

November 27, 2017

## VIA ELECTRONIC SUBMISSION

Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
P.O. Box 8016  
Baltimore, MD 21244-8016

### **Re: CMS-9930-P. Patient Protection and Affordable Care Act; CMS Notice of Benefit and Payment Parameters for 2019**

Dear Ms. Verma,

As organizations that share a strong commitment to the health of our nation's children, we appreciate the opportunity to provide comments in response to the Proposed 2019 Notice of Benefit and Payment Parameters. Overall, more than one-half of all children are covered by commercial plans with more than one million children enrolled in Qualified Health Plans (QHPs) to date. Children's commercial coverage, whether through an employer plan or a QHP, must ensure that they have access to timely, affordable and high-quality age-appropriate care that meets their unique developmental needs. All plans must also promote the health of women before, during and between pregnancies.

We thank you for your efforts to improve affordability and empower consumers as articulated in the preamble of the proposed Notice. While there are several provisions in the Notice that hold promise for improved access to appropriate and affordable coverage, in general we believe many proposals could leave pregnant women, children and families with fewer options for coverage that meet their needs while increasing their costs. We respectfully submit the following comments on the provisions in the Notice with implications for pregnant women and children, particularly children with serious, chronic or complex conditions, and hope we can work collaboratively to ensure that their access to timely, affordable and appropriate health care is not impeded.

#### **Special Enrollment Periods (§155.420)**

We support the proposal in the Notice to allow mothers who lose Children's Health Insurance Program (CHIP) coverage obtained during pregnancy to qualify for a special enrollment period. It is critically important for new mothers to have health insurance to cover any necessary postpartum care after their CHIP coverage expires and help them improve their health in preparation for any future pregnancy. We appreciate the agency's recognition that approximately 370,000 pregnant women are covered by CHIP each year,<sup>1</sup> and that many of these women are at high risk for being uninsured after their CHIP coverage ends.

#### **Essential Health Benefits (§156.111 and §156.115)**

As advocates for the health of pregnant women and children, we share the agency's concerns regarding affordability of coverage, but warn that the proposed revisions to the essential health benefit (EHB) benchmark process could leave children, particularly those with serious, chronic or complex conditions,

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<sup>1</sup>March of Dimes. CHIP Coverage for Pregnant Women. <https://www.marchofdimes.org/materials/MOD-IssueBrief-Chip-Coverage-Pregnant-Women-November-2016.pdf>.

worse off and their families with higher out-of-pocket costs. Therefore, we urge you to reconsider this approach and work to ensure that efforts to increase state flexibility encourage plan innovation that improves access to needed services, rather than limits it, and protects families from large financial burdens.

Children are not little adults; they require services and care specifically suited to their unique development and growth needs. Because of their continuous growth and development, children's need for a full set of pediatric and age-appropriate benefits is particularly acute and gaps in benefits can result in life-long health consequences that generate extensive and avoidable costs.

The EHB package should assure affordable access to care for the vast majority of relatively healthy children and, at the same time, protect families from excessive costs when children have special health needs. Essential benefits for children include all preventive, diagnostic, and treatment services that are medically necessary for children, including those who have a chronic condition, functional impairment, or significant or multiple health risks.

Essential benefits for children also include coverage of key therapies and devices that are now included in the habilitative services category of EHBs. Those services are especially important for children who may suffer from a condition at birth (such as cerebral palsy, autism or spina bifida) or from an illness or injury that prevents normal skills development and functioning. Receiving sufficient habilitative services that helps the child *acquire*, improve, or retain a skill or level of functioning that s/he did not previously possess can mean the difference between talking and not talking, walking and not walking, or needing special education and being able to join a regular classroom.

The range of covered services available in each of the EHB categories, such as rehabilitative and habilitative services, pediatric services including dental and vision, and others, provide a level of benefit protection that is vital to children's long term health, well-being and future productivity. However, we believe that the new options for states, as articulated in the proposed Notice, could undermine the basic coverage and access afforded children through the EHBs and result in higher, not lower, out-of-pocket costs for families.

Without stronger parameters for states that design their own EHB package from scratch or choose a full benchmark or parts of a benchmark from another state, it is very possible that a state could limit or drop certain benefits of particular importance for children in the interest of lowering premiums. In fact, according to the Congressional Budget Office<sup>2</sup>, benefits like habilitative services and pediatric dental would be likely targets in states that try to reduce premium costs by scaling back the EHBs. For example, a state with a relatively comprehensive EHB package that includes a range of habilitative therapies and devices and pediatric cardiology services could choose a package from another state that has a more limited benefit package. Another state with an EHB benchmark that requires coverage of autism services and changes in hearing aids and wheelchairs as a child grows could select another state's benchmark that does not cover those benefits.

In addition, the proposed requirement that a state's new benchmark must be equal in its scope of benefits to what is provided under a typical employer plan, but no more generous than the current benchmark or the state's 10 benchmark options, opens the door for much more limited benefit packages. The combination of the "generosity limit" and the proposed definition – and lack of minimum

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<sup>2</sup> Congressional Budget Office. [Cost Estimate H.R. 1628, American Health Care Act of 2017](#) (as passed by the House of Representatives on May 4, 2017), pp. 7.

standards – for a typical employer plan<sup>3</sup> means that a state could select a very limited, outlier plan with a benefit package that does not cover the range of services that every child needs, from preventive to primary to tertiary care. A state could design a package from scratch that includes full coverage of pediatric well-child and well-baby care, but does not cover other services that children with special health care needs require, such as the full cadre of regular clinic visits to assess their developmental milestones.

We also have serious reservations regarding the proposal to allow issuers to substitute benefits across the EHB categories, as well as within categories as currently allowed. The current restriction on benefit substitution is an important protection for children and families. It not only allows consumers to make more informed choices among plans, but also helps assure that plans cover necessary services. Flexibility to substitute benefits across categories could incentivize issuers to shift the actuarial value of the plan toward benefits that are less expensive and compromise the adequacy of the benefit package. As noted in the preamble, this proposal would increase the burden on consumers who would need to spend more time and effort comparing benefits offered by different plans to ensure the plan meets their needs. We urge CMS to reconsider this proposal.

Finally, we remind CMS that the proposed EHB changes will also have a profound impact on pregnant women, children and families covered in group plans outside of the Exchanges. Changes to the state benchmarks could expose consumers throughout the commercial market to annual and lifetime limits on any covered services in their plan that are not EHB. Consumers throughout the commercial market could also lose the protection of the out-of-pocket maximum for any non-EHB service that is covered by their plan. As a result, children with serious, chronic or complex conditions who get their coverage through the employer market could face gaps in coverage and their families could be confronted with exorbitant bills as they bump up against the limits.

We are pleased that the agency recognizes that the proposed changes to the benchmark process could result in inadequate coverage for individuals with medical conditions. As noted in the preamble, “...Consumers who have specific health needs may also be impacted by the proposed policy...depending on the selection made by the State in which the consumer lives, consumers with less comprehensive plans may no longer have coverage for certain services...” Allowing states to potentially ratchet back their benefit package, does all children – and ultimately the nation – a serious disservice.

We share your concerns regarding the affordability of coverage and remind you that adequate benefits will result in affordable coverage when measured by overall cost to families. It is vitally important that families are protected from the bankrupting out-of-pocket costs that can occur when their health plan does not appropriately cover the services they need. Therefore, we urge you to ensure that the EHB standard provides access to appropriate health care for all pregnant women, children and families based on *medical* standards, not on financial objectives. By doing so, you are helping ensure that children can meet their full potential and grow up to become productive adults.

### **Stand Alone Dental Plans (§156.150)**

We agree with the goal articulated in the proposed Notice of enabling “consumers [to] select from a greater variety of plans and find one that is more likely to meet their specific needs.” However, we are concerned about the impact on children of the elimination of actuarial value (AV) standards for stand alone dental plans (SADPs), particularly for children in states with an EHB benchmark that is less

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<sup>3</sup> The proposed Notice defines a “typical employer plan” as a fully insured or self-insured employer plan with at least 5,000 enrollees in one or more states. However, there are no requirements in the Notice that the “typical employer plan” meet any other criteria such as providing minimum value or covering all EHBs.

comprehensive than what is provided through the FEDVIP or CHIP. Without the protections afforded through the AV requirements, SADP issuers are more likely to offer less coverage. If no AV standard exists, a dental insurer could offer a product that covers only the minimally required benefits (such as routine exams, cleanings, x-rays, and dental sealants) but omit sufficient coverage for other necessary oral health care for children, including fillings and other services to treat and manage tooth decay.

In addition, the elimination of AV standards would make it more difficult for families to assess the value of plans and accurately compare plan options. We urge CMS to maintain emphasis on quality and value of plan products, as well as affordability, and ensure that consumers can make choices based on accurate information about plan options. As such, we request that CMS maintain a minimum standard of 70 percent AV for the SADPs and require insurers to advertise plan AV as part of the marketplace shopping experience.

### **Network Adequacy (§156.230)**

We urge CMS to retain a federal role in plan network adequacy oversight and assessment by, at a minimum, maintaining §156.230 as it is currently written. The absence of a federal minimum set of standards for provider networks will lead to a patchwork of state standards and processes and will likely reduce children's access to needed pediatric specialty care.

Children must have access to pediatric providers with the requisite training and expertise to meet their unique health care needs, regardless of the state in which they live. In particular, children with serious, chronic or complex health conditions, including children with special health care needs, must have in-network access to a range of pediatric providers, including primary, specialty and subspecialty care physicians (such as pediatric medical subspecialists and pediatric surgical specialists); pediatric nurse practitioners; pediatric mental health providers; other pediatric clinicians; and children's hospitals to ensure that their particular health conditions are appropriately addressed.

The ongoing trend toward more limited (and inadequate) networks is likely to worsen, threatening children's health and well-being, and leaving families with exorbitant out-of-pocket expenses when they must seek out-of-network care for their child because there is not an appropriate in-network provider. Without a minimum framework of standards, this inconsistency in provider network adequacy among states and plans will continue.

In the event that CMS moves forward with its proposed delegation of regulatory authority to the states, there must be clear requirements that all states – not just those with unaccredited plans – demonstrate that they have quantitative and other standards comparable to those articulated in the National Association of Insurance Commissioners Model Act. The Model Act, which was approved by all 50 states, is designed to give states options that fit the needs of their particular state. It also includes a minimum framework for a degree of quantitative network adequacy standards and reporting that addresses access to care for vulnerable children and adults.

We are pleased that the agency plans to monitor network adequacy in coordination with states, but believe that the Notice should clarify that complaint tracking will encompass complaints by providers, as well as consumers. In addition, we ask CMS to clarify that states should have established procedures that issuers must follow in the event complaint tracking indicates an inadequate network. Those procedures must address network gaps, including the identification of needed specialists to fill the gaps.

### **Essential Community Providers (§156.235)**

We thank CMS for continuing to recognize the importance of essential community providers (ECPs) in meeting the needs of underserved communities throughout the country, but continue to be opposed to

any reduction of the ECP participation standard. ECPs play a particularly critical role in the care of low-income children and children with complex or chronic conditions or special health care needs. These children rely upon a comprehensive and diverse range of medical and ancillary services to meet their unique developmental and growth needs, which ECPs are designed to provide.

Networks without a sufficient number and scope of ECPs leave children enrolled in these plans without timely access to many pediatric specialty services that are only provided by a children's hospital, such as level IV neonatal intensive care and heart, liver and intestinal transplantation. Delays in care can be particularly detrimental to children's health, resulting not only in poor health outcomes, but additional costs to the health care system and long-term costs to the nation's economy.

**CHIP buy-in programs and minimum essential coverage (§156.602 and §156.604)**

We agree with CMS that CHIP buy-in programs may be the best coverage option for certain families, depending on the benefits, cost-sharing and the family's needs. Without access to a CHIP buy-in plan, some families might forgo coverage altogether. Therefore, it is critical that well-designed plans meet children's unique needs and that they meet the minimum essential coverage (MEC) requirements so families are not penalized if they are enrolled.

However, we are concerned that some CHIP buy-in programs may not offer the same protections as CHIP (i.e. a pediatric-appropriate benefit package, pediatric provider network and cost-sharing protections) or similar consumer protections to ACA-compliant plans. Therefore, we seek clarification from CMS about ways that it will assure that CHIP buy-in programs that are considered MEC provide pediatric-appropriate benefits, ensure access to a range of pediatric providers, and protect families from financial hardship. In particular, we believe that the use of a "substantially resembles" standard for CHIP buy-in plans must be better defined and delineated to provide CMS with clear guidelines on what constitutes a qualifying buy-in plan. We look forward to working with the department on those guidelines.

In conclusion, the undersigned organizations appreciate this opportunity to share our views regarding the proposed Notice. We look forward to working with you to ensure that the unique health care needs of pregnant women, children and families are met in the individual and larger group markets. If we may provide further information or otherwise be of assistance, please contact Jan Kaplan at the Children's Hospital Association, at 202-753-5384 or [jan.kaplan@childrenshospitals.org](mailto:jan.kaplan@childrenshospitals.org).

Sincerely,

American Academy of Pediatrics  
Children's Defense Fund  
Children's Dental Health Project  
Children's Hospital Association  
Family Voices  
First Focus  
March of Dimes  
National Association of Pediatric Nurse Practitioners