CMS ALL TRIBES' CALL

Cost Sharing Reductions for American Indians and Alaska Natives who Enroll in Qualified Health Plans

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WEDNESDAY, June 25, 2014
3:00 – 4:30 PM ET
1-888-778-9063
Participant Code: 148483

The Centers for Medicare & Medicaid Services (CMS) is hosting an ALL TRIBES' CALL to obtain advice and input regarding cost sharing reductions for American Indians and Alaska Natives who enroll in closed panel Qualified Health Plans (QHPs) in the Health Insurance Marketplace. A closed panel QHP is a type of health maintenance organization (HMO) that does not cover services furnished by a provider outside of the HMO's network of providers.

In April 2013, CMS issued Frequently Asked Questions (FAQSs) explaining that cost sharing reductions are not applicable to services received by tribal members, who enroll in a closed panel QHP, when such services are provided by an out-of-network provider, including an Indian health care provider. The FAQs could have tribal implications and thus, this All Tribes' Call is being held to obtain advice and input regarding the policy outlined in the FAQs. For the convenience of participants on the call, the FAQs are provided below.

The Affordable Care Act eliminates cost sharing expenses (such as co-payments and deductibles) for tribal members with income levels at or below 300% Federal Poverty Level (FPL) [300% FPL for a family of 4 is $70,650; or $88,320 in Alaska] who enroll in a QHP, and receive Essential Health Benefits (EHBs) from an Indian health provider or a QHP provider. For tribal members who enroll in a QHP, with incomes above 300% FPL, there is no cost sharing for EHBs received from an Indian health care provider or from a QHP provider (when authorized through a contract health service referral from an Indian health care provider).

FAQs to be discussed on the All Tribes' Call

Q84: For a limited cost sharing plan variation of a **QHP that does not cover services when furnished by an out-of-network provider,** does the cost sharing need to be eliminated for EHB out-of-network services furnished directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or through referral under contract health services?

A84: As discussed in Q&A 27 of QHP FAQ #3 (published on REGTAP on April 11, 2013) in relation to the zero cost sharing plan variation, **enrollee spending for non-covered services is not considered cost sharing**. As a result, if a QHP does not cover certain services (or all **services) furnished by a provider outside of the network, the spending for these non-covered services would not need to be eliminated for the zero cost sharing plan variation or the limited cost sharing plan variation, even if the service was furnished directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or through referral under contract health services.** QHP issuers, including HMOs, should note however, that reimbursement is required in compliance with **section 206** of the Indian Health Care Improvement Act. In general, QHP issuers should be aware that they can indicate that a service is not covered by marking the service as not covered on the Benefits Package Worksheet, or, if a service or no services are covered when furnished by an out-of-network provider, the QHP issuer can set the out-of-network coinsurance for the service(s) to 100%, set the out-of-network copay(s) to "no charge," and indicate that enrollee spending for those service(s) does not count towards any deductible or towards any maximum out-of-pocket limit. In addition, as discussed in Chapter 10 of the Plans and Benefits Application, QHP issuers should be aware that **the cost-sharing reductions under the limited cost sharing plan variation do not need to be recorded in the Plans and Benefits Template**.

Frequently Asked Questions (FAQs) # 3
Date: April 11, 2013

Q27: For the zero cost sharing plan variation of a closed-panel HMO QHP, does the cost sharing for out-of-network services need to be eliminated?

A27: A zero cost sharing plan variation, as defined at 45 CFR 156.420(b)(1), is a variation of a QHP with all cost sharing eliminated. However, cost sharing is defined at 45 CFR 155.20 to be any expenditure required by or on behalf of an enrollee with respect to Essential Health Benefits, including deductibles, coinsurance, copayments, or similar charges, but excluding premiums, balance billing amounts for non-network providers, and spending for non-covered services. Therefore, **if the QHP is a closed-panel HMO that does not cover services furnished by a provider outside of the network** (i.e. cost sharing for services provided by an out-of-network provider is 100%), the spending, or cost sharing, for these non-covered services would not need to be eliminated for the zero cost sharing plan variation associated with this QHP, and should be entered as it would be for non-covered out-of-network services under the corresponding standard plan. **For covered benefits that are not Essential Health Benefits, the coinsurance and copays must be the same as the associated standard plan** (despite the template auto-populating them with 0's). For additional information, please consult the final HHS Notice of Benefit and Payment Parameters, published March 11th 2013.