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

Delivered via electronic submission to: http://www.regulations.gov

April 1, 2013

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–9964–P2
P.O. Box 8016
Baltimore, MD 21244–8016.

RE: Comments on CMS-9964-P-2:

I. Introduction.

The Tribal Technical Advisory Group (TTAG) of the Centers of Medicare & Medicaid Services (CMS) is submitting these comments in response to the request for comments published on March 11, 2013 in the *Federal Register* by the Centers for Medicare and Medicaid Services (CMS) of the Department of Health and Human Services (HHS) involving "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Small Business Health Options Program" (CMS-9964-P-2, "Proposed Rule").[1]

The TTAG advises CMS on Indian health policy issues involving Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and any other health care program funded (in whole or part) by CMS. In particular, the 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, Indian Tribes, tribal organizations and urban Indian organizations (referred to as Indian Health Care Providers or I/T/Us).

II. Discussion.

1. Restrictions on available QHPs in the SHOPs.

45 C.F.R. § 155.705(b)(2) requires Small Business Health Options Programs (SHOPs) to allow a qualified employer to select either a bronze, silver, or gold level of coverage within an Exchange and to then offer all qualified health plans (QHPs) within that level of coverage to the employer's qualified employees. CMS recently sought comments on a transitional policy in which SHOPs would only allow employers to offer their employees a single QHP from within their chosen metal level of coverage, rather than all QHPs within that level.[2] In the current

[1] 78 Fed. Reg. 15,553 (Mar. 11, 2013) [SHOP Rule].

[2] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters

Proposed Rule, CMS notes that commenters from the insurance industry strongly supported limiting the number of QHPs that employers could offer to their employees in the SHOPs, citing actuarial and logistical concerns that they felt would be aggravated if QHP issuers were required to offer a wide range of QHPs to eligible employees at the immediate outset of the SHOP program.[3]

Citing these industry concerns, CMS proposes that until January 1, 2015, SHOPs may prohibit employers from offering their employees more than one QHP from within the employer's chosen metal level category of coverage.[4] Second, CMS proposes delaying the requirement that SHOPs assist employers with premium aggregation for its employees to January 1, 2015, reasoning that this function is unnecessary given that it is geared entirely towards assisting employers whose employees are enrolled in multiple QHPs within a SHOP.[5] Finally, CMS is proposing that State-based SHOPs be allowed to offer employees the option to enroll in multiple QHPs and aggregate employer premiums before January 1, 2015, although the choice to do so would be entirely optional.[6]

We recognize the logistical difficulties surrounding the establishment and implementation of Exchanges and SHOPs, and understand that many concerns from the insurance industry regarding actuarial uncertainty may be valid. However, we believe that CMS's proposed solution ignores the fact that, as many commenters argued, SHOPs "should focus on providing employee choice."[7] One of the key purposes of the Exchange and SHOP programs is to encourage consumer choice in health plans, therefore maximizing potential benefits and helping to drive down costs through diversity and increased participation in the marketplace. Allowing SHOPs to restrict plan choice to consumers (even if only for a year), completely undercuts the goals that the Affordable Care Act was designed to effectuate. This is true for two particular reasons.

First, the language that CMS proposes to implement this delay is that until January 1, 2015, SHOPs "will only provide a qualified employer the choice to make available to qualified employees a single QHP."[8] This phrase is completely ambiguous as to who actually gets to decide which "single QHP" the employer may offer within their metal level of coverage: the

---

for 2014; Proposed Rule, 77 Fed. Reg. 73,118, 73,184 (Dec. 7, 2012).

[3] SHOP Rule, at 15,554-55.

[4] *Id.* at 15,555.

[5] *Id.*

[6] *Id.* However, federally-facilitated SHOPs will maintain the January 1, 2015 deadline. *Id.*

[7] *Id.* at 15,554.

[8] *Id.* at 15,557.

SHOP, the employer, or the QHP issuer. Unless the employer makes this choice, CMS runs the risk of the chosen QHP being inadequate to serve the needs of a particular employer's employees, or a QHP issuer choosing to issue solely a high cost or low benefit QHP in order to maximize its profits or minimize its scope of responsibility. Both situations are antithetical to the goals of the Affordable Care Act and the SHOP program and will discourage employer participation in the Exchanges.

Second, despite the fact that this limitation on employee choice will only last for the first year of the SHOP program, the initial year is when many employers will test the affordability and benefits of the SHOP in order to determine whether SHOP participation will be a viable option in the future. Should they be forced to limit their coverage at the demand of the insurance industry or the State, this could seriously discourage employers from wanting to return and maintain participation in the program moving forward. This is especially true with regard to Indian Tribes and Tribal organizations that may want to participate in a SHOP as employers: many of their employees will likely be American Indians and Alaska Natives (AI/ANs) who are entitled to health care services free of charge as part of the federal government's trust responsibility towards Indians. It will be difficult enough for Tribes to encourage their members to enroll in an Exchange or a SHOP plan given that the individuals will then be forced to pay for the health care to which they are otherwise entitled; it will be even more difficult for AI/AN Tribal employees who, upon deciding to enroll in a SHOP plan, find that they are severely limited in their choice of QHPs. In light of these concerns, we suggest the following.

First, we believe that CMS should allow individual employers to request authorization from the SHOP to offer more than one QHP within its chosen level of coverage.[9] While some employers may be satisfied offering a single QHP to its employees, others may rightfully wish to facilitate employee choice and allow for multiple plan options within the first year of SHOP operation. At the very least, we request a waiver of this proposed delay as applied to Indian Tribes, Tribal organizations, and Urban Indian organizations,[10] which, as described, already face an uphill battle in encouraging member enrollment in an Exchange or a SHOP.

Second, in the event that CMS chooses to maintain the one-year delay on employee choice and premium aggregation, it is imperative that CMS clarify that the employer has the authority to choose which single QHP it will offer to its employees through the SHOP. Vesting this power with the SHOP or, especially, with QHP issuers, will prevent employers from determining what QHP will work most effectively for its particular group of employees.

2. Reduction in timeframe for SHOP participants to choose a QHP.

---

[9] While we believe that this request should be granted automatically, even giving the SHOP the discretionary authority to consider such requests on a case-by-case basis would be preferable to the current blanket prohibition on employee choice.

[10] Throughout this comment, we refer to these entities as defined in as such terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act, 25 U.S.C. § 450b.

CMS requires that Exchanges offer special enrollment periods for individuals or their dependents upon the occurrence of certain "triggering events," such as losing minimum essential coverage, gaining or becoming a dependent through marriage, birth, adoption, etc., gaining lawful citizenship, etc.[11] Current SHOP regulations adopt these provisions by reference,[12] including the provision stating that "a qualified individual or enrollee has 60 days from the date of a triggering event to select a QHP."[13]

In the current Proposed Rule, CMS notes that this sixty-day enrollment period "differs from the length of special enrollment periods in group markets provided by HIPAA, which last for 30 days after loss of eligibility for other private insurance coverage or after a person becomes a dependent through marriage, birth, adoption, or placement for adoption," that that "there is no rationale for providing a longer special enrollment period in a SHOP than is provided in the group market outside the SHOP."[14] CMS is therefore proposing a reduction in the special SHOP enrollment period to be thirty days after the triggering event, rather than sixty days, in order to "appropriately align the SHOP provisions with provisions applicable to the rest of the group market."[15]

While CMS provides little detail as to why it proposes shortening the special enrollment period for SHOPs other than to align it with the generally, non-SHOP group market, this seems based on an assumption that the process or burden of enrollment in the SHOPs and enrollment in an existing group market plan will be identical, and so the special enrollment periods should similarly align. But this is not necessarily the case.

First, in this same Proposed Rule, CMS proposes to limit employee choice in enrolling in health plans out of concern that transitioning to the full SHOP system too quickly will be logistically difficult and confusing for insurers. It therefore seems inconsistent that CMS would then assume that SHOP enrollment will be no different, more difficult, or more confusing (procedurally or otherwise) than regular group market enrollment for employers and employees, the very groups that the SHOP programs are intended to benefit. That alone should be a distinguishing factor between SHOPs and group markets that should justify an extended special enrollment period for employees participating in a SHOP (at least for the first year of the

---

[11] *See generally* 45 C.F.R. § 155.420(d).

[12] *See* 45 C.F.R. § 155.725(a)(1) ("The SHOP must . . . Provide the special enrollment periods described in [45 C.F.R.] § 155.420 excluding paragraphs (d)(3) and (6).").

[13] 45 C.F.R. § 155.420(c).

[14] SHOP Rule, at 15,555.

[15] *Id.* As is the case for non-SHOP group plans, CMS proposes maintaining the sixty-day enrollment period when the triggering event is becoming eligible or ineligible for Medicaid or CHIP. *Id.*

program) so as to give employers and employees time to acclimatize to the new enrollment system and make the type of informed choices that the SHOPs were designed to facilitate.

Second, and particularly once employers are authorized to offer their employees the entire range of QHPs within a metal coverage level, many employees will be given a choice of employer health coverage for the first time. While some large employers might currently offer their employees a choice from multiple health plans through the non-SHOP group market, many employers likely either offer their employees only a single plan or simply do not offer coverage at all. If the latter type of employer participates in a SHOP, their employees might be given the responsibility of making an informed, personalized choice of plans (or the responsibility of choosing and understanding any health plan at all) for the first time; indeed, this type of expanded coverage and choice among the previously uninsured is one of the critical goals of the ACA. Reducing the amount of time that employees have to make an informed choice after a triggering event will make it that much more difficult to achieve these goals. This is particularly true for AI/AN employees, who are comparatively more likely to have low health literacy, and who may be inherently disinclined to enroll in a SHOP due to their eligibility for health care free of charge from the federal government. Such employees will naturally require more time to examine health plans and establish that SHOP plans offer a worthwhile benefit to them and their families.

In light of these considerations, we suggest that CMS retain the sixty-day enrollment period for SHOP plans following a triggering event; at the very least, the extended enrollment period should apply until January 1, 2015 (concurrent with the proposed restricted employee plan choice provisions) in order to give employees an opportunity to familiarize themselves with the SHOP program.

Thank you in advance for consideration of these recommendations as we jointly work to advance the health status of American Indian and Alaska Native individuals and communities across the United States.

Thank you once again for providing an opportunity to comment on the Proposed Rule. Please contact Jennifer Cooper, jcooper@nihb.org if you would like to discuss the issues addressed in this comment.

Sincerely,

Valerie Davidson

Chair, TTAG