Your Comment Tracking Number: **1jw-82nu-ivma**

December 21, 2012

Marilyn Tavenner

Acting Administrator and Chief Operating Officer

Centers for Medicare & Medicaid Services

Department of Health and Human Services

200 Independence Avenue SW

Washington, DC 20201

**RE: Comments on proposed Market Reform regulation CMS-9972-P**

Dear Ms. Tavenner:

The Georgetown University Center for Children and Families appreciates the opportunity to provide comment on the proposed rule on health insurance market reforms (CMS-9972-P). The Center for Children and Families is an independent, nonpartisan policy and research center whose mission is to expand and improve health coverage for America's children and families.

**GENERAL COMMENTS**

**Support the standardization of rate setting and enrollment practices**. In general, we are strongly supportive of the proposed market reform regulation and encourage HHS to make it final as soon as possible. The decision to require significant standardization of insurers’ rate setting and enrollment practices will help to ensure that guaranteed access to coverage, renewal of coverage, and fair pricing practices become a reality for the nation’s children and families. The market reform rule is particularly important for children with pre-existing conditions such as birth defects, developmental disabilities, and chronic health conditions whose families otherwise might be unable to secure coverage on their behalf. In particular, we encourage HHS to ensure that the final rule retains the following:

* Standards for age rating, including use of a uniform age rating curve that begins at age 21;
* Standards that limit the number and type of rating areas, including the maximum limit of seven rating areas per state;
* The uniform application of marketing rules and the prohibition on discriminatory benefit design to all individual and small group issuers, including those offering coverage outside of an Exchange; and
* The use of the same initial open enrollment period inside and outside of an Exchange.

Without such standardization, we are concerned that issuers would find ways to enroll healthier people and exclude those at risk of high medical expenses, including children with special health care needs.

**COMMENTS ON SPECIFIC PROVISIONS**

**Retain age rating structure** (§147.102(a)(1)(iii))**.** With respect to §147.102(a)(1)(iii), we strongly support the decision to limit the 3:1 age rating band to individuals who are 21 and older, as well as the use of a uniform age rating curve for those under 21. Under the curve appearing in the proposed rule, children under 21 would cost roughly 2/3rds of the amount of an adult who is age 21. We believe that such a policy makes sense because of the relatively low cost of covering children. While some are suggesting the inclusion of more young adults (e.g., those ages 21 to 26) in the definition of “child” for purposes of age rating, we are concerned that this would increase the cost of coverage for families with children under 21, an outcome that appears contrary to the clear intent of the statute to ensure that families have viable insurance options for their children.

**Exclude children from tobacco rating (§147102(a)(1)(iv)**. While we strongly support efforts in other contexts to discourage children from smoking, we do not think that charging families higher premiums based on their children’s tobacco use is an appropriate or effective strategy for combating smoking among children. Specifically, we see significant practical problems arising if parents are expected to report on their children’s tobacco usage. In many instances, parents will be unaware of their children’s usage, particularly given that it remains illegal for children under age 18 to purchase tobacco products. The prospect of causing their families to face higher insurance premiums may even encourage children to hide smoking from their parents, making it harder for them to combat the smoking. To ease the application process and avoid inserting Exchanges in the midst of family conversations about tobacco usage, we recommend that the final rule allow tobacco use rating only for individuals 18 and older (the age at which people can begin to legally purchase tobacco products). If it is not possible to mandate that all children should be excluded from tobacco rating under federal rules, we encourage you to make clear in the final market reform rule that states have the option to do so.

**Adopt a fair, clear and reliable definition of “tobacco use.”** As noted above, we believe it would be appropriate to exclude children from tobacco rating. But, if the final rule is not modified to reflect this recommendation, it is imperative that it includes a clear, standardized definition of “tobacco use” that will help ensure that this rating factor is applied to families in a fair and consistent manner. The definition should provide clarity on both what is meant by “tobacco” (i.e., which products are included) and by “use” (i.e., how frequently a person uses tobacco over a reasonable look-back period, such as, for example, 30 days). To arrive at the specific definition, HHS should consult with outside experts and should subject possible definitions to consumer testing to ensure that consumers understand the definition. Moreover, Exchanges should be required to rely on self-reporting when identifying tobacco users. Other methods, such as blood or saliva tests, are intrusive and often inaccurate. Indeed, they can result in people who are using tobacco replacement products inappropriately being classified as tobacco users.

**Allow children who do not live with their families to secure coverage through network plans** (§147.104(c)). We are concerned about the implications for families of the proposal to allow network plans to decline to cover individuals unless they live, work or reside in the plan’s service area. As currently drafted, the proposed policy could create complexity and financial hardship for families who have members residing in more than one service area (e.g., parents living at home while their children are away at college). We recommend that the final rule modify and narrow the special rules for network plans to apply only to individuals without families. If a family has one or more adult members living, working, or residing in the plan’s service area, it should be allowed to enroll all of its members in coverage. Under such a policy, families would be able to purchase family-based coverage that also includes their dependent children residing in a different service area. While the preamble to the rule notes that individuals residing outside of a service area could always purchase coverage through a different issuer, such an option does not work well for families. If they are forced to split coverage among plans serving different areas, they will have to buy multiple plans and will be at risk for higher cost-sharing obligations.

**ADDITIONAL COMMENTS**

**Require issuers to provide family coverage.** The proposed market rule and the ACA statute itself appears to clearly contemplate that issuers will offer both individual and family coverage, but there does not appear to be a requirement to this effect in the proposed market rules. We strongly recommend that you make it clear that issuers must offer family-based coverage if they elect to offer individual coverage. (Such a policy would be similar to the proposed requirement that issuers who want to participate in the federally-facilitated Exchange also offer coverage on the federally-facilitated SHOP Exchange.) It is not enough to say that families could simply purchase multiple individual plans because families would then face separate deductibles and out-of-pocket maximums for each individual within the unit. This does not appear to be what Congress intended, given that it explicitly called for allowing rating variation by individual and family tiers (§2701(a)(1)(A)(i)) and that it assumed family-based coverage would be available when designing the APTC (§36B(b)(3)(B)(ii)(II)).

**Provide a floor on the definition of which children are part of a “family”**. We recommend that you create a “floor” on the definition of which children must be included as part of a family for purposes of purchasing health insurance. The final rule should require that states at a minimum allow the following children to be included in a family unit for insurance purposes: biological children, adoptive children step-children, grand children (if being cared for by the grandparent), children of other caretaker relatives, foster children, children under guardianship, and any other child who would be considered a tax dependent under IRS rules for purposes of the APTC. Without such clarity, there is a risk that in some states adults who are caring for children and responsible for their health and well-being will not be able to purchase coverage on their behalf.

**Strengthen enforcement mechanisms.** We recommend that the final rule be much stronger in outlining the steps that will be taken to ensure proper and fair enforcement of the market reforms. States should specifically be advised that if they are unwilling or unable to substantially enforce the consumer protections in the ACA, the federal government will take action to enforce those protections so that consumers receive their full rights under the law. In assessing whether a state is adequately enforcing the market reforms, HHS should consider both whether a state has adopted conforming legislation and if it is actually enforcing the provisions. As evidence of enforcement, HHS, for example, could evaluate whether a state is actively monitoring issuers’ behavior in the market place; conducting rate and form review, and tracking and responding to consumer complaints. In the absence of appropriate enforcement, there is a risk that the insurance reforms will prove illusory and children will continue to be denied or dropped from coverage due to their medical conditions.

Thank your for considering our comments. Any questions on these comments may be directed to Jocelyn Guyer, Co-Executive Director, at jag99@georgetown.edu or 202-784-4077.

Sincerely,

Georgetown University Center for Children and Families.