Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

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September 16, 2011

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9983-P
P.O. Box 8010
Baltimore, MD 21244-8010

RE: Comments on CMS-9983-P: Establishment of Consumer Operated and Oriented Plan (CO-OP) Program

I write on behalf of the Tribal Technical Advisory Group (TTAG) to the Centers for Medicare and Medicaid Services (CMS) regarding the "Establishment of Consumer Operated and Oriented Plans (CO-OP) Program" (CMS-9983-P; Proposed Rule). The TTAG advises CMS on Indian health policy issues involving Medicare, Medicaid, the Children's Health Insurance Program, and any other health care program funded (in whole or part) by CMS. [1] 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/AN) 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 (I/T/U).

We appreciate the opportunity to comment on this Proposed Rule. A number of tribal organizations are considering the pros and cons of establishing a health insurance plan that would be offered through an Exchange. To a significant degree, the way the CO-OP Program is structured will influence this decision making.

As requested, the comments offered here reference the specific section on which a comment is made, and the comments are presented in the general order of the sections in the Proposed Rule.

[1] Sec. 5006(e) of the American Recovery and Reinvestment Act codifies in statute, at sections 1902(a)(73) and 2107(e)(1)(C) of the Social Security Act, the requirement for the Secretary of Health and Human Services to maintain a Tribal Technical Advisory Group within CMS and the requirement that States seek advice from Tribes on a regular and ongoing basis where one or more Indian health program or urban Indian organization furnishes health care services.

I. Background

C. Purpose of the Consumer Operated and Oriented Plan (CO–OP) Program

Section 1322(b)(2) of the Affordable Care Act[2] directs CMS to ensure that there is sufficient funding to establish at least one qualified nonprofit health insurance issuer in each State and the District of Columbia. It permits CMS to fund additional qualified nonprofit health insurance issuers in any State if the funding is sufficient to do so. If no entities in a State apply, CMS may use funds to encourage the establishment of a qualified nonprofit health insurance issuer in the State or the expansion of another qualified nonprofit health insurance issuer. Under the CO-OP Program, CMS is to give priority to organizations capable of offering CO-OP qualified health plans on a State-wide basis. The overall goal of the CO-OP Program, as indicated in the Proposed Rule, is "to expand the number of qualified health plans available in the Exchanges with a focus on integrated care and greater plan accountability." [3]

The TTAG recommends that the Proposed Rule be modified to indicate that, in order to achieve the goal of expanding the number of health plans available in regions of the country comprised largely of Indian reservations and other tribally-controlled land, priority also will be given to funding at least one, and preferably more than one, CO-OP health plan sponsored by an Indian Tribe, tribal organization, or an Indian Controlled Managed Care Entity under section 5006(d)(1) of the American Recovery and Reinvestment Act.[4]

In giving priority to funding tribally-sponsored CO-OP health plans, CMS should also give favorable consideration to the potential need of tribally-sponsored CO-OP health plans to limit the service area of the plan to primarily encompass Indian reservations and other tribally-controlled lands, and areas adjacent to these Indian reservations and other tribally-controlled lands.[5] A clear final rule, stating that this funding priority exists and that CMS allows non-Statewide service areas for tribally-sponsored plans, will help Tribes as they assess whether their investment of time and effort will be reciprocated with an offer of flexibility and partnership from CMS.

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[2] Refers collectively to the Patient Protection and Affordable Care Act (Pub. L. 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), and referred to herein as the Affordable Care Act or ACA.

[3] Federal Register, Vol. 76, No. 139, Wednesday, July 20, 2011, page 43246, "B. Statement of Need, Health Insurance Markets and CO-OP Plans."

[4] Section 5006(d)(1) of the American Recovery and Reinvestment Act established a new section 1932(h)(4)(B) of the Social Security Act, titled "Rules Applicable Under Medicaid and CHIP to Managed Care Entities with Respect to Indian Enrollees and Indian Health Care Providers, and Indian Managed Care Entities."

[5] In the narrative on CO-OP Standards under § 156.515 and discussed on pages 43243 – 43244, it is recognized that CO-OP health plans may have a "market area" that is a subset of the overall geographic market covered by an Exchange.

II. Provisions of the Proposed Regulation

§ 156.510 C. Eligibility

2. Exclusions from Eligibility

Under § 156.510, paragraph (b)(1)(ii) codifies that, if an organization is sponsored by a State or local government, any political subdivision thereof, or any instrumentality of such government or political subdivision, it is not eligible to be a CO-OP and cannot apply for a loan under the CO-OP program.

We concur and appreciate the confirmation that "[t]his prohibition would not apply to Indian tribes" as an Indian tribe is neither a State nor a local government.

§ 156.515 D. CO–OP Standards

3. Requirements to Issue Health Plans and Become a CO–OP

The CO-OP Advisory Board recently recommended that CMS include provisions in the Proposed Rule that give CO-OP health plans maximum flexibility, within the boundaries set by the Affordable Care Act and other pertinent Federal laws, in setting up and operating these plans.[6] The TTAG strongly encourage CMS to heed this advice, and accordingly recommends the inclusion of a new paragraph (e) at the end of § 156.515, that reads:

> (e) *Application of requirements to tribally-sponsored health plans.* To the extent necessary to facilitate the sponsorship of a CO-OP health plan by Indian Tribes, tribal organizations, or an Indian Controlled Managed Care Entity under section 5006(d)(1) of the American Recovery and Reinvestment Act, maximum flexibility within the boundaries set by statute will be provided in the consideration and application of this regulation and other applicable laws and regulations.

§ 156.520 E. Loan Terms

2. Repayment Period

The Proposed Rule, under § 156.520, paragraph (b), Repayment Period, proposes to codify five year and fifteen year repayment periods, respectively, for the Start Up Loans and Solvency Loans. Under (b)(3), it is further indicated that "Changes to the loan terms, including the repayment periods, may be executed if CMS determines that the loan recipient is unable to repay the loans as a result of State reserve requirements, solvency regulations, or requisite surplus note arrangements or without compromising coverage stability, member control, quality of care, or market stability."

[6] Report of the Federal Advisory Board on the Consumer Operated and Oriented Plan (CO-OP) Program, April 15, 2011, Summary of Recommendations, page 6. Also, see "B. Statement of Need, Health Insurance Markets, and CO-OP Plans" on page 43246 of the *Federal Register*, published July 20, 2011.

The TTAG concurs with the intent of and the proposed language in paragraph (b)(3). The TTAG recommends, though, that "market competition" be added to the above list of considerations. In certain areas of the country where few (if any) health plans actively work to meet the needs of American Indians and Alaska Natives, the departure of one otherwise functioning CO-OP health plan due to a loan repayment issue could significantly reduce competition. Reducing competition will result in higher premiums and potentially diminish the quality of services offered by the remaining plans. This, in turn, will disproportionately affect American Indian and Alaska Native populations.

3. Interest Rates

Under § 156.520, Loan Terms, paragraph (c) indicates that for the Start Up Loans and Solvency Loans the "interest rate will be determined based on the date of award." In the narrative, the Proposed Rule indicates that "CMS proposes that loan recipients pay an interest rate benchmarked to the average interest rate on marketable Treasury securities of similar maturity" but that "CMS is considering reductions to the benchmarked rate for Start-Up Loans and Solvency Loans to make it easier for new CO-OPs to repay their loans." (*Federal Register*, page 43245)

In order to encourage CO-OP plans to operate in AI/AN communities and offer services to otherwise underserved populations, The TTAG recommends that CMS allow for reductions to the benchmarked rate where doing so will increase the likely entry and potential success of a CO-OP plan in markets where there is inadequate market competition among the health plans that are offered, or are likely to be offered, through an Exchange. The interest rates offered for the Start Up Loans and Solvency Loans could determine, in large measure, the willingness of tribal organizations and others to sponsor CO-OP plans and the ability of CO-OP plans to successfully compete with non-consumer driven Exchange plans.

5. Deeming of CO–OP Qualified Health Plans

Under § 156.520, paragraph (e), CMS proposes to codify a requirement that "[a]n Exchange must recognize a health plan offered by a loan recipient as an eligible participant of the Exchange if it is deemed certified by CMS or an entity designated by CMS." A CO-OP loan recipient that is deemed certified to participate in the Exchange would be exempt from the certification procedures for each applicable Exchange. The Proposed Rule further indicates that this "deemed status" for CO-OP Program loan recipients may be for a period "of up to ten years following the life of any loan awarded to the loan recipient."

This provision is critically important for Tribes, as recognizing the applicability and supremacy of federal law, and the correct application of the same, will remove a potential barrier to the tribal-sponsorship of health plans and ensure that Tribes are not subjected to burdensome, state-specific attempts to regulate Tribal plans. The TTAG notes that American Indian law and programs are almost exclusively Federal; the pertinent Federal laws apply to all Federally-recognized Tribes in all States; and these Federal laws and the associated implementing regulations have supremacy over State laws and regulations. Furthermore, a host of Federal laws and regulations govern Tribes and Indian Health Care Providers[7] and impact the structure and policies of such providers. These Federal laws and regulations (including, but not limited to, the Indian Health Care Improvement Act, the Federal Tort Claims Act and the Anti-Deficiency Act[8]) will impact tribally-sponsored CO-OP health plans as well. For all of these reasons, a prominent Federal role in the "deeming" process is particularly appropriate and welcome.

Tribes and American Indian and Alaska Native persons will not be the only ones benefiting from the Federal review and certification of tribally-sponsored CO-OP health plans. State-run Exchanges will be able to rely upon the determinations of the Federal government in the application of Indian-specific laws to these tribally-sponsored CO-OP health plans. Similarly, States will be able to emulate the Federal approach to tribally-sponsored CO-OP health plans when considering applications by Tribes for non-CO-OP, tribally-sponsored health plans. Finally, State-run Exchanges will be able to draw upon the examples provided by the tribally-sponsored and Federally-certified CO-OP health plans to identify the appropriate application of Federal Indian-specific laws to the extent they apply to other State-regulated health plans that are contracting with Indian Health Providers and/or serving American Indian/Alaska Native people.

In terms of specific suggestions, we recommend clarifying the Proposed Rule to indicate that "following the life of a loan" (in § 156.520, paragraph (e) of the Proposed Rule) means that the ten year maximum deeming period is calculated beginning from the date the loan is repaid by the loan recipient, not from the initial date the loan is made to a CO-OP loan recipient. The TTAG also recommends exempting deemed CO-OP

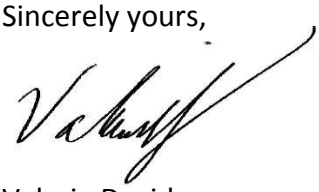
[7] The term "Indian Health Care Provider" means the Indian Health Service (IHS), an Indian tribe, tribal organization or urban Indian organization, and are sometimes referred to as "I/T/U". The term "Indian Health Service" means the agency of that name within the U.S. Department of Health and Human Services established by Sec. 601 of the Indian Health Care Improvement Act (IHCIA), 25 USC §1661. The term "Indian tribe" has the meaning given that term in Sec. 4 of the IHCIA, 25 USC §1603. The term "tribal organization" has the meaning given than term in Sec. 4 of the IHCIA, 25 USC §1603. The term "urban Indian organization" has the meaning given that term in Sec. 4 of the "IHCIA", 25 USC §1603.

[8] A more complete listing of the Federal laws and regulations affecting Indian Health Care Providers can be found in the Indian Addendum proposed by NIHB, the Tribal Technical Advisory Group to CMS (TTAG), and others to be used by Exchange plans when contracting with Indian Health Care Providers. (Refer to the letter and the attached draft Indian Addendum from TTAG to Dr. Donald Berwick dated April 13, 2011 titled "Indian Health Addendum for ACA Exchange Plan Provider Network Contracts".) Also, see the discussion on the value of an Indian Health Addendum on page 41900 of the Federal Register contained in the Proposed Rule on Establishment of Exchanges and Qualified Health Plans (CMS-9989-P), published July 15, 2011.

qualified health plans sponsored by an Indian Tribe, tribal organization or an Indian Controlled Managed Care Entity from the time limitations in the proposed rule. The TTAG suggests that once deemed by CMS, these plans keep their deemed status unless or until affirmatively revoked.

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.

Sincerely yours,



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