.

It is unclear if premium payments for MSPs must be made to the plan issuers directly or to OPM itself under the contracting and premium provisions in proposed 45 C.F.R. § 800.303 and .304. This is another logistical issue relating to Tribal sponsorship (and to any other group sponsorship payments made in an MSP), and we similarly suggest that the Final Rule include explanation as to how this process would work. Tribal sponsorship with aggregate payment is virtually the only way that many AI/ANs will obtain health insurance through the exchanges.

Model Indian Addendum

In our comments on non-discrimination, cost-sharing, network adequacy, and other provisions of the rule, we have discussed the importance of MSPs understanding the special rules that apply to AI/ANs and I/T/Us and of OPM ensuring compliance by the MSPs with these federal laws that were written to assist the United States in fulfilling its special trust responsibility to AI/ANs and Tribes. One of the important tools to achieving these objectives is assuring that plans are required to offer in network status to all I/T/U health providers with an Indian health program addendum in which the unique provisions applicable to I/T/Us are set forth.

Medicare Part D plans are required to use an Indian-specific addendum and also offer in network status to all Indian health programs. This has been exceedingly successful in cutting through the rampant misunderstandings of insurers about working with Indian health providers.

CMS has developed a Model Qualified Health Plan ("QHP") Addendum based on a draft proposed by the Tribal representatives on the TTAG ACA Policy Subcommittee. It was recently the subject of Tribal comment. We enclose 1) the Tribal recommended version of the Indian Addendum, 2) CMS Draft of the Model QHP Addendum that was the subject of a request for

comment that just closed on December 19, 2012, and 3) the comments submitted by the TTAG (as well as others), and incorporate these documents into this comment for consideration. We urge that OPM require a Model Addendum (or establish through regulation equivalent rules). OPM has the flexibility to do this even if CMS chooses to *only encourage* the use of the Addendum.

National MSPs

We appreciate the request for comment regarding how an MSP issuer could potentially achieve consistency in benefits across all states in which the MSP is offering coverage. We cannot respond to whether the particular options described[32] are more or less likely to encourage or discourage the issuers' participation in MSPP. We are convinced, however, that an MSP that does provide multi-state consistency will have decided advantages over those plans that do not.

Multi-state consistency would be especially helpful for Tribes and Tribal organizations that may consider purchasing coverage for their members and for those Tribes that cross state borders.[33] As a result of historical policies affecting AI/ANs and economic pressures, many AI/ANs now live far from their Tribal center, although they maintain close ties to the Tribe. Extending coverage to each of these dispersed members, as well as those at home, will be substantially easier and more equitable if the Tribe can sponsor individuals in a single MSP with comparable benefits..

The problem of Tribes with land that crosses state borders is that they must deal with more than one state or federal exchange. If there are no MSPs that offer a "national" plan, then the Tribe cannot offer all of its members the same benefits.

Tribal Consultation.

We end these comments as we began with a request for formal Tribal consultation regarding these proposed rules and any other implementation of MSSP that OPM will undertake. Representatives of the National Indian Health Board will contact you to discuss plans for such a consultation.

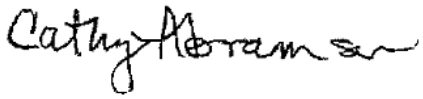
The Indian health system, as a community-based delivery system, supplies culturally-appropriate health care services essential to promoting a healthy lifestyle. Existing health disparities, high rates of poverty, and the remote, rural nature of Indian communities demand the support for the Indian health care delivery system. Furthermore, across the United States, Indian cultures, resources, and health system structures differ greatly. Implementation of the MSPP by OPM, like other ACA provisions, present a challenge to ensure that they work in all of these situations. These challenges can be addressed through workgroups and direct consultation with the Tribes.

[32] 77 Fed. Reg. 72588-89.

[33] *E.g.*, the Shoshone Paiute Tribe of Duck Valley (Idaho and Nevada), Navajo Nation (Arizona, New Mexico, and Utah), Standing Rock Sioux Tribe (North Dakota and South Dakota), to name just a few.

The unique government-to-government relationship requires the federal government to deal directly with Tribes. A commitment to honoring this relationship was reiterated through the Presidential Memorandum issued on November 5, 2009. OPM demonstrated effective consultation as it implemented the FEHB Program by Indian Tribes for their employees. We look forward to working with you to make sure the MSPP is responsive to the unique needs and circumstances of Indian communities.

Sincerely,



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