



VIA ELECTRONIC SUBMISSION (FFECOMMENTS@CMS.HHS.GOV)

January 12, 2015

Department of Health & Human Services
Centers for Medicare & Medicaid Services
Center for Consumer Information & Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

To Whom It May Concern:

Thank you for the opportunity to comment on the draft 2016 Letter to Issuers in the Federally-facilitated Marketplaces. 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 related to all insurance affordability programs, including Medicaid, CHIP, and qualified health plans (QHPs). Our comments on the draft letter to issuers are focused on Chapter 2, Section 9: Discriminatory Benefit Design.

We support the letter's clarification that discrimination based on age or chronic health needs violates the essential health benefits standard. We acknowledge that states provide the first line of enforcement for the EHB standard. However, we urge CMS to go beyond merely encouraging states to consider strategies for assessing compliance. CMS should also provide active assistance to states to aid in their analysis of benefit design. CMS should offer guidance and tools to help states identify discriminatory benefit designs before plans are marketed to consumers.

We strongly support CMS reviews of QHPs to identify outliers in out of pocket costs for certain conditions and to identify discriminatory wording in Plans and Benefits Templates. Such reviews are key ways to identify and eliminate discriminatory benefit design and the procedures for conducting these reviews should be among the tools provided to states. We urge CMS to conduct both reviews and to so do with attention to the needs of child enrollees, particularly those with chronic and developmental conditions.

Children with chronic conditions are particularly vulnerable to discriminatory benefit design. This is especially true when all pediatric specialists are in high cost-sharing tiers of provider networks and/or when a plan limits treatments like habilitative, rehabilitative, physical, speech, or occupational therapies that children may need to develop to their full potential. Because these types of benefits were often limited in the 2012 employer plans that will continue to serve as the EHB benchmarks in 2016, special attention to how QHPs provide them is warranted.

When identifying out-of-pocket cost outliers, we urge CMS to add to the list of modeled conditions physical and intellectual development disorders among children. These disorders often require frequent and ongoing visits to pediatric specialists (who are often in plans' high cost-sharing tiers) as well as therapists (where benefit limits often apply). Such health needs put families at risk for high out-of-pocket costs and should be included among a range of other conditions as part of the outlier analysis.

Review of the Plans and Benefits Template to uncover discriminatory features is also an important protection. Again, we recommend that CMS share the procedures for these reviews with states so that they can be applied to all EHB-covered plans, including those sold in plan management and state-based marketplace states. Further, we urge CMS to make the findings of these reviews public, including any supporting documentation plans submit to justify plan designs. Public disclosure will allow consumer advocates and outside clinical experts to have confidence that benefits are clinically indicated and based on reasonable medical management practices.

Finally, we support the review of prescription drug benefits for clinical appropriateness. We urge CMS to add more conditions, including pediatric conditions, to the list to be analyzed. Plans may be more likely to restrict access through lack of coverage or inappropriately use utilization management techniques for conditions that are expensive to treat, either because they have high prevalence or high per patient costs. Adding more conditions will allow CMS to ensure that a wider range of enrollees have access to sufficient prescription drug coverage.

Thank you for your consideration of these comments. Please contact Joan Alker at jca25@georgetown.edu if we can provide any additional information or context.

Sincerely,

Georgetown University Center for Children and Families