Georgetown University
Health Policy Institute
CENTER FOR CHILDREN
AND FAMILIES

October 6, 2016

VIA ELECTRONIC SUBMISSION

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

Attention: CMS-9934-P; Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018

Dear Sir or Madam:

Thank you for the opportunity to comment on CMS-9934-P, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018" (hereinafter referred to as "the proposed notice").

The Center for Children and Families is a center based at Georgetown University's Health Policy Institute with the mission of improving access to health care coverage among the nation's children, particularly those in low-income families. As such, we have a long history of conducting analysis, research, and advocacy on issues relating to children's health care access in public programs.

We would like to comment on two aspects of the proposed notice: (1) the child age band and factor and (2) language access.

Proposed Changes to Child Age Band and Factor

§ 147.102 Fair Health Insurance Premiums

We are concerned about the proposed changes to the child age band and factor because it would result in higher costs for children. Analyses by the Department of Health and Human Service (HHS) and the Medicaid and CHIP Access Commission (MACPAC) have documented the affordability challenges for families in the marketplace well. HHS found that average premiums and cost sharing for children in silver-level marketplace plans ranged from $638 to $1,969 whereas the range for children in the Children's Health Insurance Program (CHIP) was $0 to $829 in the 36 states studied.[1] Similarly, MACPAC found that premiums and cost sharing average $158 per year in CHIP compared to $1,073 in silver-level marketplace plans.[2] High upfront costs, like premiums, lead to families forgoing coverage altogether, and high point-of-service costs, like copays and deductibles, lead to families

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delaying needed care. This is concerning because it is clear from 50 years of Medicaid coverage that children with affordable health care coverage become healthier adults with greater academic and economic success.[3]

With this in mind, it is concerning that the proposed notice considers increasing costs for children. Coverage is already unaffordable for many families, and given the uncertainty about future federal funding for CHIP, many more children could be impacted by these changes in addition to the approximately one million children covered by marketplace plans currently.

We supported the single age band for children ages zero to 20, particularly because of our concern about the potential for very high premiums for newborns. Newborn coverage is critical to development and life-long health. However, we also recognize that the single age band for children, taken together with the 1.0 premium ratio at age 21, has led to a spike in premiums for 21-year-olds. One of the goals of the Affordable Care Act's (ACA) rating rules was to minimize premium spikes as people age, promoting continuous coverage across the lifespan. We support the effort to smooth the premium spike at age 21 but urge HHS to give full consideration to the impact on children and young adults in order to avoid creating a new spike at age 15 (as currently proposed) or at any other age. Older children already have higher rates of uninsurance than their younger peers, with 6.5 percent of children ages 6 to 17 uninsured in 2014 compared to 4.9 percent of children under 6 years old.[4] Young adults, ages 19 to 25, are the most likely to be uninsured, with an uninsurance rate of 20.4 percent in 2014.[5] To the extent that high costs in marketplace plans may suppress enrollment in this age group, HHS could consider methods to lower costs for young adults rather than increasing costs for adolescents.

In addition to the proposed change to add single-year age bands beginning at age 15 to smoothen premium levels into young adulthood, the proposed notice also suggests increasing the premium ratios to better reflect the cost of children's coverage. However, it is unclear from the data presented whether the higher costs associated with certain age ranges (0-4, 5-14, and 15-20) are due to age or severity of need. Costs due to age are appropriately handled by premiums, as age is one of five factors that may be considered in setting premium amounts. However, costs due to severity of need should not be incorporated into the premium calculation but factored in to the back-end risk adjustment instead. We believe that more information is needed to determine whether the proposed factor increase is actuarially justified and in keeping with the ACA's rating rules to end insurance underwriting based on health status.

> **Recommendation 1:** Given these concerns, we recommend that HHS delay making any changes to the child age band and premium ratio until more information is available to fully assess the options. To meet the goal of smoothing premiums for adolescents as they become young adults, HHS should consider methods to lower costs for young adults rather than increasing costs for adolescents. To meet the goal of accurately reflecting children's health care costs, HHS should consider whether age or health status are the driving factors and use the appropriate tools to address

the need, including updating the risk adjustment methodology to better reflect pediatric risk.

Recommendation 2: If HHS decides to proceed with implementing single-year age bands for 15 to 20 year olds as well as increasing the premium ratio for all children, we recommend that HHS phase in these changes over at least 3 years. If HHS were to implement these changes in 2018 as proposed, the result would be premium spikes for older adolescents (19- and 20-year-olds) comparable to the premium spike the proposal is intended to mitigate for 21-year-olds, as well as premium spikes for all adolescents that outpace the year-to-year changes as the adolescent ages. HHS could strike a better balance by phasing in any changes over time.

Recommendation 3: We further recommend that HHS carefully monitor the coverage impact of any changes to premiums. Currently, there is very little data available publicly to monitor child enrollment by key demographic factors (age, income, state, race and ethnicity, family size, etc.), making it impossible to fully assess the current state of affairs and the impact of any proposed changes. For example, it is unclear if the premium spike at age 21 is resulting in individuals dropping coverage now. HHS should monitor the enrollment impact carefully to understand how families react to any premium increases, for example, by dropping coverage or by enrolling only some children in the family. HHS should fully implement the data transparency requirements in section 1311(e) of the ACA to inform these discussions.

Proposed Changes to Language Access Provisions

§ 155.205 Consumer Assistance Tools and Programs of an Exchange

With regard to language access provisions, we have two primary recommendations: (1) only allow aggregation if an issuer or other entity documents that it would be a hardship not to aggregate due to increased costs (recognizing that the entity would not have costs in producing taglines since model taglines are available from HHS) and (2) retain specific tagline requirements in § 155.205 rather than merely cross-reference to 42 C.F.R. § 92.8 or omit references. We provide support for each of these recommendations below.

Recommendation 1: Only allow aggregation if an issuer or other entity documents that it would be a hardship not to aggregate due to increased costs (recognizing that the entity would not have costs in producing taglines since model taglines are available from HHS).

We are concerned that the proposed regulation allows marketplaces, qualified health plans and other entities to aggregate limited English proficient populations across all states served. This aggregation reduces the availability of tag lines for groups that have a large presence in certain states but when states are aggregated, their language needs do not rise to the top 15 languages.

From a practical standpoint, since HHS provides sample taglines and state-by-state data of the top 15 languages, it should not require significant resources from a covered entity to use them. Additionally, since many entities may comply by creating one webpage or an addendum to written materials with the taglines, space would be a potential legitimate constraint on the number of taglines. Yet more than 15 taglines could easily fit on a one-page addendum or webpage without adding cost or confusion.

Further, entities operating in more than one state likely have to tailor materials to the requirements of that state already by creating state-specific materials, so providing state-specific taglines would not be an onerous requirement. For example, issuers have to provide notice of appeal rights and disclose the availability of and contact information for any applicable health insurance consumer assistance or ombudsman, which differs from state to state.[6] In Washington, DC issuers have to list the DC Ombudsman and the Department of Insurance as sources of help for consumers and provide detailed contact information.[7] We should err on the side of over-inclusion rather than under-inclusion to ensure adequate notice of available language services for those who need them.

When issuers offering QHPs in multiple states aggregate Limited English Proficiency (LEP) populations, large LEP groups in one state will lose access to tagline/ notice.

The proposed regulation would allow marketplaces, qualified health plans, and other entities to aggregate limited English proficient populations across all states served. For example, Kaiser serves California, Colorado, District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, and Washington. Using HHS's data, even though there are more than 27,000 people with limited English proficiency in California who speak Thai, that language does not rise to the top 15 languages when California language needs are combined with those of other states that Kaiser serves.[8] California is a very large state with large numbers of residents with limited English proficiency, thus when smaller states like Maryland are aggregated with California, residents lose access to several languages including French, Urdu, Kru, Ibo, Yoruba, Gujarati, French Creole, and Portuguese.[9]

When an entity that operates multiple exchanges or relies on an eligibility or enrollment platform used in multiple states, LEP groups that are vibrant in one state will lose access to notice/tagline.

The proposed regulation also allows aggregation by an entity that operates multiple Exchanges or relies on an eligibility or enrollment platform that is relied upon by multiple Exchanges. While we recognize the intent might have been to specifically address the FFM, we are concerned that this language could also be read to include a contractor that might contract with a number of states to develop state-based Exchanges. That is, if the same contractor operates Exchanges in, for example, three different states, would that contractor be permitted to aggregate LEP data? We would recommend not. While one contractor may work with multiple states, each state has its own unique needs and will likely have different LEP population groups. We do not believe it is the intent of the proposed regulation to allow aggregation in this situation since the impact could seriously reduce notification to LEP consumers.

For example, both Connecticut and Maryland have used the same contractor to develop their state-based Exchange platforms. Using HHS' data,[10] Connecticut's top 15 languages are: Spanish, Portuguese, Polish, Chinese, Italian, French, French Creole, Russian, Vietnamese, Arabic, Korean, Albanian, Hindi, Tagalog and Greek. Maryland's top 15 languages are Spanish, Chinese, Korean, Vietnamese, French, Tagalog, Russian, Amharic, Kru/Ibo/Yoruba, Urdu, Persian, French Creole, Portuguese, Arabic and Gujarati.[11] Allowing aggregation, Maryland would lose two languages and Connecticut would lose three languages. One of Maryland's lost languages – Persian– had more individuals in Maryland (4,756) than either state's Arabic (3,365 in Maryland and 3,805 in Connecticut) population yet allowing aggregation would delete the Persian from the list.[12]

Given the consolidation of issuers in the healthcare arena, the resulting issuers will operate across larger swaths of the country, reducing access to taglines to groups that are not in the top 15 nationwide or an aggregation of multiple states.

Another concern arises given the ongoing consolidation of issuers in the healthcare arena. As more issuers merge, forming bigger conglomerates that operate across larger and larger swaths of the country, allowing aggregation will likely result in a loss of one of the two important policy objectives recognized by HHS in the preamble – ensuring that LEP individuals have notice of language assistance services. While we recognize the competing objective of minimizing burdens on entities subject to the rule, we are very concerned that taglines often provide the only in-language information to LEP individuals.

> **Recommendation 2:** Retain specific tagline requirements in § 155.205 rather than merely cross-reference to 42 C.F.R. § 92.8 or omit references to taglines altogether.

We believe that this rule differs from the final regulations implementing Section 1557 in that many of the entities covered by this rule – including the Exchanges and issuers – operate on a much larger scope than the entities covered by Section 1557. While many may be covered by both rules, the Section 1557 rules were necessarily written to cover a broader array of covered entities than this rule – from a solo practitioner to a large hospital to a multi-state issuer. We thus believe that greater specificity and greater requirements are justified in this rule given the fact that many of the entities are much larger and both financially and programmatically able to provide greater taglines.

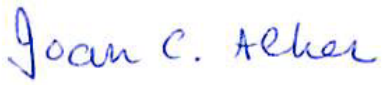
We believe that once an entity has to provide taglines, an entity that seeks to aggregate should first include as many taglines as will fit on one page rather than simply aggregate and include the top 15 languages only. Aggregation should only be permitted when the number of taglines would require additional pages involving additional cost to the entity. The same should apply to websites – since HHS provides model taglines and a specific webpage of taglines would not have space limitations – all taglines should be included rather than an aggregated number. As the regulation recognizes, if an entity is putting information on a homepage, then the name of the language can be included with a link to a tagline. But that linked page – such as that used by healthcare.gov[13] – could easily include all disaggregated taglines without eliminating any through aggregation. Given that model

taglines are provided by HHS, and that more than 15 taglines could easily fit on one page, we believe HHS should require any entity seeking to aggregate to provide a written justification as to how aggregation would be overly burdensome to the entity. This must be balanced with the need to inform consumers.

In fact, it is because many of the entities covered by this proposed regulation are likely much larger in scope and size than entities generally covered by the Section 1557 regulations – such as individual provider offices, clinics, and hospitals – that there should be a higher standard for taglines and language services, because these entities have more resources. Given the acknowledged difficulties in reaching non-English speaking consumers, and the lack of comprehensive data collection of applicants' and enrollees' language needs, taglines offer one of the least costly methods to help inform LEP individuals of their rights and the availability of in-language assistance. We strongly believe that the tagline provisions should remain in these regulations and not merely included as a cross-reference to Section 1557.

Thank you for this opportunity to comment on the proposed notice. We look forward to continuing to work with you to ensure that the marketplace offers comprehensive and affordable coverage for children and families. If you have any questions about our comments, please contact Kelly Whitener at 202.687.0331 or kdw29@georgetown.edu (child age band and factor) or Sonya Schwartz at 202.784.4077 or ss3361@georgetown.edu (language access).

Sincerely,



Joan Alker

Attachment A: Example of Top 15 Languages When Aggregating the 9 States That Kaiser Permanente Serves

	California	Washington	Colorado	Maryland	District of Columbia	Georgia	Virginia	Oregon	Hawaii	Kaiser All States	Old Rank All States	New Rank All States
Spanish	4,490,408	232,748	226,453	174,142	17,465	342,161	217,843	140,093	6,974	5,848,287	1	1
Chinese	610,934	42,812	10,489	29,766	2,070	23,196	23,706	13,886	19,649	776,508	2	2
Vietnamese	316,886	38,432	12,078	12,905	389	26,867	25,813	15,643	6,349	455,362	3	3
Korean	218,938	27,088	8,475	21,344	240	25,239	30,193	5,322	11,595	348,434	5	4
Tagalog	260,443	19,128	2,055	10,644	627		12,976		31,449	337,322	4	5
Russian	73,133	25,421	6,405	8,713	552	5,146	5,332	9,547		134,249	6	6
Japanese	63,441	9,016	1,635		281	3,114		3,036	21,288	101,811	10	7
Arabic	62,500	6,417	4,093	3,363	216	4,485	13,844	2,610		97,528	9	8
Persian	74,437		1,280	4,756		3,618	9,316	1,342		94,749	8	9
Armenian	94,516									94,516	7	10
Panjabi	53,335	6,145								59,480	11	11
Mon-Khmer, Cambodian	41,476	9,046						1,666		52,188	12	12
Hindi	31,256					5,381	4,552			41,189	14	13
Amharic		7,590	4,200	7,435	2,475	5,585	8,550			35,835		14
Hmong	34,953									34,953	13	15
Ilocano									33,085	33,085		
Samoan									4,400	4,400		
Marshallese									3,840	3,840		
Trukese									3,410	3,410		
Hawaiian									3,010	3,010		
Micronesian									2,210	2,210		
Bisayan									1,640	1,640		
Tongan									1,515	1,515		
Laotian		3,712							1,362	5,074		
Ukranian		12,555						3,065		15,620		
Romanian								2,350		2,350		
Cushite		6,965	1,610					1,580		10,155		
German		3,863	2,865		217	3,394	4,056	1,459		15,854		
French			2,528	12,695	1,824	6,923	6,755	1,241		31,966		
Thai	27,573				230			1,208		29,011	15	
Urdu				5,456			8,094			13,550		
Bengali					305		4,000			4,305		
Kru, Ibo, Yoruba			1,220	5,605	360		3,805			10,990		
Gujarati				3,270		6,945				10,215		
French Creole				3,854		5,169				9,023		
Portuguese				3,496	475	3,623				7,594		
Italian					432					432		
Nepali			2,095							2,095		

Attachment B: Example of Top 15 Languages When Aggregating Maryland and Connecticut, Which Are Served by the Same Marketplace Contractor

Language	Maryland	Connecticut	Sum	Rank
Spanish	174,142	156,861	331,003	1
Chinese	29,766	13,409	43,175	2
Korean	21,344	3,535	24,879	3
French	12,695	7,501	20,196	4
Portuguese	3,496	16,008	19,504	5
Vietnamese	12,905	4,681	17,586	6
Polish		15,109	15,109	7
Russian	8,713	4,916	13,629	8
Tagalog	10,644	2,639	13,283	9
Italian		10,037	10,037	10
French Creole	3,854	5,567	9,421	11
Amharic	7,435		7,435	12
Arabic	3,363	3,805	7,168	13
Kru, Ibo, Yoruba	5,605		5,605	14
Urdu	5,456		5,456	15
Persian	4,756		4,756	
Albanian		3,295	3,295	
Gujarati	3,270		3,270	
Hindi		2,930	2,930	
Greek		2,242	2,242	

Attachment C: CareFirst Notice with DC-Specific Contact Info for Appeals

Explanation of Benefits

CareFirst

Internal Expedited Review

If your situation meets the definition of an emergency or urgent under the law, your review will be conducted on an expedited basis. Generally, an emergent or urgent situation is one in which your physical, mental or emotional health may be in serious jeopardy; serious impairment to bodily, mental or emotional functions; or serious dysfunction of any bodily organ, part or mental or emotional functions; or if pregnant placing your health or the health of your unborn child in serious jeopardy could occur while you wait for a decision on your grievance. If you believe your situation is an emergency or urgent, you may request an expedited grievance in writing or orally (please contact the customer service number on the back of your membership card). CareFirst shall respond with a benefit determination within 24 hours of receipt of the expedited grievance request.

External Appeals

Upon exhaustion of our internal grievance process, you may have the right to have our decision reviewed by health care professionals who have no association with us, if our decision involved making judgments as to the medical necessity, medical appropriateness, health care setting, level of care or effectiveness of the health care service or treatment, by submitting a request for external review to:

For DC Members with Medical Necessity Issues:

DC Office of the Health Care Ombudsman and Bill of Rights
One Judiciary Square
441 4th Street, NW, 9th Floor
Washington, DC 20001
Telephone: (877) 685-6391
Email: healthcareombudsman@dc.gov

For DC Members with Non-Medical Necessity Issues:

District of Columbia Department of Insurance,
Securities and Banking, Consumer Services Division
810 First Street NE, Suite 701, Washington, DC 20002
Telephone: (202) 727-8000
Fax: (202) 535-1197 or (202) 354-1085

Questions

You may call the telephone number on the back of your member ID card if you:

- Are not sure what this explanation regarding your claim means;
- Have unanswered questions about how to request a grievance or appeal; or
- Wish to request, at no charge, copies of the relevant information regarding your claim, including copies of the benefit provision, guideline, protocol or other similar criterion on which this determination was based.

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services, "Certification of Comparability of Pediatric Coverage Offered by Qualified Health Plans," November, 25, 2015, available at https://www.medicaid.gov/chip/downloads/certification-of-comparability-of-pediatric-coverage-offered-by-qualified-health-plans.pdf.

[2] Medicaid and CHIP Payment and Access Commission, "Design Considerations for the Future of Children's Coverage: Focus on Affordability," March 2016, available at https://www.macpac.gov/wp-content/uploads/2016/03/Design-Considerations-for-the-Future-of-Children%E2%80%99s-Coverage-Focus-on-Affordability.pdf.

[3] A. Chester and J. Alker, Georgetown University Center for Children and Families, "Medicaid at 50: A Look at the Long-Term Benefits of Childhood Medicaid," July 2015, available at http://ccf.georgetown.edu/wp-content/uploads/2015/08/Medicaid-at-50_final.pdf.

[4] J. Alker and A. Chester, Georgetown University Center for Children and Families, "Children's Health Insurance Rates in 2014: ACA Results in Significant Improvements," October 2015, available at http://ccf.georgetown.edu/wp-content/uploads/2015/10/ACS-report-2015.pdf.

[5] Ibid.

[6] 45 C.F.R. § 147.136(b)(2)(E)(5).

[7] See Attachment C.

[8] See Attachment A. Data source is Appendix A – Top 15 Non-English Languages by State. https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Appendix-A-Top-15.pdf

[9] Ibid.

[10] See attachment B. Data source is Appendix A – Top 15 Non-English Languages by State, https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Appendix-A-Top-15.pdf.

[11] Ibid.

[12] Ibid.

[13] See https://www.healthcare.gov/language-resource/#french.