



Tribal Technical Advisory Group



To the Centers for Medicare & Medicaid Services

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Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: Comments on CMS-9944-P; Notice of Benefits and Payment Parameters for 2016

This letter is sent on behalf of the Tribal Technical Advisory Group (TTAG) of the Centers for Medicare and Medicaid Services (CMS) regarding the proposed rule titled “Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016” (CMS-9944-P; Proposed Rule), published in the Federal Register on November 26, 2014. This Proposed Rule requested comments on a range of provisions involving the implementation and administration of the Patient Protection and Affordable Care Act (Affordable Care Act or ACA), primarily for the 2016 coverage year.

TTAG advises CMS on Indian health policy issues involving Medicare, Medicaid, the Children’s Health Insurance Program, and any other health care programs funded (in whole or part) by CMS. In particular, 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 (IHS), Indian Tribes, tribal organizations, and urban Indian organizations (referred to as I/T/Us, Indian health care providers, or IHCPs).¹

We appreciate the opportunity to provide comments on the Proposed Rule. In addition, the TTAG would like to express its appreciation for the attention paid in this Proposed Rule to

¹ In this letter, the term “American Indians and Alaska Natives” is used to describe all persons eligible for services from an Indian Health Care Provider. The term “Indian” is used to describe individuals who meet the definition of Indian as found in the Affordable Care Act.

prior comments made to CMS by TTAG, in particular those addressing the need for greater information on Indian-specific cost-sharing protections and the need to foster inclusion of Indian health care providers (IHCPs) in Qualified Health Plan (QHP) networks.² We do believe, though, that additional modifications are warranted to simplify and clarify the proposed language, which will result in a better understanding of the provisions, and subsequently lead to increased compliance with the provisions.

Summary of Recommendations

In summary, we are recommending the following:

- Recommendation 1: Retain the proposed requirement for QHP issuers to provide a Summary of Benefits and Coverage (SBC) that accurately represents each plan variation.
- Recommendation 2: Encourage issuers to prepare an SBC for use during the 2015 benefit year but no later than the first day of the Exchange open enrollment period for the 2016 benefit year.
- Recommendation 3: Add a cross-reference to the requirement to prepare an SBC in the regulation on SBCs (45 § 147.200).
- Recommendation 4: In the preamble to the Final Rule on CMS-9944, and in subsequent guidance documents, provide examples of when SBCs are to be issued in order to comply with the requirements set forth in § 147.200 and § 156.420(h) and the circumstances, if any, under which a single SBC can satisfy the requirement for multiple plans.
- Recommendation 5: Retain the proposed § 155.605(g)(6)(iii) codifying the newly-established exemption claiming process for IHS-eligible persons.
- Recommendation 6: Re-commit CMS attention to fixing the paper-based exemption application process through the Federally-facilitated Marketplaces by allocating sufficient resources and making the current status of individual applications—as well as applications in the aggregate—more transparent.
- Recommendation 7: Retain the provision correcting the cross-reference to the definition of Indian under 42 § 447.51.

² IHCPs also referred to as Indian Health Service, Indian Tribes, Tribal organizations, and urban Indian organizations providers, or I/T/Us.

- Recommendation 8: Retain the proposal to require QHP issuers to offer contracts to all IHCPs in the QHP service area.
- Recommendation 9: At a minimum, maintain the minimum standard of contracting with at least 30 percent of available essential community providers (ECPs) at least until such time as it has been demonstrated quantitatively that enrollees have reasonable and timely access to health services.
- Recommendation 10: Retain the provision that contract offers to IHCPs be made “in good faith” but—
 - Clarify that the minimum payment rate provision to be included is a requirement, rather than an “expectation”; and
 - Include the minimum payment rate provision in the proposed regulation, rather than limiting the directive to the preamble to the Proposed Rule.
- Recommendation 11: Modify the language referencing the use of the QHP Addendum to make it consistent with the wording of the CCIO 2015 Issuer Letter.
- Recommendation 12: Strengthen the “alternative standard” for QHP issuers to comply with the clearly stated requirements of the Affordable Care Act by—
 - Adding a requirement that the QHP issuer indicate what efforts have been taken to date to meet the ECP standard; and
 - Making publicly available the QHP issuer’s narrative description of efforts taken to date, as well as the QHP issuer’s plan on “how the plan’s provider network will be strengthened toward satisfaction of the ECP standard prior to the start of the benefit year.”
- Recommendation 13: Add language in the preamble to the Final Rule “urging” State-based Exchanges to apply the IHCP contracting standards to QHPs offered through State-based Exchanges.
- Recommendation 14: Implement the tribal recommendations to eliminate the potential for an increase in the aggregate premiums and to prevent shifting of out-of-pocket (OOP) liabilities to non-Indian family members that were made in comment letters on CMS-9964-P in December of 2012, as the concerns stated in the earlier comment letter are still at issue, and as CMS indicated its willingness to consider doing so for the 2016 benefit year or, as an alternative to recommendation 14, implement recommendation 15.

- Recommendation 15: Until such time as recommendation 14 is implemented, or as an alternative to recommendation 14, provide as an administrative convenience the ability of other IHS-eligible family members to enroll in the same zero cost-sharing variation or limited cost-sharing variation in which Indian members of the family are eligible to be enrolled.
- Recommendation 16: Codify the current operational provision permitting non-Indian dependents to enroll with an individual who is eligible for the Monthly Special Enrollment Period (SEP) as an Indian.
- Recommendation 17: Retain the provision clarifying that the maximum out-of-pocket costs for an individual, whether in self-only coverage or in a family plan, is \$6,850 in 2016.

Analysis and Recommendations

ISSUE 1: Summary of Benefits and Coverage: CMS is proposing to establish a requirement that QHP issuers prepare a Summary of Benefits and Coverage (SBC) for each plan variation, such as the “zero cost-sharing variation” and the “limited cost-sharing variation”. [§ 156.420]

On May 29, 2014, the TTAG sent a letter to Center for Consumer Information and Insurance Oversight (CCIIO) Director Mandy Cohen requesting the addition of a requirement that QHP issuers prepare an SBC for each plan variation of a Qualified Health Plan (QHP).³ The May 29 letter was generated as a follow-up to discussions with CMS on the topic. Previously, on May 12, 2014, TTAG submitted similar comments in response to CMS-10320, a Paperwork Reduction Act notice on “Health Care Reform Insurance Portal Requirements.”⁴

PROPOSED REGULATION: CMS is proposing to add the following regulatory language:

“§ 156.420 Plan variations. * * * * (h) *Notice.* No later than the first day of the Exchange open enrollment period for the 2016 benefit year, for each plan variation that an issuer offers in accordance with the rules of this section, an issuer must provide a summary of benefits and coverage that accurately represents each plan variation consistent with the requirements set forth in § 147.200 of this subchapter.” [Emphasis added.]

³ <http://www.nihb.org/tribalhealthreform/wp-content/uploads/2014/07/TTAG-Letter-to-CCIIO-QHPs-and-AI-AN-CS-Var-2014-05-20d.pdf>

⁴ <http://www.nihb.org/tribalhealthreform/wp-content/uploads/2014/07/Comments-on-CMS-10320-OCN-0938-1086-Health-Care-Reform-Insurance-Portal-Requirements.pdf>

We strongly support the addition of the requirement at 45 § 156.420 for issuers of QHPs to prepare and make available for the 2016 benefit year an SBC for each plan variation, including the “zero cost-sharing variation” (for persons eligible under § 155.350(a)) and the “limited cost-sharing variation” (for persons eligible under § 155.350(b)).

To date, information on Indian-specific cost-sharing protections provided by health plans to consumers, if any, is oftentimes confusing or incorrect.

In many cases, issuers have not prepared any SBCs explaining the zero cost-sharing or limited cost-sharing variations. In these instances, potential QHP enrollees have available only the general SBC. The general SBC appears to indicate to Indians (erroneously) that they will be required to contribute substantial out-of-pocket (OOP) payments in order to access health services. When potential Indian enrollees have an understanding of the cost-sharing protections that are available to them, but the available, general SBC contradicts their understanding of the cost-sharing provisions that they are eligible to receive, uncertainly results. Not surprisingly, some Indians have chosen not to enroll in coverage through a Marketplace because of the lack of accurate information.

In other cases, issuers have attempted to describe the Indian-specific cost-sharing protections but have done so using a non-SBC format and issuing just one document to describe multiple plans—and possibly multiple products—on multiple metal levels. This gives the impression that there is one “Indian” plan available through a Marketplace, rather than (two) Indian-specific cost-sharing variations for each plan that varies with regard to provider network or benefits.⁵

And finally, when issuing documents (whether using the SBC template or not), plan issuers have sometimes inaccurately described the Indian-specific cost-sharing protections. For example, in the attached document issued by Premera Blue Cross Blue Shield in Washington State for the 2014 coverage year, the document indicates—erroneously—that under this “AI/AN” Preferred Provider Organization (PPO) QHP there are substantial deductibles and copayments for essential health benefits (in addition to possible balance billing charges) when an Indian of any income level is seen by non-network providers.⁶ However, an individual eligible for a limited cost sharing plan should not have these costs if they obtain

⁵ In §144.103, the Proposed Rule contains a revision to the definition of “plan” to make clear that plans that differ in their cost-sharing requirements (such as co-payments, coinsurance or deductibles), or that have different networks of contracted providers or different service areas, are considered to be different plans. The definition of “plan” was previously codified in the 2015 Market Standards Rule (CMS-9949-F) issued on May 16, 2014.

⁶ See Attachment A, “Premera Blue Cross Preferred Bronze 5500/6350 AI / AN”.

Contract Health Service (CHS) referrals from their I/T/U facility, and an individual eligible for a zero cost-sharing plan does not need a referral from an I/T/U.

In contrast to the above examples, when an issuer provides an SBC accurately describing an Indian cost-sharing variation for a plan, potential enrollees have access to critical and useful information. An example of this is an SBC issued by Moda Health for coverage in Alaska for the 2015 coverage year.⁷ The SBC issued for this PPO plan type indicates that there is no deductible and that there are no cost-sharing requirements for an Indian whether seen by in-network or out-of-network providers, and it allows Indians to make an informed decision about which plan to choose. In some instances when such information is not available, an Indian individual or family might choose a higher cost plan because cost-sharing may be reportedly lower (bronze versus a silver plan) in the SBC. Requiring QHP issuers to provide a SBC for each plan variation will avoid this confusion and likely encourage more Indian people to enroll in the Marketplace.

- **Recommendation 1: Retain the proposed requirement for QHP issuers to provide an SBC that accurately represents each plan variation.**
- **Recommendation 2: Encourage issuers to prepare SBCs for use during the 2015 benefit year but no later than the first day of the Exchange open enrollment period for the 2016 benefit year.** In the preamble to the Proposed Rule, CMS noted, “We seek comments on whether the proposed applicability date would present implementation challenges for QHP issuers as well as on other aspects of this proposal.” As stated above, the current absence of an SBC for each plan variation impedes a potential enrollee’s ability to evaluate plan options. We would like to stress that the preparation of the SBCs for all plan variations should not be delayed further.
- **Recommendation 3: Add a cross-reference to the requirement to prepare an SBC in the regulation on SBCs (45 § 147.200).** Currently, the proposal to add a requirement to prepare an SBC for each plan variation is to be inserted only in the regulatory section on plan variations (45 § 156.420). Adding a cross-reference in the section on SBCs will strengthen the knowledge of, and compliance with, the requirement.

⁷ See Attachment B, “Moda Health Plan, Inc.: Be Adventurous CSV0 (Select) (Bronze) Coverage Period: 01/01/2015 – 12/31/2015”. In this example, though, Moda Health used the indicator “CSV0” to describe both the zero cost-sharing variation and the limited cost-sharing variation rather than issue a version describing the “02” version and a separate document describing the “03” version, or issuing a combined document but indicating the requirement to secure a referral from contract health services when receiving services at a non-Indian health care provider.

Suggested language to be added to the existing §147.200 is shown in brackets and bold below:

“§147.200 Summary of benefits and coverage and uniform glossary. (a) Summary of benefits and coverage—(1) In general. A group health plan (and its administrator as defined in section 3(16)(A) of ERISA), and a health insurance issuer offering group or individual health insurance coverage, is required to provide a written summary of benefits and coverage (SBC) for [each plan variation of] each benefit package[, as indicated in §156.420(h)] without charge to entities and individuals described in this paragraph (a)(1) in accordance with the rules of this section.

- **Recommendation 4:** In the preamble to the Final Rule on CMS-9944, and in subsequent guidance documents, **provide examples of when SBCs are to be issued in order to comply with the requirements set forth in § 147.200 and § 156.420(h) and the circumstances, if any, under which a single SBC can satisfy the requirement for multiple plans.** Given the codification of the definition of “plan” earlier this year, and the modification to the definition contained in the Proposed Rule, as well as the complexity of the relationship of a plan to an issuer’s product, there is likely to be continued uncertainty as to when a separate plan variation and the associated SBC are to be established.

ISSUE 2: Hardship Exemption: The Proposed Rule codifies the newly-established exemption process for the hardship exemption from the tax penalty for IHS-eligible persons. [§ 155.605(g)(6)(iii)]

Over the past three years, tribal representatives have made numerous requests, first, to establish an exemption from the tax penalty for all AI/ANs and, second, to provide AI/ANs with the ability to apply for and/or claim an exemption through a Marketplace or solely through the Federal tax-filing process.⁸

The Department of the Treasury, as well as HHS, announced earlier this year that the two departments will align the exemption processes for members of Federally-recognized Tribes and those for individuals who are eligible for services through an Indian health care provider (IHCP). CMS is proposing to add the following regulatory language to codify the policy:

PROPOSED REGULATION: § 155.605 Eligibility standards for exemptions. (6) * * * (i)

The Exchange must determine an applicant eligible for an exemption for any month if he

⁸ See TTAG comments on “Patient Protection and Affordable Care Act; Exchange Functions: Eligibility for Exemptions; Miscellaneous Minimum Essential Coverage Provisions” filed on March 18, 2013.

or she is an Indian eligible for services through an Indian health care provider, as defined in 42 CFR 447.51 and not otherwise eligible for an exemption under paragraph (f) of this section, or an individual eligible for services through the Indian Health Service in accordance with 25 U.S.C. 1680c(a), (b), or (d)(3). * * * * (iii) The IRS may allow an applicant to claim the exemption specified in paragraph (g)(6) of this section without obtaining an exemption certificate number from an Exchange.”

We strongly support the provisions in the Proposed Rule to provide two avenues to apply for and/or claim an exemption from the tax penalty for American Indians and Alaska Natives.

Current CMS regulations need to be updated to be consistent with the revised IRS regulations. Under current CMS regulations, members of Federally-recognized Tribes can apply for an exemption from the shared responsibility payment directly from the Exchange, or they can claim the exemption when they file their tax returns without applying for an exemption from the Exchange. However, those who are applying for a hardship exemption based on their eligibility to receive services from an IHCP are required to submit an exemption application to the Exchange and are not allowed to simply claim an exemption on their Federal taxes without first securing an Exemption Certificate Number (ECN).

These varying application requirements (for members of Federally-recognized tribes versus other IHCP-eligible persons) are confusing and disruptive to AI/AN families (for example, as federal taxes would not be able to be filed until an ECN is secured for those AI/AN family members who do not meet the definition of Indian under the Affordable Care Act), and they greatly increase the time and resources associated with assisting AI/AN families to comply with these requirements.

The proposed amendment would make the CMS regulations consistent with the Internal Revenue Service regulations which provide individuals who are eligible for services through an IHCP with the same two exemption process options as are available to AI/ANs who meet the definition of Indian under the Affordable Care Act by also permitting IHCP-eligible persons to claim the exemption on their Federal income tax returns without first obtaining an ECN.

It is important to note, though, that the Marketplace application process whereby an Indian or other AI/AN is able to secure a permanent ECN will continue to be preferred and used by some AI/ANs.⁹ Sadly, the experience has been problematic for many AI/ANs who have used the existing paper-based ECN application process through a Marketplace over the past year.

⁹ Through the Federal tax-filing process, eligible individuals are able to claim an exemption from the ACA’s tax penalty but are not able to secure an exemption certificate number.

Rather than abandon the Marketplace application process because a second exemption application process is being established, the Marketplace application process needs to be fixed.

- **Recommendation 5: Retain the proposed § 155.605(g)(6)(iii) in the Final Rule codifying the newly-established exemption claiming process for IHS-eligible persons.**
- **Recommendation 6: Re-commit CMS attention to fixing the paper-based exemption application process through the Federally-facilitated Marketplaces by allocating sufficient resources and making the current status of individual applications—as well as applications in the aggregate—more transparent.**

ISSUE 3: Code Citation to the Definition of Indian Under Medicaid: The Proposed Rule updates a cross-reference to the definition of Indian under Medicaid for purposes of defining who is eligible for the hardship exemption for IHCP-eligible persons.

In the Proposed Rule, CMS proposes to amend § 155.605(g)(6)(i) to correct the citation to 42 § 447.50 by changing it to 42 § 447.51, which cross-references the definition of Indian used for Medicaid purposes.

CMS is proposing to add the following regulatory language:

PROPOSED REGULATION: § 155.605 Eligibility standards for exemptions. (6) * * * (i) The Exchange must determine an applicant eligible for an exemption for any month if he or she is an Indian eligible for services through an Indian health care provider, as defined in 42 CFR 447.51 and not otherwise eligible for an exemption under paragraph (f) of this section, or an individual eligible for services through the Indian Health Service in accordance with 25 U.S.C. 1680c(a), (b), or (d)(3). * * * * (iii) The IRS may allow an applicant to claim the exemption specified in paragraph (g)(6) of this section without obtaining an exemption certificate number from an Exchange.” (Emphasis in underline added.)

The cross-reference became inaccurate when CMS restructured § 447.50. The location of the definition of Indian used for Medicaid purposes is now contained in § 447.51.

- **Recommendation 7: Retain the provision correcting the cross-reference to the definition of Indian under 42 § 447.51.**

ISSUE 4: Network Adequacy and Essential Community Provider Provisions: The Proposed Rule codifies some of the network adequacy and essential community provider (ECP) provisions from the CCIIO 2015 Issuer Letter that apply solely under the FFM and include:

(a) Codifying the requirement that QHP issuers offer contracts to all Indian health care providers (IHCPs);

(b) Requiring/encouraging “good faith” offers pertaining to payment rates;

(c) Adding a requirement that QHP-IHCP contracts apply the special terms and conditions under Federal law pertaining to IHCPs (which are contained in the QHP Addendum); and

(d) Applying the requirement that QHP issuers offer contracts to IHCPs.

In the draft CCIIO 2015 Issuer Letter released on February 4, 2014, CMS stated the following:¹⁰

“i. Evaluation of Network Adequacy with respect to ECP

ECP Standard: **We intend to propose in rulemaking** that an application for QHP certification adhere to a general ECP inclusion standard in order to meet the regulatory standard established at 45 C.F.R. 156.235(a) without further documentation. If finalized, we intend for certification year 2015 to utilize a general ECP standard whereby the application would first have to demonstrate that at least 30 percent of available ECPs in each plan’s service area participate in the provider network. We also intend to propose that, in addition to achieving a level of 30 percent participation of available ECPs, **the issuer would have to offer contracts in good faith prior to the benefit year to:**

All available Indian health providers in the service area, using the model QHP Addendum for Indian health providers developed by CMS ...

To be offered in good faith, a contract should offer terms that a willing, similarly-situated, non-ECP provider would accept or has accepted.” (Emphasis added.)

As shown above (in bold), CMS stated its intention in the draft CCIIO 2015 Issuer Letter to propose subsequent rulemaking that requires, as a condition for QHP certification, that QHP issuers “offer contracts in good faith ... to: All available [IHCPs] in the service area, using the model QHP Addendum for [IHCPs] developed by CMS.”

In the final CCIIO 2015 Issuer Letter issued on March 14, 2014, the references to promulgating rules were removed, but the stated requirement on QHP issuers to offer contracts to all available IHCPs in the QHP’s service area, and to do so using the model QHP

¹⁰ See “Draft 2015 Letter to Issuers in the Federally-facilitated Marketplaces”, February 4, 2014, pp. 20-21.

Addendum and including payment rates that meet a minimum standard, was retained.¹¹
The final CCIIO 2015 Issuer Letter reads:

“In addition, and as required for the prior year, we expect that the issuer offer contracts in good faith to:

- All available Indian health providers in the service area, to include the Indian Health Service, Indian Tribes, Tribal organizations, and urban Indian organizations, using the recommended model QHP Addendum for Indian health providers developed by CMS ...”

The final CCIIO 2015 Issuer Letter continued with the following:

“As part of the issuer’s QHP application, we expect that the issuer list the contract offers that it has extended to all available Indian health providers and at least one ECP in each ECP category in each county in the service area. **To be offered in good faith, a contract should offer terms that a willing, similarly-situated, non-ECP provider would accept or has accepted.** We would expect issuers to be able to provide verification of such offers if CMS chooses to verify the offers.” (Emphasis added.)

In contrast to the draft CCIIO 2015 Issuer Letter and the final CCIIO 2015 Issuer Letter, the Proposed Rule codifies some but not all of the ECP-related provisions in the Issuer Letter.

The preamble, and subsequently the proposed regulation, in the Proposed Rule read as follows:

PREAMBLE:¹² “[W]e propose in paragraph (a)(2)(ii) of this section that, to satisfy the general ECP standard, the issuer of the plan seeking certification as a QHP in an FFE would be required to offer contracts for participation in the plan for which a certification application is being submitted to the following: (1) All available Indian health providers in the service area, applying the special terms and conditions necessitated by Federal law and regulations as referenced in the recommended model QHP addendum for Indian health providers developed by HHS; and (2) at least one ECP in each ECP category (see Table 10) in each county in the service area, where an ECP in that category is available and provides medical or dental services that are covered by the issuer plan type. We expect that issuers will offer contracts in good faith. **A good faith contract should offer the same rates and contract provisions as other contracts**

¹¹ The model QHP Addendum for IHCPs is available at <http://www.cms.gov/cciio/programs-and-initiatives/health-insurance-marketplaces/qhp.html>.

¹² 79 Fed Reg 70727.

accepted by or offered to similarly situated providers that are not ECPs.” (Emphasis added.)

PROPOSED REGULATION:¹³ “§ 156.235 Essential community providers.

(a) General ECP standard.

(1) A QHP issuer that uses a provider network must include in its provider network a sufficient number and geographic distribution of essential community providers (ECPs), where available, to ensure reasonable and timely access to a broad range of such providers for low income individuals or individuals residing in Health Professional Shortage Areas within the QHP’s service area, in accordance with the Exchange’s network adequacy standards.

(2) A plan applying for QHP certification to be offered through an FFE has a sufficient number and geographic distribution of ECPs if it demonstrates in its QHP application that—

(i) The network includes as participating providers at least a minimum percentage, as specified by HHS, of available ECPs in each plan’s service area with multiple providers at a single location counting as a single ECP toward both the available ECPs in the plan’s service area and the issuer’s satisfaction of the ECP participation standard; and

(ii) The issuer of the plan offers contracts to—

(A) All available Indian health providers in the service area, applying the special terms and conditions necessitated by federal law and regulations as referenced in the recommended model QHP addendum for Indian health providers developed by HHS; and

(B) At least one ECP in each of the five ECP categories (Federally Qualified Health Centers, Ryan White Providers, Family Planning Providers, Indian Health Providers, Hospitals and other ECP providers) in each county in the service area, where an ECP in that category is available and provides medical or dental services that are covered by the issuer plan type.

(3) If a plan applying for QHP certification to be offered through an FFE does not satisfy the ECP standard described in paragraph (a)(2) of this section, the issuer must

¹³ 79 Fed Reg 70758.

include as part of its QHP application a narrative justification describing how the plan’s provider network provides an adequate level of service for low-income enrollees or individuals residing in Health Professional Shortage Areas within the plan’s service area and how the plan’s provider network will be strengthened toward satisfaction of the ECP standard prior to the start of the benefit year.” (Emphasis added.)

The “good faith” effort standard pertaining to payment rates is not worded as a requirement (rather an “expectation”), and it is not contained in the regulatory language, but solely the preamble to the Proposed Rule.

In addition to the IHCP-specific policy, the general ECP policy requires that QHPs have a sufficient number and geographic distribution of ECPs in the QHP’s network to ensure reasonable and timely access to a broad range of ECPs. According to the CCIIO 2015 Issuer Letter, QHP issuers are to have at least 30 percent of available ECPs in each plan’s service area in their network.

- **Recommendation 8: Retain the proposal to require QHP issuers to offer contracts to all IHCPs in the QHP service area.**
- **Recommendation 9: At a minimum, maintain the minimum standard of contracting with at least 30 percent of available ECPs at least until such time as it has been demonstrated quantitatively that enrollees have reasonable and timely access to *health services*.**
- **Recommendation 10: Retain the provision that contract offers to IHCPs be made “in good faith” but—**
 - **Clarify that the minimum payment rate provision to be included is a requirement rather than an “expectation”; and**
 - **Include the minimum payment rate provision in the proposed regulation rather than limiting the directive to the preamble to the Proposed Rule.**
- **Recommendation 11: Modify the language referencing the QHP Addendum to make it consistent with the wording of the CCIIO 2015 Issuer Letter.** The requirement in the CCIIO 2015 Issuer Letter is for QHP issuers to “offer contracts in good faith to: All available Indian health providers in the service area, to include [IHCPs], using the recommended model QHP Addendum for [IHCPs] developed by CMS”¹⁴ (emphasis added). In contrast, the standard in the Proposed Rule is to offer contracts “applying

¹⁴ CCIIO 2015 Issuer Letter, page 19.

the special terms and conditions necessitated by Federal law and regulations as referenced in the recommended model QHP addendum for Indian health providers developed by HHS.”

In comparing the CCIIO 2015 Issuer Letter to the Proposed Rule, the Proposed Rule fails to require “using the recommended model QHP Addendum” and instead requires “applying the special terms and conditions necessitated by federal law and regulations as referenced in the recommended model QHP addendum.” The difference appears to be that CCIIO is requiring in the Proposed Rule application of the Indian-specific provisions in federal law but not (as is required in the CCIIO 2015 Issuer Letter) actual use of the Indian Addendum.

If the language in the Proposed Rule is not modified to mirror the CCIIO 2015 Issuer Letter, potentially lost in the executed QHP-IHCP contracts are: (1) A listing of each Indian-specific provision in federal law that is applicable to the provider contract; and (2) a clear statement of the meaning of each applicable Indian-specific provision.

- **Recommendation 12: Strengthen the “alternative standard” for QHP issuers to comply with the clearly stated requirements of the Affordable Care Act by—**
 - **Adding a requirement that the QHP issuer to indicate what efforts have been taken to date to meet the ECP standard; and**
 - **Making publicly available the QHP issuer’s narrative description of efforts taken to date, as well as the QHP issuer’s plan on “how the plan’s provider network will be strengthened toward satisfaction of the ECP standard prior to the start of the benefit year.”¹⁵**

Section 1311(c)(1)(C) of the Affordable Care Act clearly states: “The Secretary shall, by regulation, establish criteria for the certification of health plans as qualified health plans. Such criteria shall require that, to be certified, a plan shall, at a minimum ... (C) include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals ...”

The current regulations already lessened the ECP standard contained in the ACA by requiring that QHP issuers include only a minimum percentage of available ECPs in the plan’s service area—quantified in the CCIIO 2015 Issuer Letter as 30 percent of the available ECPs—rather than all available ECPs. And, for QHP issuers that become

¹⁵ Phrase included in quotation marks taken from the Proposed Rule at 79 Fed Reg 70758.

subject to the alternative standard as they have not meet the percentage-of-ECPs standard, the requirement to include a specified percentage of ECPs, and possibly any ECPs at all, is absent. In its place, this alternative standard requires QHP issuers to prepare a narrative justification indicating that the provider network “provides an adequate level of service.”

A greater sense of urgency is needed to compel QHP issuers that do not meet the ECP standard to come into compliance with the ECP standard without delay.

➤ **Recommendation 13: Add language in the preamble to the Final Rule “urging” State-based Exchanges to apply the IHCP contracting standards to QHPs offered through State-based Exchanges.**

The Proposed Rule would apply the requirement to offer contracts to IHCPs solely under Federally-facilitated Marketplaces and not under State-based Exchanges. We would prefer that CMS apply this proposed rule to both State-operated exchanges and the Federally-facilitated exchange. In some States with State-based Exchanges, tribal representatives have had difficulty convincing the State-based Exchange representatives to apply a similar requirement, sometimes with the State representative stating that they have no direct authority from CMS to do so.

Earlier in the preamble to the Proposed Rule, CMS stated when discussing application of the “reasonable access standard” contained in the CCIIO 2015 Issuer Letter: “We urge State-based Exchanges to employ the same standard when examining network adequacy.”¹⁶ (Emphasis added.) CMS should use the same terminology to encourage State-based Exchanges to require QHP issuers to offer contracts to all IHCPs in the QHPs service area, as this might provide the stated authority that some States feel is lacking. This is particularly important for those IHCPs that might have tribal members in State-based Exchanges and also FFM states (e.g. the Navajo Nation (AZ, UT, NM); Southern Ute Tribe (CO, AZ, NM); Umatilla Tribe and Cowlitz Tribes (WA, OR); among others). These tribal members continue to rely on their IHCP for health care and bringing consistent standards to network adequacy will improve their choice in health providers.

ISSUE 5: Application of Cost-Sharing Protections for AI/AN Families: Responses from CMS to earlier regulatory proposals indicated a willingness to address problems with the application of cost-sharing protections for families with AI/AN and non-AI/AN members beginning with the 2016 benefit year, but the Proposed Rule is silent on this issue.

¹⁶ 79 Fed Reg 70726.

In prior comments, TTAG, the National Indian Health Board, the Northwest Portland Area Indian Health Board, the Tribal Self-Governance Advisory Committee, and other tribal organizations recommended that CMS address the issue of potentially higher premiums and cost-sharing being paid as a result of families that contain family members who are AI/ANs and non-AI/ANs being required to enroll in separate plans in order for the AI/AN family members to secure the comprehensive cost-sharing protections for Indians. Specific remedies were recommended by TTAG and the other tribal organizations in comments submitted in December 2012 on CMS-9964-P, titled “HHS Notice of Benefit and Payment Parameters for 2014.”¹⁷

PREAMBLE TO 2013 FINAL RULE ON CMS-9964: In the preamble to the Final Rule on the benefit and payment parameters for 2014, the following discussion was included by CMS on these issues:¹⁸ (Emphasis added.)

“... For the reasons described in the proposed rule, and considering the comments we received, we are finalizing the policy as proposed, **though we continue to welcome comments on what approach HHS should adopt for benefit year beginning on or after January 1, 2016.**

Comment: Several commenters expressed their support for the proposed policy at §155.305(g)(3), noting that the alternative approach would be difficult to administer and would require QHP issuers to make significant changes to their claims systems because issuers today are not able to administer member-based cost-sharing rules. One commenter was concerned that it would be difficult for issuers to waive cost sharing for Indians at or below 300 percent of FPL at the point of service under the alternate approach.

Other commenters, however, expressed concern that the proposed approach would require families with Indian members and non-Indian members to purchase multiple plans in order for each family member to receive the full value of the cost-sharing reductions to which they are entitled. Commenters stated that under this policy, the cost savings available to Indians could be negated by shifting the liability to other non-eligible family members.

A number of commenters recommended a different approach to address the potential increase in costs to be paid by Indian and non-Indian members who elect to enroll in different plans in order to take full advantage of the cost-sharing reductions available to them. These commenters recommended that if family members are enrolled in separate plan variations, the combination of the premiums be required to be no greater than the premium the family would pay if all members

¹⁷ 77 Fed Reg 73118.

¹⁸ 78 Fed Reg 15493, March 11, 2013.

were enrolled in the same plan variation. They also recommended that the maximum out-of-pocket liability for the plan variation in which the non-Indians enrolled be set at a proportion of the maximum liability of a single family plan. These commenters also suggested that HHS should implement the alternative approach sooner than 2016.

Response: We will consider adopting the approach recommended by commenters for future benefit years; however, given the current timeframe and operational concerns, we believe that for the 2014 benefit year it is infeasible to require issuers to submit plan variations that take into account cost-sharing obligations for Indian and non-Indian family members covered under a single QHP policy.

Therefore, in accordance with the policy in the proposed rule that we are finalizing here, the assignment of Indians to plan variations would be subject to §155.305(g)(3). **If we propose to change the policy for years beginning in 2016, we will provide issuers with sufficient notice and opportunity to comment to effectuate the required operational change.”**

CURRENT REGULATORY LANGUAGE: The introductory paragraph to the existing regulation on families with family members eligible for different cost-sharing protections reads as follows:

§155.305(g)(3) *“Special rule for family policies.* To the extent that an enrollment in a QHP in the individual market offered through an Exchange under a single policy covers two or more individuals who, if they were to enroll in separate individual policies would be eligible for different cost sharing, the Exchange must deem the individuals under such policy to be collectively eligible only for the category of eligibility last listed below for which all the individuals covered by the policy would be eligible ...”

The regulation continues with a hierarchy ranging from individuals not eligible for changes to cost-sharing” to eligibility for individuals described in §155.350(a) (the cost-sharing rule for Indians with household incomes under 300 percent of the FPL)” —the most comprehensive of the cost-sharing protections.

As indicated above, CMS did express a willingness to consider tribal recommendations on this issue, stating that “we continue to welcome comments on what approach HHS should adopt for benefit year beginning on or after January 1, 2016.”

In addition, CMS indicated that it is the administrative complexity of the proposed remedy that impedes CMS from taking action. CMS commented, “We will consider adopting the approach recommended by commenters for future benefit years;

however, given the current timeframe and operational concerns, we believe that for the 2014 benefit year it is infeasible to require issuers to submit plan variations that take into account cost-sharing obligations for Indian and non-Indian family members covered under a single QHP policy.”

PREVIOUSLY RECOMMENDED REMEDIES: In late 2012, the TTAG recommended the following actions to address the problems with the application of cost-sharing protections for families with AI/AN and non-AI/AN members:

- Specifically, with regard to premiums, TTAG recommended that CMS ensure the sum of the premiums charged for multiple single plans (or some combination of single and/or family plans) does not exceed the premium required if all family members were enrolled in the same family plan. (When enrolling in a family plan, there is a cap on the number of children for whom a premium is charged. The cap is set at three children.) For reference, in 2015 the premium for an individual under age 21 is \$1,632 in Alabama and \$3,444 in Alaska.
 - With regard to cost-sharing reductions, TTAG recommended that CMS establish proportional out-of-pocket (OOP) liabilities under each separate (individual and/or family) plan. Together, the OOP liabilities would total the OOP amount if all members were enrolled in the same family plan (\$13,700 in 2016). Alternatively, if no adjustment to the OOP caps was made, separating family members into separate plans would subject the family members to multiple (and higher effective) out-of-pocket caps.
- **Recommendation 14: Implement the tribal recommendations to eliminate the potential for an increase in the aggregate premiums and to prevent shifting of OOP liabilities to non-Indian family members that were made in comment letters on CMS-9964-P in December of 2012, as the concerns stated in the earlier comment letter are still at issue, and as CMS indicated its willingness to consider doing so for the 2016 benefit year or, as an alternative to recommendation 14, implement recommendation 15.**

Although the recommendation made in 2012 by tribal representatives would address many of the issues associated with the current implementation of the Indian-specific cost-sharing protections for families with Indian and other IHS-eligible family members, other issues would persist. For example, the method of equalizing the OOP maximum for two family plans is very difficult to explain to people with low health insurance literacy. It would be much easier to provide messaging and enrollment assistance if all AI/AN members of the family were able to enroll in the same plan without losing

benefits that accrue to AI/ANs who meet the definition of Indian under the Affordable Care Act.

- **Recommendation 15: Until such time as recommendation 14 is implemented, or as an alternative to recommendation 14, provide as an administrative convenience the ability of other IHS-eligible family members to enroll in the same zero cost-sharing variation or limited cost-sharing variation in which Indian members of the family are eligible to be enrolled.**

Ultimately, the alternative in recommendation 15 may be the preferred approach as it is the simplest administratively for QHPs, the Marketplace and AI/AN families, and the most cost-effective to the Federal government. And, application of a consistent policy for all AI/AN family members would ease outreach and education efforts.

As CMS has done with allowing other AI/AN family members to participate in the monthly special enrollment periods with eligible Indians, simplifying the application of the cost-sharing protections as recommended here for families with Indians and other IHS-eligible persons would likewise facilitate the implementation of the Affordable Care Act. A consistent approach across all AI/AN family members was also implemented when CMS extended the ability of all family members in a family with Indians and other IHS-eligible persons to claim exemptions from the tax penalty through the tax-filing process. The ability to facilitate enrollment in the Marketplace and secure exemptions from the tax penalty for AI/AN families has been greatly enhanced by making the rules consistent across family members in these two instances. A similar result is expected if this recommendation is implemented.

With regard to cost, the added marginal cost borne by the Federal government if this recommendation is adopted appears to be only a fraction of the costs that are added to AI/AN families if this issue is not addressed.

- As described above, if required to enroll in separate QHPs in order to secure the Indian-specific cost-sharing, AI/AN families will be subject to at least two OOP caps, rather than a single OOP cap. For instance, for a family with two parents and four children (with one of the parents and two of the children meeting the ACA's definition of Indian and eligible for the limited cost-sharing protection under §155.350(b) and the other three family members IHS-eligible persons), the three individuals eligible for the Indian-specific benefits would enroll in one family plan with a \$13,700 OOP max (in 2016) and the other three family members would enroll in a separate family plan with a \$13,700 OOP max, effectively doubling the potential OOP liability incurred by the family as a whole.

- With regard to a potential increase in aggregate premium costs as a result of family members enrolling in two family plans, the example cited above would result in the payment of an additional child premium. When enrolled in one plan as a family unit, the total family premium is subject to a three child maximum. In contrast, when split across two family plans, premium payments are required for all four children.¹⁹ As noted above, the premium in 2015 for one individual under age 21 is \$1,632 in Alabama and \$3,444 in Alaska.
- In contrast, the additional costs, if any, to the Federal government would be only a fraction of the cost incurred by impacted AI/AN families.
 - According to the U.S. Census Bureau, the median income of American Indian and Alaska Native households in 2013 was \$36,252.²⁰ (This compares with \$52,176 for the nation as a whole.) At this income level, AI/AN families are already eligible for substantial cost-sharing protections under the ACA. In fact, depending on family size, this income level roughly equates to 150 percent of the federal poverty level (FPL). A family at 150 percent FPL enrolled through the Marketplace is eligible for enrollment in a silver-level plan with an actuarial value (AV) of 94 percent, and a family with household income at 200 percent FPL is eligible for enrollment in a silver-level plan with an actuarial value of 87 percent.
 - In comparison, the estimated AV of a bronze or silver-level QHP with a zero cost-sharing variation is 100 percent and the actuarial value of a bronze or silver-level QHP with a limited cost-sharing variation is only 87 percent, according to figures included in the Notice of Benefit and Payment Parameters for 2015.²¹

For AI/AN family members at 200 percent FPL who are eligible for a silver-level QHP with an AV of 87 percent, they would instead be eligible for a zero cost-sharing plan variation with an AV of 100 percent. This 13 percentage point increase equates to an average of \$530 in increased cost-sharing protections for the IHS-eligible individual.²² For a higher income AI/AN

¹⁹It is recognized that Federal premium assistance will limit how much of the additional premium amounts the family would be required to pay, but these additional premium costs – incurred solely to gain access to the Indian-specific benefits authorized in federal law – could be substantial.

²⁰ <http://www.infoplease.com/spot/aihmcensus1.html>.

²¹ 79 Fed Reg 13806.

²² This estimate is based on figures published by the Internal Revenue Service that the average annual bronze plan premium in 2014 was \$2,448.

family, enrollment in a limited cost-sharing plan variation could at most result in a change in the AV of the enrollee's plan from 70 percent to 87 percent, or a 17 percentage point increase in the portion of total health care expenditures paid for by the QHP. This is in contrast to not implementing the recommendation and having the potential for an effective doubling of the family's OOP maximum from \$13,700 to \$27,400 and the addition of one or two child premiums of approximately \$2,000 each.

- And a final point is, since the IHS-eligible family members are already eligible for services paid for by the Federal government through the Indian Health Service, the actual net cost to the Federal government would be reduced even further.

ISSUE 6: AI/AN Family Tag-Along Policy: At the request of tribal representatives, CCIIO issued guidance to enrollment assisters on November 15, 2014, indicating that family members of persons eligible for the Monthly Special Enrollment Period for Indians are permitted to enroll in Marketplace coverage with the eligible Indian.²³

The provision reads:

“Special Enrollment Periods: AI/ANs can enroll in the Health Insurance Marketplace throughout the year, not just during the yearly Open Enrollment period.

In Federally-facilitated Marketplace (FFM) states, non-tribal members applying on the same application as a tribal member can take advantage of this SEP. For State Based Marketplace states, check with the state's website for its policy.”

The Proposed Rule contains several proposed modifications to regulations on Special Enrollment Periods (§155.420) but does not contain a provision seeking to codify the CCIIO guidance on family members of eligible Indians.²⁴

- **Recommendation 16: Codify the provision permitting non-AI/AN dependents to enroll with an individual who is eligible for the Monthly SEP as an Indian. To achieve this result, CMS should modify §155.420(d)(8) to read:**

“(8) The qualified individual who is an Indian, as defined by section 4 of the Indian Health Care Improvement Act, **or his or her dependent**, may enroll in a

²³ Department of Health and Human Services, “Information and Tips for Assisters: Working with American Indians/Alaska Natives”, updated October 15, 2014.

²⁴ 78 Fed Reg 70708-10.

QHP or change from one QHP to another one time per month;” (added text shown in bold).

This recommended modification to the existing rule, if implemented, would parallel the structure of the regulations for several other SEP categories that permit family members to enroll along with the family member who is eligible for the SEP. For instance, under §155.420(d)(3), the existing regulations read:

“3) The qualified individual, **or his or her dependent**, which was not previously a citizen, national, or lawfully present individual gains such status;” (emphasis added).

By implementing this recommendation, compliance with the protection for dependents of Indians would likely be increased, as the regulatory provision would be contained in the relevant regulatory section along with other similar provisions (rather than solely in a CMS/CCIIO guidance document), and the protection afforded family members of Indians would apply in all states (including states with State-based Marketplaces), rather than just in states with an FFM.

ISSUE 7: Maximum Out-of-Pocket Costs for Individuals: In the Proposed Rule, CMS clarified (for the 2016 benefit year and beyond) that the annual limitation on cost-sharing for self-only coverage applies to all individuals, regardless of whether the individual is covered by a self-only plan or a family plan. In both cases, QHPs are prohibited from charging an individual more than the self-only annual limitation on cost-sharing (\$6,850 in 2016). Today, some high deductible QHPs impose the family deductible on individuals (which exceeds the OOP maximum permitted for an individual) prior to the plan making payments under the plan.

For Indians in limited cost-sharing plans, for other AI/ANs, and for non-Indians, this clarification will help ensure that the statutory cap on out-of-pocket costs enacted as a part of the Affordable Care Act will, in fact, be provided to all health plan enrollees.

- **Recommendation 17: Retain the provision clarifying that the maximum out-of-pocket costs for an individual, whether in self-only coverage or in a family plan, is \$6,850 in 2016.**²⁵

The TTAG appreciates the opportunity to comment on the Proposed Rule and looks forward to working with CMS and CCIIO to refine and implement the tribal recommendations.

²⁵ 79 Fed Reg 70723.

Sincerely,

A handwritten signature in black ink that reads "W. Ron Allen". The signature is written in a cursive style with a large, stylized "W" and "A".

W. Ron Allen
Co-Chair, TTAG

Cc:

Kitty Marx, Director, CMS Division of Tribal Affairs

Preferred Bronze 5500/6350 AI / AN

In Exchange Washington plans for individuals & families
Beginning January 1, 2014



BLUE CROSS

An Independent Licensee of the Blue Cross Blue Shield Association

AI/AN do not pay in-network cost shares (deductible, copay, coinsurance) if they are enrolled in a federally recognized Tribe or registered with an Alaska Native Corporation AND they are at or below 300% of the federal poverty level (FPL).

AI/AN receive healthcare services at NO cost from Tribal or urban Indian health clinics or if they are referred to an outside provider through the Indian Health, Tribal, or Urban Indian Health system.

PREFERRED BRONZE 5500/6350 AI / AN

PCY = per calendar year
Network = Heritage Signature

Annual Deductible	PCY (choose one) Family = 2x individual (In-network only)
Coinsurance	Amount you pay after your deductible is met
Out-of-Pocket Maximum	Includes deductible, coinsurance, and copays Family = 2x individual (In-network only)
Office visits	Designated PCP office visit Non-designated PCP or specialist office visit

Heritage Signature providers ≤ 300% FPL	Heritage Signature providers > 300% FPL	Non-Heritage Signature providers
\$0	\$5,500 / \$6,350	2x Individual Deductible
0%	20% / 0%	50%
\$0	\$6,350	Unlimited
\$0	\$15 / \$20 copay	Deductible, then 50%
\$0	\$45 / \$50 copay	Deductible, then 50%

10 Essential Benefits Covered Services

1 Ambulatory Patient Services	Outpatient	\$0	Deductible, then coinsurance	Deductible, then 50%
	Spinal manipulation (10 visits PCY); Acupuncture (12 visits PCY)	\$0	\$15 / \$20 copay	Deductible, then 50%
2 Emergency Services	Copay waived if directly admitted to an inpatient facility	\$0	\$250 copay, then deductible, then 20% Ambulance: Deductible, then 20%	
3 Hospitalization	Inpatient	\$0	Deductible, then coinsurance	Deductible, then 50%
	Organ and tissue transplants, inpatient unlimited, except \$20,000 donor coverage limit and \$5,000 travel and lodging per transplant	\$0	Deductible, then coinsurance	Deductible, then 50%
	Hospice: unlimited/Respite care: 14 days lifetime	\$0	Deductible, then coinsurance	Deductible, then 50%
4 Maternity & Newborn Care	Prenatal, delivery, postnatal	\$0	Deductible, then coinsurance	Deductible, then 50%
5 Mental Health & Substance Use Disorder Services, including Behavioral Health Treatment	Office visit	\$0	\$45 / \$50 copay	Deductible, then 50%
	Inpatient hospital; mental/behavioral health	\$0	Deductible, then coinsurance	Deductible, then 50%
	Outpatient services	\$0	Deductible, then coinsurance	Deductible, then 50%
6 Prescription Drugs <i>3-Tier: Generic/Brand/Specialty</i>	Retail 30-day supply Mail Order 90-day supply; 3x retail copay (5500 plan) Specialty Rx 30-day supply Drug List See X3 (5500) or X1 (6350 plan) formulary	\$0/\$0/\$0	5500 plan —\$25/ Deductible, then 50%/ Deductible, then 20% 6350 plan —Deductible, then 0%	Not covered
7 Rehabilitative & Habilitative Services & Devices <i>Therapy</i> <i>Rehabilitative and habilitative benefits have the same number of visits but are counted separately.</i>	Inpatient rehabilitation: 30 days PCY	\$0	Deductible, then coinsurance	Deductible, then 50%
	Physical, speech, and occupational therapy: 25 visits PCY	\$0	Deductible, then coinsurance	Deductible, then 50%
	Durable medical equipment	\$0	Deductible, then coinsurance	Deductible, then 50%
	Skilled nursing facility: 60 days PCY	\$0	Deductible, then coinsurance	Deductible, then 50%
8 Laboratory Services	Includes X-ray, pathology, imaging/diagnostic, MRI, CT, PET	\$0	Deductible, then coinsurance	Deductible, then 50%
9 Preventive/Wellness Services & Chronic Disease Management	Screenings	Covered in full	Covered in full	Deductible, then 50%
	Exams and immunizations	Covered in full	Covered in full	Not covered
10 Pediatric Services, including Vision Care <i>Under 19 years of age</i>	Eye exam: 1 PCY	\$0	\$45 / \$50 copay	\$45 / \$50 copay
	Eyewear: 1 pair lenses/contacts and 1 pair frames PCY	Covered in full	Covered in full	Covered in full

Definitions

Allowable charge:* The negotiated amount for which an in-network provider agrees to provide services or supplies.

Coinsurance: Your share of the fee for a service. If your plan's coinsurance share is 20%, you pay 20% of the allowable charge and your plan benefit pays the other 80% of the allowable charge.

Network: A group of doctors, dentists, hospitals, and other healthcare providers that contract with Premera to provide services and supplies at negotiated amounts called allowable charges.

Copay: A flat fee you pay for a specific service, such as an office visit, at the time a service is rendered.

Covered in full: Services your plan pays for in full. Benefits provided at 100% of the allowable charges; not subject to deductible or coinsurance.

Deductible: The amount of money you pay every year before the plan pays for certain services.

Formulary: A list of drugs the plan covers for specific uses. To find the formulary for your plan, go to premera.com and select Pharmacy on the Member Services tab.

Out-of-pocket maximum: A preset limit after which your plan pays 100% of the allowable charge for services received in-network. All in-network essential benefits apply to the out-of-pocket maximum.

Producer: Previously referred to as a broker or agent.

Primary care provider (PCP): The provider who helps coordinate your care. You can choose a different primary care provider for each family member from: physicians and internists, physician assistants, and nurse practitioners; ob/gyns and women's health specialists, pediatricians, and geriatric specialists; or naturopaths. To get reduced office visit copay with the PCP plans, you must choose a provider contracted as part of the Premera network and inform us this is your designated PCP.

Contact us

For information about how a health plan works, visit premera.com and click the Health Plan Basics tab. You'll find information there about help with monthly healthcare rates for low-income members (government subsidies).

For information or questions about Premera Blue Cross:

- Visit premera.com
- Call customer service at 800-722-1471 from 8 a.m. to 5 p.m. Pacific time, Monday – Friday
- Talk to your producer

This is only a summary of the major benefits provided by our plans. This is not a contract. Please see premera.com/SBC for the Summary of Benefits and Coverage and Glossary. On our website, you can also find a Supplemental Guide with information about privacy policies, provider organization, key utilization management procedures, and pharmaceutical management procedures.

*Note that if you see a non-contracted provider, you will be responsible for the difference between the allowable charge and the provider's billed charges, in addition to the coinsurance and any applicable copay. The allowable charge for a non-contracted provider is determined by Premera as described in your benefit book.

General exclusions and limitations

Benefits are not provided for treatment, surgery, services, drugs, or supplies for any of the following:

- Cosmetic or reconstructive surgery (except as specifically provided)
- Experimental or investigative services
- Infertility
- Learning disorders
- Obesity/morbid obesity, including surgery, drugs, foods, and exercise programs
- Orthognathic surgery (except when repairing a dependent child's congenital abnormality)
- Orthotics, up to \$300 PCY; except for treatment of diabetes, unlimited
- Services in excess of specified benefit maximums
- Services payable by other types of insurance coverage
- Services received when you are not covered by this program
- Sexual dysfunction
- Sterilization reversal

For a list of services and procedures that require an OK for coverage from your plan before you get them (prior authorization), visit premera.com.



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.modahealth.com or by calling 1-888-873-1395.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	No	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the out-of-pocket limit?	This plan has no out-of-pocket limit.	Not applicable because there is no out-of-pocket limit on your expenses.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.modahealth.com or call 1-888-873-1395 for a list of participating providers.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services .

Questions: Call 1-888-873-1395 or visit us at www.modahealth.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf> or call 1-888-873-1395 to request a copy.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$0 copay/visit	0% coinsurance	—————none—————
	Specialist visit	0% coinsurance	0% coinsurance	—————none—————
	Other practitioner office visit	0% coinsurance	0% coinsurance	Spinal manipulation 12 visit per year limit; acupuncture 12 visit per year limit.
	Preventive care/screening/immunization	0% coinsurance	0% coinsurance	Each type of service may be subject to limitations. A list of preventive health care benefits can be viewed at http://www.healthcare.gov/what-are-my-preventive-care-benefits/ or by calling 1-888-873-1395.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	0% coinsurance	Include other tests such as EKG, allergy testing and sleep study.
	Imaging (CT/PET scans, MRIs)	0% coinsurance	0% coinsurance	Prior authorization is required for many services to avoid a penalty of 50% up to a maximum deduction of \$2,500.

Questions: Call 1-888-873-1395 or visit us at www.modahealth.com.

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Moda Health Plan, Inc.: Be Adventurous CSV0 (Select) (Bronze)

Coverage Period: 01/01/2015 – 12/31/2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual + Family | Plan Type: PPO

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.modahealth.com	Value drugs	\$0 copay	\$0 copay	Covers up to a 90-day supply retail and mail order drugs. Copay per 30 day supply. Covers up to a 30-day supply specialty drugs. Prior authorization may be required.
	Select tier drugs	\$0 copay	\$0 copay	
	Preferred brand drugs	0% coinsurance	0% coinsurance	
	Non-preferred brand drugs	0% coinsurance	0% coinsurance	
	Specialty drugs	0% coinsurance	0% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	0% coinsurance	Prior authorization required to avoid a penalty of 50% up to a maximum deduction of \$2,500.
	Physician/surgeon fees	0% coinsurance	0% coinsurance	
If you need immediate medical attention	Emergency room services	0% coinsurance	0% coinsurance	—————none—————
	Emergency medical transportation	0% coinsurance	0% coinsurance	—————none—————
	Urgent care	\$0 copay/visit	0% coinsurance	—————none—————.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	0% coinsurance	Prior authorization required to avoid a penalty of 50% up to a maximum deduction of \$2,500.
	Physician/surgeon fee	0% coinsurance	0% coinsurance	

Questions: Call 1-888-873-1395 or visit us at www.modahealth.com.

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Moda Health Plan, Inc.: Be Adventurous CSV0 (Select) (Bronze)

Coverage Period: 01/01/2015 – 12/31/2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual + Family | Plan Type: PPO

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	0% coinsurance	0% coinsurance	—————none—————
	Mental/Behavioral health inpatient services	0% coinsurance	0% coinsurance	Prior authorization required to avoid a penalty of 50% up to a maximum deduction of \$2,500.
	Substance use disorder outpatient services	0% coinsurance	0% coinsurance	—————none—————
	Substance use disorder inpatient services	0% coinsurance	0% coinsurance	Prior authorization required to avoid a penalty of 50% up to a maximum deduction of \$2,500.
If you are pregnant	Prenatal and postnatal care	0% coinsurance	0% coinsurance	Includes voluntary abortion services rendered by a licensed and certified professional provider, including those for which federal funding is prohibited.
	Delivery and all inpatient services	0% coinsurance	0% coinsurance	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	0% coinsurance	Calendar year maximum of 130 visits. Prior authorization required to avoid a penalty of 50% up to a maximum deduction of \$2,500.
	Rehabilitation services	0% coinsurance	0% coinsurance	Calendar year maximum of 30 days for inpatient and 45 sessions for outpatient rehabilitation and habilitation.
	Habilitation services	0% coinsurance	0% coinsurance	
	Skilled nursing care	0% coinsurance	0% coinsurance	Calendar year maximum of 60 days.

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Moda Health Plan, Inc.: Be Adventurous CSV0 (Select) (Bronze)

Coverage Period: 01/01/2015 – 12/31/2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual + Family | Plan Type: PPO

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Durable medical equipment	0% coinsurance	0% coinsurance	Include items such as supplies and prosthetics. Prior authorization may be required. Failure to obtain prior authorization results in a penalty of 50% up to a maximum deduction of \$2,500.
	Hospice service	0% coinsurance	0% coinsurance	Lifetime maximum of 10 inpatient days and 240 hours respite.
If your child needs dental or eye care	Eye exam	0% coinsurance	0% coinsurance	Covers one exam per calendar year, under age 19. For children age 3 to 5, covered at no cost share under preventive care
	Glasses	0% coinsurance	0% coinsurance	Covers one pair of glasses per calendar year, under age 19.
	Dental check-up	0% coinsurance	0% coinsurance	For members under age 19. Frequency limits apply to some services.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)		
<ul style="list-style-type: none"> Bariatric surgery Cosmetic surgery, except as required for certain situations Dental care (Adult) except for accident-related injuries 	<ul style="list-style-type: none"> Hearing aids Infertility treatment Long-term care Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> Private-duty nursing Routine eye care (Adult) Routine foot care, with exception for diabetics Weight loss programs
Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
<ul style="list-style-type: none"> Acupuncture 	<ul style="list-style-type: none"> Chiropractic care 	

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Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your premium.

There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact ODS Alaska at 1-888-873-1395. You may also contact your state insurance department at 1-907-269-7900 or www.commerce.state.ak.us/insurance/filingacomplaint.htm

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the insurer at 1-888-873-1395. Additionally, a consumer assistance program can help you file your appeal. Contact the Alaska Division of Insurance 1-907-269-7900 or www.commerce.state.ak.us/insurance/filingacomplaint.htm.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 888-786-7461

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 888-873-1395

CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 888-873-1395

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 888-873-1395

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan pays** \$7,340
- **Patient pays** \$200

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$0
Copays	\$0
Coinsurance	\$0
Limits or exclusions	\$200
Total	\$200

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan pays** \$5,320
- **Patient pays** \$80

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$0
Copays	\$0
Coinsurance	\$0
Limits or exclusions	\$80
Total	\$80

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Questions and answers about the Coverage

Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the

prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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