YOUR HEALTH IDAHO 2015 QUALIFIED HEALTH PLAN STANDARDS

The Idaho Department of Insurance (DOI) is providing the following guidelines for carriers who wish to have their Qualified Health Plans (QHPs), including Stand-Alone Dental Plans (SADPs), certified by Your Health Idaho (YHI). DOI will review the information that carriers submit and recommend QHPs to YHI for certification for 2015. These guidelines provide the criteria DOI will use when performing reviews and ultimately making recommendations for certification. They align with the regulatory requirements of Idaho Code title 41, chapter 61 and 45 C.F.R. Parts 155 and 156.

This notice focuses on certain requirements for QHPs, most of which apply only to plans that will be offered through YHI. There are many other requirements that are not directly addressed in this notice, for example the market wide reforms. DOI assumes the carriers are aware of those requirements with which they must comply. DOI or YHI will provide additional guidance as needed. Please contact Wes Trexler at 208-334-4315 or Weston.Trexler@doi.idaho.gov or Alberto Gonzalez at 208-991-3985 or Alberto.Gonzalez@yourhealthidaho.org with questions or comments.

Section One: QHP Review and Certification Process

DOI and YHI developed the preliminary timeline for the 2015 QHP certification process shown in the table below. Individual and Small Group QHPs, including SADPs, follow the same timeline. The dates are approximate, subject to change, and all occur during 2014.

<table>
<thead>
<tr>
<th>Event</th>
<th>Date</th>
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<tbody>
<tr>
<td>Carriers to notify DOI of their intent to offer QHPs</td>
<td>April 1</td>
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<tr>
<td>Carriers without YHI-certified 2014 QHPs to submit QHP application</td>
<td>May 9</td>
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<tr>
<td>Carriers with YHI-certified 2014 QHPs to submit QHP application</td>
<td>May 30</td>
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<tr>
<td>Carrier Plan Preview begins</td>
<td>July 1</td>
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<tr>
<td>Final day for carriers to submit corrections and objection responses</td>
<td>August 29</td>
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<tr>
<td>DOI to provide final QHP recommendations to YHI</td>
<td>September 19</td>
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<tr>
<td>QHP certification notices and agreement sent to carriers</td>
<td>September 30</td>
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<tr>
<td>Carriers to return YHI participation agreement</td>
<td>October 10</td>
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<tr>
<td>Open Enrollment begins</td>
<td>November 15</td>
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DOI’s February 14, 2014 notice regarding QHP filing submissions describes the DOI’s expectations concerning the carrier’s notice of intent and QHP application. For Idaho, the QHP application refers to a carrier submitting all QHP related forms, rate manuals, templates, and other requested documents to DOI through SERFF. There is no separate application to complete. Plans submitted by the U.S. Office of Personnel Management (OPM) as Multi-State Plans and Consumer Operated and Oriented Plans (CO-OPs) are to meet the same May 9 filing date as all other newly participating carriers.

In the case that SERFF is not ready to accept binder filings by the May 9 or May 30 due dates specified above, carriers will still be expected to still submit their forms and rates through standard (non-binder) filings. DOI will expect carriers to complete their application by submitting the remaining components in a binder within one week of the SERFF binder functionality becoming available.

YHI expects that the carrier Plan Preview functionality will be available on the YHI website through the Plan Management module after July 1. DOI will transfer the QHP data from SERFF to the YHI Plan Management module when available, and the carriers will be able to view plan data in the Plan Preview environment concurrent with DOI’s review of the QHP submissions. DOI will work with carriers to resolve objections and transfer updated SERFF data to the Plan Management module for Plan Preview in a timely manner. Carriers should attempt to bundle corrections identified through Plan Preview into periodic requests and submit the requests to make corrections to DOI through email or SERFF.

DOI will allow carriers to make approved corrections to QHP data through SERFF until August 29, after which DOI will finish any outstanding review of the QHPs. DOI plans to present the final certification recommendations to YHI in September. YHI expects to send out certification notices and the YHI participation agreement to carriers by the end of September, with the carriers returning the signed agreement no later than October 10.

**Section Two: QHP Certification Standards**

YHI will rely upon DOI to review potential QHPs for compliance with the regulatory and other requirements and to recommend QHPs to be certified and available for sale through YHI. The standards and processes do not differ between first-time certifications and re-certifications, therefore in this document we refer to both situations when discussing certification. This section provides the criteria set by YHI in order to meet certain regulatory requirements for QHPs pursuant to 45 C.F.R. Parts 155 and 156. DOI will evaluate QHP applications against these criteria.

1. **Licensure and Good Standing**

Consistent with 45 C.F.R. 156.200(b)(4), each carrier offering QHPs must be licensed and in good standing in each state in which it applies for the applicable market, product type, and service area. Carriers must attest that they meet this standard as part of the signed Attestations Document, which carriers will access through SERFF. DOI’s Company Activities Bureau maintains the records associated with this requirement. Carriers are therefore not required to submit any supporting documentation of licensure and good standing in Idaho.
2. Service Area

Consistent with regulations at 45 C.F.R. 155.1055(a), YHI will ensure that each service area of a QHP covers a minimum geographic area that is at least the entire geographic area of a county, or a group of counties defined by YHI, unless YHI determines that serving a smaller geographic area is necessary, nondiscriminatory, and in the best interest of the qualified individuals and employers. YHI will also ensure that the service area of a QHP has been established without regard to racial, ethnic, language, or health status-related factors as specified under § 2705(a) of the Public Health Service (PHS) Act, or other factors that exclude specific high utilizing, high cost or medically-underserved populations.

Carriers that submit new service areas that include partial counties or carriers that wish to modify their current service areas must include justification that explains the need and describes how the service area meets the regulatory standards listed above.

3. Network Adequacy

Pursuant to 45 C.F.R. 156.230(a)(2), carriers offering QHPs that have a provider network must maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, to assure that all services will be accessible to enrollees without unreasonable delay.

Carriers seeking certification of QHPs in Idaho are required to attest that the networks associated with QHPs meet this standard. Additionally, carriers must demonstrate that each network associated with QHPs meets or exceeds the Health Plan network adequacy related accreditation standard of the National Committee for Quality Assurance (NCQA), the Accreditation Association for Ambulatory Health Care (AAAHC) or URAC. Carriers can demonstrate that they meet one of the accreditation standards by providing proof of accreditation or by providing a network access plan showing how the standards are met.

4. Essential Community Providers

45 C.F.R. 156.235 establishes requirements for inclusion of Essential Community Providers (ECPs) in QHP provider networks and provides an alternate standard for carriers that provide a majority of covered services through physicians employed by the carrier or a single contracted medical group.

For the 2015 benefit year, YHI adopted the same criteria regarding the inclusion of ECPs as described in the March 14, 2014 Centers for Medicare & Medicaid Services (CMS) 2015 Letter to Issuers in the Federally-facilitated Marketplace (CMS 2015 Letter), chapter 2, section 4. Portions of the criteria are summarized below; however, carriers should reference the CMS 2015 Letter for the full details.

To meet the ECP standard for YHI, carriers must demonstrate that at least thirty percent (30%) of available ECPs in each plan’s service area participate in the provider network. In addition to achieving a level of 30% participation of available ECPs, the carrier must attest that it will offer contracts in good faith prior to the benefit year 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; and

- At least one ECP in each ECP category (includes 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.

As part of the carrier’s application, the carrier must list the contract offers that it 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.

If a carrier’s network does not satisfy the 30% ECP standard described above, the carrier is required to include as part of its application a satisfactory narrative justification. The justification must describe how the carrier’s provider network, as currently designed, provides an adequate level of service for low-income and medically underserved enrollees and how the carrier plans to increase ECP participation in the carrier’s provider network in future years, as necessary.

To assist carriers in identifying these providers, CMS published a non-exhaustive list of available ECPs based on data maintained by CMS and other federal agencies. Carriers should use this CMS-developed list to calculate their satisfaction of the 30% ECP standard. Carriers must use the federally designed ECP template to report participating ECPs to DOI.

Carriers may write in ECPs not on the CMS-developed list for consideration as part of the certification review. Allowable write-ins count toward the satisfaction of the 30% ECP standard and count toward the denominator of available ECPs for the carrier writing in the additional ECPs. Only one ECP, including write-ins, is permitted per address.

5. Accreditation

Requirements at 45 C.F.R. 155.1045(b) establish the timeline by which QHP carriers offering coverage in a Federally Facilitated Marketplace (FFM) must be accredited. Pursuant to 45 C.F.R. 156.275 YHI adopted the same phased approach to the accreditation requirement. This section does not apply to SADPs.

Carriers without YHI-certified 2014 QHPs that do not have an existing commercial, Medicaid, or Exchange health plan accreditation granted by a recognized accrediting entity (NCQA, AAAHC, or URAC) for Idaho must schedule a review for accreditation from a recognized accrediting entity. The carrier must submit an attestation that they have scheduled a review for accreditation as supporting documentation, which should reference the accrediting entity and the anticipated review date.

Carriers with YHI-certified 2014 QHPs must submit the completed accreditation template corresponding to their accrediting entity. The template must reflect the accreditation status of the policies and procedures that are applicable to the carrier’s QHPs. Alternatively, a carrier must have Idaho specific commercial or Medicaid health plan accreditation granted by a recognized accrediting entity and the administrative policies and procedures underlying that accreditation must be the same or similar to the administrative policies and procedures used in connection with the QHPs.
6. Patient Safety Standards

Regulatory requirements at §156.1110 in the HHS Notice of Benefit and Payment Parameters for 2015, Final Rule, 79 Federal Register 13744 (March 11, 2014) (2015 Payment Notice) outline how carriers can demonstrate compliance with the patient safety standards. Beginning January 1, 2015, QHP carriers that contract with a hospital with greater than 50 beds are to verify that the hospital, as defined in § 1861(e) of the Social Security Act (SSA), is Medicare-certified or has been issued a Medicaid-only CMS Certification Number (CCN) and is subject to the Medicare Hospital Condition of Participation requirements for:

- A quality assessment and performance improvement program as specified in 42 C.F.R. 482.21; and
- Discharge planning as specified in 42 C.F.R. 482.43.

In addition, carriers would be required to collect and maintain documentation of the CCNs from their applicable network hospitals.

As part of the certification for the 2015 benefit year, YHI will require carriers (other than SADP carriers) to demonstrate compliance with these patient safety standards as part of the QHP application with an attestation that they have collected and are maintaining the required documentation from their network hospitals.

7. QHP Agreement

Carriers offering QHPs (including SADPs) in YHI will be required to sign an agreement with YHI at the end of the 2015 plan year certification process. YHI will release this agreement later. The agreement will cover all of the QHPs offered by a carrier at the HIOS Issuer ID level, and must be signed by an officer of the carrier who has legal authority to contractually bind the QHP carrier.

8. Discriminatory Marketing and Benefit Design

The regulation at 45 C.F.R. 156.200(e) provides that carriers must not, with respect to their QHPs, discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation. 45 C.F.R. 156.225(a) requires that in order to have a plan certified as a QHP, a carrier must comply with all applicable state laws on health plan marketing by health insurance carriers. In addition, 45 C.F.R. 156.225(b) states that a QHP carrier must not employ marketing practices that will have the effect of discouraging the enrollment of individuals with significant health needs in QHPs.

YHI recommends that all marketing materials distributed to enrollees or potential enrollees include the following language suggested by CMS: “[Insert plan’s legal or marketing name] does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.” YHI and DOI will monitor consumer complaints regarding a carrier’s marketing activities and complaints concerning an agent’s, broker’s, or web-broker’s conduct. Determinations of discrimination may result in a QHP decertification and potentially additional enforcement action against the carrier, agent, broker, or web-broker.
For purposes of QHP certification, YHI will assess compliance with the non-discrimination standard through an attestation filed by the carrier. Carriers must attest that they will not discriminate against individuals on the basis of health status, race, color, national origin, disability, age, sex, gender identity or sexual orientation. As part of the QHP application review, DOI will apply the same outlier analysis on benefit cost sharing explained in the CMS 2015 Letter. DOI may require changes to certain QHP cost sharing provisions that potentially discourage the enrollment of individuals with significant health needs. DOI will consider an unusually large number of drugs subject to prior authorization and/or step therapy requirements in a particular category and class to be potentially discriminatory. Finally, DOI will review the “explanations” and “exclusions” applicable to benefits for discriminatory language.

9. Prescription Drug Coverage

Regulations at 45 C.F.R. 156.122 establish that a health plan that provides EHB must cover at least the greater of (1) one drug in every United States Pharmacopeial Convention (USP) category and class or (2) the same number of prescription drugs in each USP category and class as the EHB benchmark plan. The CMS website lists the 2014-2015 EHB benchmark prescription drug category and class counts for Idaho. DOI will use the federal prescription drug template to collect and review compliance with this standard. The drug template allows carriers to demonstrate that a plan’s formulary is sufficiently broad to meet the Idaho benchmark formulary drug count by USP category and class. YHI expects carriers to provide reasonable justification for any deficiencies in drug lists compared to the Idaho benchmark. Since the final 2015 drug template does not include the flexibility to include drugs covered under a plan’s medical benefit, carriers that do not meet the benchmark using only their formulary drugs should include as part of their justification an excel spreadsheet listing the drugs covered under the medical benefit. The spreadsheet should include the RxCUI, drug name, if prior authorization or step therapy is required, and a description of the applicable cost sharing provisions in and out-of-network.

As part of the QHP application, carriers must provide a URL to their formulary and provide information regarding their formulary to consumers, pursuant to 45 C.F.R. 147.200(a)(2)(i)(K). YHI expects the URL link to direct consumers to an up-to-date formulary from which they can view the list of covered drugs along with the corresponding tiers and cost sharing applicable to the QHP of interest. The URL provided to YHI as part of the QHP application should link directly to the formulary, such that consumers do not have to log on, enter a policy number or otherwise navigate the carrier’s website before locating it. If a carrier has multiple formularies, it should be clear to consumers which directory applies to the selected QHP. While the drugs covered only under a plan’s medical benefit can be used in demonstrating compliance with the Idaho benchmark drug count, carriers are not required to include those drugs on the formulary that is accessible to consumers.

YHI encourages carriers to closely monitor requests for non-formulary medications and utilize this information, along with market factors, when reviewing medications for formulary coverage, especially regarding new drugs that enter the pharmacy market. Requests during at least the first 30 days of coverage for medications requiring prior
authorization or step therapy should be reviewed promptly with the goal to limit disruptions in ongoing treatment for new enrollees. YHI recommends carriers ensure their exceptions and appeals processes for prescription drugs meet the requirements of 45 C.F.R. 156.122(c) and do not result in treatment delays. YHI will consider stricter guidelines if the needs of enrollees are not being met in a timely manner.

10. Meaningful Difference

CMS has recommended at § 156.298 in the 2015 Payment Notice an approach to assess whether all benefit packages proposed to be offered by potential QHP carriers are meaningfully different from another. YHI plans to apply the criteria from the notice to identify potential QHPs for additional review, and YHI may consider additional criteria if deemed necessary. This standard does not pertain to SADPs.

The meaningful difference criteria is applied to each carrier’s QHPs matching a subgroup of the same plan type, metal level, and service area. DOI may not recommend certification of a carrier’s plan, and YHI may not certify a carrier’s plan, if within a subgroup, plans do not differ from each other by at least one of the following criteria:

- Different network;
- Different formulary;
- $50 or more difference in both individual and family in-network deductibles;
- $100 or more difference in both individual and family in-network annual limit on cost sharing;
- Difference in covered benefits;
- Difference in Health Savings Account (HSA) eligibility; and
- Difference in child-only, adult-only, or adult and child coverage offerings.

DOI may ask carriers with plans identified as potentially not meaningfully different to modify or withdraw one or more of the identified plans to meet this requirement. Alternatively, DOI will review a carrier’s justification to how the identified plans are meaningfully different and add to meaningful consumer choice.

11. Stand-Alone Dental Plan Considerations

For the 2014 benefit year, YHI established an annual limitation on cost sharing for the pediatric dental EHB offered by SADPs of $1,000 per child, in accordance with 45 C.F.R. 156.150(a). All SADPs in 2014 were also required to meet an actuarial value of seventy percent (70%) or eighty-five percent (85%) within 2 percentage points, in accordance with 45 C.F.R. 156.150(b).

CMS has issued revisions to § 156.150 in the 2015 Payment Notice which set a national annual limitation on cost sharing for the pediatric dental EHB offered by SADPs of $350 for one covered child and $700 for two or more covered children. Carriers submitting SADPs to YHI for certification are expected to adjust their plans to meet this new requirement, while demonstrating that the plan meets either the 70% (low) actuarial value or the 85% (high) actuarial value. We understand that with the reduction in the annual limit on cost sharing, it may be difficult to meet the 70% actuarial value target, and so carriers may choose not to offer SADPs at the lower level.
12. Cost Sharing Reduction Plan Variation Reviews

Regulations at 45 C.F.R. 156.420 generally require QHP (excluding SADP) carriers to submit three plan variations for each silver level QHP in the individual market as well as zero and limited cost sharing plan variations for all QHPs in the individual market. YHI expects QHP applications to comply with 45 C.F.R. part 156, subpart E and the new plan variation standards for 2015 as described in the 2015 Payment Notice at §156.420. These requirements include:

- Silver plan variations shall not have an annual limitation on cost sharing that exceeds the permissible threshold for the specified plan variation
- Cost sharing (for EHBs and non-EHBs) for enrollees under any silver plan variation shall not exceed the corresponding cost sharing in the standard silver plan or any other silver plan variation of the standard silver plan with a lower AV
- Zero cost sharing plan variations shall not have positive cost sharing for any EHB both in and out-of-network (with an exception for closed-panel MCOs – not applicable in Idaho per Idaho Code § 41-3905(3))
- For limited cost sharing plan variations, the cost sharing values for non-EHBs must be the same or less than the values of the associated standard plan
- For zero cost sharing plan variations, the cost sharing values for non-EHBs must be the same or less than the value of all other variations of the associated standard plan

13. Oversight of Agents/Brokers (Producers)

YHI and DOI will not allow agents and brokers (licensed as producers) to use “YHI,” “Your Health Idaho,” “Marketplace,” or “Exchange” in the names of their businesses or names of their websites. Agents and brokers should also be careful in representations that might tend to mislead or confuse consumers. As required by 45 C.F.R. 155.220(c)(3), if a producer assists a qualified individual with QHP selection through the agent, broker, or web-broker’s website, a standardized disclaimer must be prominently displayed on each page to indicate that the site is not Your Health Idaho, the Idaho Health Insurance Exchange, and it must also include a link to the YHI website. Failure to comply with the preceding may result in the loss of an agent or broker’s Exchange certification and may constitute a violation of Idaho Code §§ 41-1016(1)(h) or 41-1321, resulting in a potential administrative action against the producer that could affect the producer’s license.

14. Idaho’s Small Employer Health Options Program

As a state-based marketplace, Idaho will have a Small Employer Health Options Program (SHOP) in 2015. The details of Idaho’s 2015 SHOP are still under development, and the information will be distributed at a later date.

15. Minimum Participation and Contribution Rates and Renewals

The guaranteed availability regulation at 45 C.F.R. 147.104(b)(1) requires that a small employer be allowed to purchase coverage from November 15 through December 15, even if the employer cannot meet the carrier’s minimum participation or contribution requirements. Similar to CMS, YHI and DOI believe it would impose undue burden on employers and their employees for carriers to non-renew coverage under the exception to guaranteed renewability for failure to meet minimum participation or contribution rates.
and then re-enroll employers under guaranteed availability during this period. Therefore, carriers offering small group plans must not enforce minimum participation or contribution requirements for renewals of policies purchased between November 15 and December 15.

16. Coverage Appeals

QHPs are required to meet the standards for internal claims and appeals and external review established at 45 C.F.R. 147.136, which requires an effective process for internal claims appeals and external review. DOI will also review all applicable policy forms for compliance with title 41, chapter 59, Idaho Code and IDAPA 18.01.05.

17. Meaningful Access

Pursuant to 45 C.F.R. 155.205(c), 155.230(b), and 156.250, QHP carriers must ensure meaningful access by limited-English proficient (LEP) speakers and by individuals with disabilities. All applications, correspondence containing information about eligibility and participation criteria, notices pertaining to the denial, reduction, modification, termination of services, benefits, non-payment, or coverage or any other document that contains information that is critical for obtaining health insurance coverage or access to care through the QHP must be accessible to LEP speakers and by individuals with disabilities.

18. Summary of Benefits and Coverage and Variable Language in Forms

As requested in DOI’s February 14, 2014 notice regarding QHP filing submissions, carriers must include on the SERFF form schedule the federally mandated Summary of Benefits and Coverage (SBC) that corresponds to each base HIOS Plan ID and each plan variation included in the carrier’s SERFF binder. Carriers may submit the SBCs up to two weeks after their QHP submission provided that carriers notify DOI of the delay. SBCs can be filed without a form number present within the document, but there must be a form number attached to each SBC within SERFF. The DOI will accept a generic form number (such as INDSBC2015) to be attached to each SBC within SERFF.

Policy forms (including SBCs) should not include variable language unless it is approved by DOI prior to submission. Variable language that the DOI may allow would generally not affect the benefits or cost sharing. The DOI will allow variable language in the following contexts without prior approval:

- Religious exemption for a specific benefit
- Benefits exclusive to eligible tribal members above 300% FPL
- Employer choice to offer coverage to spouses, dependents, or domestic partners
- Employer group number
- Employer name
- Internal plan/product identifier

19. Transparency

Per Idaho Code § 9-340D(1) and DOI Bulletin 95-2, DOI generally considers as proprietary or “trade secret” any rates or rating information that is flagged as confidential within a filing. While flagging a document within a filing as confidential does not conclusively resolve the question, it assists DOI in its identification of confidential trade
secrets. Consistent with Idaho Code and historical practices, DOI will not treat form filings for QHPs as confidential.

QHP carriers are required to submit specified information to YHI, CMS and DOI in a timely and accurate manner as required by 45 C.F.R. 156.220, implementing § 1311(e)(3) of the Affordable Care Act. As clarified in Affordable Care Act Implementation FAQs Set 15 Q4, QHP carriers will begin submitting information after they have been certified as QHPs for one benefit year. CMS intends to provide details on the implementation of the transparency in coverage reporting requirements, including what information must be provided and timing of submissions, through future guidance.

20. Provider Directory

Pursuant to 45 C.F.R. 156.230(b), YHI requires QHPs to make their provider directories available for publication online by providing the URL link as part of the QHP Application and by having the directory openly accessible from the carrier’s website. The URL that carriers provide to YHI as part of the QHP application should link directly to an up-to-date provider directory corresponding to the selected QHP. Consumers should not have to log on, enter a policy number, or otherwise navigate the carrier’s website in order to view the directory. If a carrier has multiple provider directories, it should be clear to consumers which directory applies to the QHP of interest. Further, YHI expects the directory to include location, contact information, specialty, medical group, and any institutional affiliations for each provider, and whether the provider is accepting new patients. YHI encourages carriers to include languages spoken, provider credentials, and whether the provider is an Indian health provider.

21. Tribal Relations and Support

The Affordable Care Act (ACA) at Subtitle K, section 2901, of Title II includes Protections for American Indian and Alaska Natives (AI/AN), which extends special benefits and protections to AI/AN including limits on cost sharing and clarifies payer of last resort requirements for health programs operated by the Indian Health Service (IHS), Indian tribes, tribal organizations and urban Indian organizations.

In coordination with the leadership of the five federally recognized tribes in Idaho, YHI developed a tribal consultation policy that outlines YHI’s commitment to achieving culturally appropriate interactions between YHI and Indian Tribes and greater access to the services that will be provided by the YHI Insurance Exchange for AI/AN. Among the goals of the policy are to:

- Maximize participation by AI/AN in QHPs offered by YHI
- Assure that AI/AN receive the benefits and protections provided under federal law
- Assure that AI/AN can choose to receive their health care from the Indian Health Services, a tribally-operated program, or an urban Indian program

As noted in the Essential Community Providers section above, YHI strongly encourages QHPs to engage with Indian health care providers, through which a significant portion of American Indians access care. When offering contracts in good faith, YHI recommends QHPs include considerations for culturally specific terms. To promote contracting between carriers and Indian health care providers, YHI expects carriers to offer contracts...
to Indian health care providers and use the CMS Model QHP Addendum described in the CMS 2014 Letter to Issuers and the CMS Overview of the Addendum.

As noted in the Cost Sharing Reduction Plan Variation Reviews section above, QHPs are required to offer two plan variations specifically for tribal communities; zero and limited cost sharing plan variations.

For each of its health plans at any level of coverage that a carrier offers or intends to offer in the individual market through YHI, a carrier must submit for certification the health plan and two variations of the health plan, as follows:

- For individuals eligible for cost sharing reductions under 45 C.F.R. 155.350(a), a variation of the health plan with no positive cost sharing for any EHB both in and out-of-network; and
- For individuals eligible for the special cost sharing rule under 45 C.F.R. 155.350(b), a variation of the health plan with no cost sharing on any item or service that is an EHB furnished directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization (each as defined in 25 U.S.C. 1603), or through referral under contract health services.

The ACA also allows members of federally recognized tribes to purchase and enroll in Exchange health insurance coverage monthly rather than just during the annual open enrollment period. QHPs must accept and support tribal members in accordance with this special enrollment option.

Regulations at 45 C.F.R. 155.240(b) provide YHI with flexibility to permit Indian tribes, tribal organizations, and urban Indian organizations to pay QHP premiums—including aggregated payment—on behalf of members who are qualified individuals, subject to terms and conditions determined by YHI. During YHI consultations with tribal governments, tribal leaders indicated the importance of tribes having the ability to pay premiums on behalf of their members.

For the 2014 benefit year, CMS assessed its various systems to determine how YHI could establish a process to facilitate Tribal Premium Sponsorship or the ability of Indian tribes, tribal organizations, and urban Indian organizations to pay premiums on behalf of American Indians. Because for benefit years 2014 and 2015 YHI does not collect premiums directly from individuals, there was no process identified that would facilitate premium sponsorship (such as Tribal Premium Sponsorship), beyond tribes working directly with carriers to pay premiums on behalf of their members.

YHI recognizes that aggregating premium payments is a beneficial mechanism for increasing the enrollment of American Indians in QHPs. YHI wishes to work with tribes to implement Tribal Premium Sponsorship for benefit year 2016. This effort will require close consultation with our tribal members, carriers, and our technology vendor. In the interim, YHI encourages carriers to work directly with each of the five federally recognized tribes to establish protocols for Tribal Premium Sponsorship for plan year 2015.