Georgetown University
Health Policy Institute
CENTER FOR CHILDREN
AND FAMILIES

March 7, 2017

VIA ELECTRONIC SUBMISSION (marketreform@cms.hhs.gov)

Dr. Patrick Conway, Acting Administrator, Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201
Attention: CMS-9929-P

Re: Notice of Proposed Rulemaking - PPACA Market Stabilization

The Center for Children and Families is based at Georgetown University's Health Policy Institute with the mission of improving access to health care coverage among the nation's low- and moderate-income children and families. As such, we have a long history of conducting analysis, research and advocacy on issues relating to enrollment in all insurance affordability programs, including Medicaid, CHIP, and Qualified Health Plans (QHPs).

More than 1.1 million children were enrolled in QHPs at the end of the open enrollment period for 2016 coverage. These children and their families would be impacted by the proposed rule in specific ways that concern us, as detailed below. It is also important to point out that, if finalized, these rules will weaken consumer protections while lowering premium tax credits, which undermines – rather than strengthens – the Health Insurance Marketplace.

Thus, we urge you to:

- **Maintain the current three-month open enrollment period. (§155.410)** President Trump recently noted "who knew health care could be so complicated?" This applies to low-income families who need personalized assistance to enroll and make informed plan choices. Shortening the open enrollment period would stress consumer assistance resources and the single Medicaid-QHP integrated eligibility and enrollment systems that are operated in some states that run their own state-based exchange.

- **Retain the current actuarial value (AV) requirements for QHPs at -2/+2 percent. (§156.140)** Lowering the requirement to -4% AV will mean that families may have additional cost-sharing that is particularly harmful for children with complex or chronic conditions. Weakening this standard has the potential to lower the actuarial value of the second lowest cost Silver plan on which premium tax credits are based, thereby reducing the financial assistance provided to enrollees who select plans that provide greater value and are better able to meet their health

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care needs. Furthermore, research has found that families faced with additional financial burden may delay needed care, which can increase inappropriate utilization of emergency room care and affect a child's long-term health outcomes and future productivity. For example, a 2014 study[1] examined how children with asthma obtained care under different levels of cost-sharing and the financial stress their families faced because of their child's illness. The researchers found that families with higher levels of cost-sharing were significantly more likely to delay or avoid going to the doctor or emergency room for their child's asthma, to borrow or cut back on necessities to afford care, and to avoid care.

- **Maintain minimum federal standards for network adequacy. (§156.230)** The proposed rule fails to describe how children and family access to providers will be impacted by the removal of federal network adequacy review. We are interested in understanding how HHS will ensure consumers have the same or better access to providers in all states if this proposal is implemented. On the other hand, by establishing a minimum framework for state regulations, HHS can protect against "skinny networks" that are not sufficient to meet the needs of children. In particular, networks must include adequate access to pediatric specialists. By punting these decisions to the states, there will be variability in access to needed care based on geography, which is unfair and harmful to children and other enrollees.

- **Retain the current provision that requires QHPs to contract with a minimum of 30 percent of available essential community providers and phase in higher thresholds in the future. (§156.235)** Essential community providers include community health centers, rural clinics, and other safety net providers that are well equipped to provide for vulnerable, low-income and underserved children and families. Rather than reducing network requirements for inclusion of essential community providers, HHS should incrementally increase the threshold over the next few years until a majority of essential community providers are included in all QHP networks.

- **Allow parents who give birth or adopt a child to change to a different QHP or metal tier in order to meet the family's changing health care needs. (§155.420)** The plan in which a parent has enrolled may not meet the needs of a newborn or adopted child, so it is important that families be given the flexibility to switch QHPs or metal levels when they qualify for a special enrollment period due to the birth or adoption of a child. This is particularly true if network adequacy standards are lowered and key pediatric providers are not included in the plan that the parents had chosen prior to adding dependents.

Thank you for the opportunity to comment on the "Market Stabilization NPRM." If you have questions about our comments, please contact Tricia Brooks, at 202-365-9148 or pab62@georgetown.edu.

Sincerely,
Joan Alker, Executive Director

[1] See Financial Barriers to Care Among Low-Income Children With Asthma, JAMA Pediatrics, July 2014.