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AGENDA ITEM

[X] **For Possible Action**

[ ] **Information Only**

Date: June 22, 2023

Item Number: VII

Title: Proposed Language related to CFR 156.1250 for Aggregated Billing for Tribal Health Clinics

PURPOSE

The purpose of this report is to provide information to the Board and public regarding the implementation of the Tribal Sponsorship Program and provide a comment period for stakeholders on proposed language that will be included in the annual Issuer Agreement and the Nevada Health Link Policy Manual.

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TRIBAL SPONSORSHIP PROGRAM OVERVIEW:

Under the Affordable Care Act (ACA) of 2010, Indian tribes, tribal organizations, Tribal Health Clinics, and urban Indian organizations can pay for Qualified Health Plan (QHP) premiums that are subsidized on behalf of their tribal members who are enrolled in health insurance through Nevada Health Link. A Tribal sponsorship program enables Nevada Tribal Nations to provide financial support, which helps pay the cost of premiums and/or out-of-pocket expenses for their tribal members who qualify to enroll in a QHP through Nevada Health

Link. Tribal sponsor entities choose who they will cover, what plans to include, and what level of coverage to provide. The establishment of a Tribal Sponsorship program lies within 45 C.F.R. 155.240(b) – Payment of premiums, and 45 C.F.R 156.1250 – Acceptance of certain third-party payments.

To date, the Exchange has the Ft. McDermitt Paiute-Shoshone Wellness Center currently participating in the Tribal Sponsorship Program. Other Tribal clinics are close to participating in this program or have expressed interest and have spoken with the Silver State Health Insurance Exchange (Exchange) about how to best operationalize such a program.

Tribal Health Directors have expressed concerns and, more specifically, barriers with at least two areas of the program, thus hindering their ability to implement the program fully. Two overreaching areas of concern were:

1) Aggregated billing set up with Tribal administrative oversight

2) Exchange Enrollment Facilitator/Certified Enrollment Counselor (EEF/CEC) certification process that is required by the Division of Insurance (DOI) for enrolling individuals into a qualified health plan.

The first area of concern is actively being addressed by way of proposing language to include the Exchange Issuer Agreement and Nevada Health Link Policy Manual and allowing partnered insurance carriers to provide comments and feedback during a two-week comment period.

The second barrier has already been addressed thanks to the Exchange Executive Board voting to waive the Division of Insurance (DOI) certification process for Tribal Exchange Representatives (TERs), who will be enrolling tribal clinic members into Exchange plans on NevadaHealthLink.com.

EXISTING CFR:

§ 156.1250 Acceptance of certain third-party payments.

Issuers offering individual market QHPs, including stand-alone dental plans, and their downstream entities, must accept premium and cost-sharing payments for the QHPs from the following third-party entities from plan enrollees (in the case of a downstream entity, to the extent the entity routinely collects premiums or cost sharing):

(a) A Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act;

(b) An Indian tribe, tribal organization, or urban Indian organization; and

(c) A local, State, or Federal government program, including a grantee directed by a government program to make payments on its behalf.

PROPOSED LANGUAGE FOR PLAN YEAR 24 DRAFT ISSUER AGREEMENT:

4.6 Aggregated Billing for Tribal Health Clinics:

45 CFR 156.1250 requires QHP Issuers to accept premium and cost-sharing payments for tribal members directly from Indian tribes, tribal organizations, or urban Indian organizations. By default, the monthly premiums for these enrollments are managed on an individual-policy basis. The Exchange has

therefore further leveraged the authority granted by 45 CFR § 155.240(b) to establish terms and conditions which will standardize the aggregated payment of premiums for tribal enrollees by Nevada's Tribal Health Clinics.

Issuers who participate in the Aggregated Billing process can simplify the administration of these enrollments by receiving a single, aggregated monthly payment for all policies belonging to a Tribal Clinic. Before participation can begin, issuers must submit a completed copy of SSHIX's Intent to Participate in Aggregated Billing for Tribal Health Clinics form. A list of participating issuers, as well as their rating areas and supported payment methods, will be made available at https://www.nevadahealthlink.com/tribes/.

Tribal Health Clinics who participate in the Aggregated Billing process are required to maintain a minimum of one (1) certified Tribal Enrollment Representative (TER) on staff at all times. TER's are individually certified by SSHIX to offer enrollment assistance to tribal consumers. Participating issuers are required to make educational resources regarding their plan offerings available to TER's in the same manner as these resources are made available to Navigators or In-Person Assisters.

Tribal enrollments leverage existing functionality within the Exchange platform, and no information can be provided via 834 to distinguish them from non-tribal enrollments. To facilitate aggregated billing SSHIX will provide a list of applicable enrollments, referred to as the Tribal Enrolled Consumers report, to participating Tribal Clinics by the fifth (5th) of each month. This report, which includes columns for Exchange Assigned Policy ID and Subscriber ID, is derived from the invoices that SSHIX sends to issuers each month for their Carrier Premium Fee. This process ensures parity between the two sets of reports by guaranteeing that every enrollment listed on the Tribal Enrolled Consumers report will have a matching enrollment on SSHIX's monthly invoice, including any adjustments that might be required by retroactive corrective action.

Tribal Clinics are responsible for keeping their enrollments up to date, and clinics will be financially responsible for all active enrollments as of the first (1st) of each month. After the clinics have verified the completeness and accuracy of each monthly report, they will forward the report to the applicable issuer for generation of a monthly Aggregated Invoice. The Aggregated Invoice, which must include individual line-item detail for each enrollment, will then be sent back to the clinic for review.

Once the invoice is approved the clinic will remit a single, aggregated premium payment using a payment method supported by the issuer, and the issuer will be responsible for ensuring that aggregated premium payments are appropriately applied to each of the individual policies listed on the Aggregated Invoice. For a detailed illustration of the monthly process please refer to the SSHIX Tribal Aggregated Billing Workflow.

PROPOSED LANGUAGE, NEVADA HEALTH LINK POLICY MANUAL:

6.20 Aggregated Billing for Tribal Health Clinics

45 CFR § 156.1250 requires Qualified Health Plan (QHP) Issuers to accept premium and cost-sharing payments for tribal members directly from Indian tribes, tribal organizations, or urban Indian organizations. By default, the monthly premiums for these enrollments are managed on an individual-policy basis. The Exchange has therefore leveraged the authority granted by 45 CFR § 155.240(b) to establish terms and conditions which standardize the aggregated payment of premiums

for tribal enrollees by Nevada's Tribal Health Clinics.

The intent of this policy is to simplify the administration of tribal enrollments by allowing clinics to remit a single, aggregated monthly payment representing their entire enrolled population. To facilitate aggregated billing SSHIX will provide a list of applicable enrollments, referred to as the Tribal Enrolled Consumers report, to participating Tribal Clinics by the fifth (5th) of each month.

Tribal Health Clinics who participate in the Aggregated Billing Process are subject to the terms and conditions of the Operator Agreement. Tribal Clinics are also responsible for keeping their enrollments up to date, and clinics will be financially responsible for all active enrollments as of the first (1st) of each month.

Issuers who participate in the Aggregated Billing Process are subject to the terms and conditions of SSHIX's annual Issuer Agreement. Issuers are responsible for generating a monthly Aggregated Invoice for participating clinics, and also for ensuring that aggregated premium payments are appropriately applied to each of the individual policies listed on the Aggregated Invoice.

PUBLIC COMMENT PERIOD GUIDELINES:

The Exchange is opening a two-week comment period for partnered Issuers to provide feedback on the additions made to the Annual Issuer Agreement, Section 4.6 and the Nevada Health Link Policy Manual, Section 6.20. The comment period is from June 22, 2023 to July 6, 2023. Please direct all feedback, comments, and questions to Janel Davis, the Exchange's Chief Operations Manager, at j-davis@exchange.nv.gov.

The Exchange is requesting that the Board consider for approval the draft proposed language and the two-week comment period for partnered Issuers and all stakeholders to provide feedback on the additions made to the Annual Issuer Agreement, Section 4.6 and the Nevada Health Link Policy Manual, Section 6.20, following the guidelines mentioned in the previous paragraph.

At the next board meeting, after the two-week comment period has concluded, the Board will take into consideration any comments from stakeholders and approve final language as is or with revisions.