July 28, 2021

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9906-P
P.O. Box 8016
Baltimore, MD 21244-8016
[Submitted electronically]

Dear Administrator Brooks-LaSure,

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 rule, “Patient Protection and Affordable Act; Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022” (proposed rule). Our organizations believe that all coverage for children must ensure access to timely, affordable, high-quality and age-appropriate health care (including dental, vision and hearing services) that meets their unique developmental needs and enables them to meet their full potential as adults. It must also promote the health of women before, during and between pregnancies. Access to health care for children and their families is vital to long-term health, well-being and productivity.

Our comments below highlight our general support for key policy changes that are included in the proposed rule and have positive implications for children’s health and health care. We also provide you with our recommendations for additional actions that we believe are necessary to ensure that private coverage options for children—particularly children with serious, chronic and complex conditions—meet their unique needs. In particular, we urge you to take action in future rulemaking to:

- Rescind the revisions to the essential health benefit (EHB) benchmark process, established through the 2019 Notice of Benefit and Payment Parameters (Notice), which give states and issuers more flexibility in the design of their benefit plans.
- Strengthen the pediatric services category of the EHBs to include all age-appropriate 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.
- Design a federal network adequacy framework that uses a set of multi-faceted metrics to take into account the full range of children’s health and developmental needs—including children who have serious, chronic or complex conditions—geographic challenges, and the regionalization of pediatric specialty care.
- Rescind the final rules that extended the availability of non ACA-compliant plans, including short-term limited duration insurance plans, association health plans and health care sharing ministries.

Our detailed comments are below.

**Standardized Options (§155.20)**

We are pleased that CMS will be resuming the designation of standardized options and proposing plan designs in the 2023 Notice. We respectfully provide the following recommendations on ways the options can best meet the needs of children, particularly children with serious, chronic or complex health concerns.

- Clarify that deductible exemptions apply to the full range of pediatric preventive services, including those provided by a pediatric specialist. Children with chronic or complex medical conditions visit their medical specialists more frequently and may rely on them for their well-child and other preventive screenings, including immunizations.
- Apply the deductible exemption and cost-sharing limits to habilitative services. Coverage of habilitative services and devices is a critically important benefit 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.
Standardized cost-sharing structures for these services should be incorporated into the options to both inform consumer plan choice and convey the potential financial impact of using these important therapies.

- Delineate the specific types of adult and pediatric specialist visits that are exempt from the deductible and if there are any limits on the number of visits that are allowed under the exemption.
- Require the use of copayments, rather than coinsurance for specialty visits and specialty drugs in all the options. Coinsurance is a confusing concept for many consumers that does not allow them to accurately determine their costs of care and can result in a higher financial burden.

**Navigator Program Standards (§155.210)**

We support the proposal to reinstate the requirement that Navigators provide post-enrollment assistance to enable enrollees to effectuate coverage, resolve issues related to both their enrollment and their coverage and understand how their coverage works. We recommend that Navigators be trained on the specific concerns and issues that children and families may face while navigating their plan options and coverage, including:

- How differences in plans’ benefit designs and provider networks can impact children, particularly those with serious, chronic or complex conditions who need specialized medical and therapeutic services, which may be covered differently by plans.
- The state-specific eligibility pathways for children under Medicaid and the Children’s Health Insurance Program (CHIP). This is particularly important for some children with special health care needs who may need to supplement their private coverage with Medicaid.

**Exchange Direct Enrollment Options (§155.221(j))**

We support the repeal of the Direct Enrollment Exchange option for states, which would have permitted states, without a section 1332 waiver, to require individuals and families to enroll only through private web brokers and insurers, rather than through the Exchanges. Families in states that choose this option, similar to how Georgia’s Section 1332 waiver would work, would thus lose access to the full range of information about their coverage options, including ACA-compliant plans, Medicaid and CHIP, and access to financial assistance. This would cause confusion and misinformation and could result in brokers and insurers steering families away from ACA-compliant plans to short-term and other non-compliant plans with large gaps in coverage and few consumer protections. We are pleased that this policy is being reversed and look forward to working with you to continue to improve enrollment efforts and identify ways to further improve information about all coverage options for children and their families.

**Open Enrollment Period Extension; Monthly Special Enrollment Period (SEP) for APTC-Eligible Qualified Individuals with a Household Income No Greater than 150 Percent of the Federal Poverty Level (FPL) (§155.410(c); §155.420(d)(16))**

We support the extension of the open enrollment period for the 2022 coverage year so that it begins on Nov. 1, 2021 and runs through Jan 15, 2022. We agree that the extended enrollment period will give consumers, especially those who had been auto-enrolled, more time to make informed health coverage choices and increase their access to coverage. The extended SEP will also allow more time for outreach and enrollment efforts.

We also support the establishment of a monthly SEP for individuals or their dependents who are APTC-eligible and have a monthly income that is no greater than 150% of the FPL. A straightforward SEP for those with incomes below 150% of the FPL would better ensure greater enrollment among low-income families who experience changes in circumstances, as well as new enrollment among the uninsured over the course of the year.

Both families that have a loss of income during the year and those that may lose Medicaid coverage when the Medicaid state maintenance of effort ends in conjunction with the end of the COVID-19 public health emergency can benefit from timely access to the Exchanges. In the past, many people who are eligible for SEPs, including those losing Medicaid coverage, have not used them due to lack of awareness, timing requirements and the complexity of the process. This new SEP will reduce complexity and provide timely access to the comprehensive, tailored consumer assistance the Exchanges can provide to help ensure that families with children find appropriate and affordable coverage.
Furthermore, we note that there will likely be low risk of adverse selection under the proposed SEP. Those who are eligible for this SEP would likely be doing so due to the above reasons—once they are aware of their eligibility—rather than due to any pressing health needs.

**Provision of EHB (§156.115)**

We strongly support the clarification in the proposed rule that qualified health plans (QHPs) must comply with the Mental Health Parity and Addiction Equity Act, including those under the Consolidated Appropriations Act of 2021 (Act) related to non-quantitative treatment limits. This clarification of parity requirements for QHPs is an important step towards strengthening private coverage of mental health services, as well as state and federal oversight of plans’ compliance with parity requirements. As illustrated by the lawsuit, *Wit v. United Behavioral Health*, without adequate review and enforcement of parity requirements plans may resort to restrictive medical review criteria and other medical utilization techniques rather than generally accepted standards of care as the basis to reject mental health disorder claims. Absent the federal courts’ ruling that found that the plan’s rejection of claims was an unreasonable parity violation, thousands of children and youth enrolled in the plan would continue to be denied the services they need. The actions by United are illustrative of the challenges many families face as they navigate their health plans’ coverage policies and demonstrate the importance of parity enforcement in all insurance markets to promote access to necessary care.

We also provide the following recommendations to strengthen the EHBs for children.

**EHB benchmark process.** We urge you to rescind the revisions to the EHB benchmark process that were established through the 2019 Notice and give states and issuers more flexibility in the design of their benefit plans. When the new approach was proposed we expressed our strong concern that it could leave children, particularly those with serious, chronic or complex conditions, with limited access to needed services and their families with higher out-of-pocket costs. We continue to be concerned about the potential impact on children’s coverage of the additional flexibility afforded to states and issuers, including greater leeway to substitute benefits across categories, and the requirement that benchmarks must be equal in scope to a typical employer plan. It is possible under these criteria 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.

The flexibility to substitute benefits across EHB categories is particularly concerning. Restrictions on benefit substitution that were adopted under the Obama-Biden administration were an important protection for children and families. They not only allowed consumers to make more informed choices among plans, but also helped assure that plans covered necessary services. A Congressional Budget Office analysis\(^1\) predicted that, given more flexibility to design their own benefits, states would likely try to reduce premiums by scaling back key benefits for children, including mental health services, habilitative services and pediatric dental services.

**Strengthening the pediatric services category.** We applaud you for your commitment to strengthening coverage for individuals, families and children across the nation, particularly those who are most vulnerable. As you move forward with this work, we urge you to establish a federal standard for the pediatric services category that requires coverage of all age-appropriate 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. We recommend that, at a minimum, the pediatric benefit category should be defined based either on the benefits provided in a state’s CHIP plan or on the American Academy of Pediatrics’ Scope of Health Care Benefits for Children\(^2\). CHIP benefits are specifically tailored to children and meet their continuous, and changing, growth and developmental needs. States should be required to assess the pediatric benefits that are included and excluded from their selected benchmark and use their CHIP benefits or those included in the Scope of Health Benefits to supplement as needed so the plan fully covers pediatric services.

Children are not little adults and require health care benefits distinct from those provided for adults. They must have access to medically necessary, age-appropriate services, regardless of their plan choice. Those services must be specifically

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suited to children’s unique and continuous development and growth needs and must also include key therapies and devices that are now included in the habilitative services category of the EHBs. Habilitative 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 they 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.

Even the benchmark approach established under the Obama-Biden administration failed to ensure that children had access to a pediatric-appropriate set of benefits. The plans that serve as benchmarks were not developed with consideration of children’s unique needs, unlike Medicaid’s Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit standard and the benefits in state CHIP plans. Children often need services with greater frequency and intensity than adults, so certain benefit limits (for instance, limits on number of visits, frequency of service or device replacement, etc.) established for adults may be inappropriate for children who are continuing to develop and grow.

We look forward to working with you to strengthen pediatric benefits for children to ensure that children have adequate, age-appropriate coverage that is representative of all of their health needs. 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, must provide a level of benefit protection that is vital to children’s long term health, well-being and future productivity.

Network Adequacy (§156.230)
We are pleased that CMS plans to reestablish the federal reviews of network adequacy beginning in plan year 2023. An active federal role in the review and oversight of provider networks, based on a strong framework of standards, is critical to helping ensure that families are not faced with exorbitant out-of-pocket expenses because they must seek out-of-network care for their child if there is not an appropriate in-network provider.

As you consider new regulatory standards for network adequacy we urge you to go beyond a reliance on time and distance standards for pediatric networks. Time and distance metrics are a generally appropriate measure of a network’s pediatric primary care capacity, but cannot account for the many children who travel long distances and across state lines to receive necessary care from appropriate pediatric specialty providers, including children’s hospitals equipped to meet their unique tertiary and quaternary medical needs. A study in the June 2018 issue of Health Affairs found that nearly half of pediatric specialty hospitalizations took place outside of adult-focused distance standards. Similarly, an earlier Children’s Hospital Association analysis found that approximately 50% of children nationwide would not have access to the services of an acute care children’s hospital if adult Medicare Advantage time and distance standards are used.

A comprehensive, multi-faceted set of quantitative standards—such as enrollee ratios by specialty; wait times by specialty; geographic accessibility, etc.—will help assure that children have in-network access to the full range of covered services under their plan. Specifically, children must have access to pediatric providers with the requisite training and expertise to meet their unique health care needs, including their mental health care needs, regardless of the state in which they live. Furthermore, 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.

We are extremely pleased that you will be restoring the federal oversight role and ask that you establish minimum, uniform procedural standards for states, as well. Oversight, including regular audits of plans’ provider networks, is absolutely critical to ensuring that children have access to timely care and the providers they need, particularly pediatric specialists. The oversight and monitoring of plan networks must include procedures to monitor, identify, and address

3 See Children’s Hospital Association. Implications of adult network adequacy standards on children’s access to pediatric specialty care, June 2018.
pediatric provider network gaps or access barriers, including wait times and transportation complexities. As part of that oversight, plan’s consumer-facing information regarding their networks must be reviewed regularly to ensure that it includes up-to-date provider directories and clearly explains cost-sharing responsibilities, approval processes for out-of-network services, and appeals procedures for denied services. Plans also must be able to provide consumers with their provider selection standards, including the use of quality as a factor in network design and/or any emphasis on centering network design on lower cost providers, which may exclude some more highly specialized and trained providers that children might need.

We urge you to consult closely with a spectrum of pediatric provider/facility types, caregivers, child health advocates, and health plans as you move forward with the development of standards and a review process. That expertise can help you design a federal network adequacy framework that takes into account the full range of children’s health and developmental needs, geographic challenges, and the regionalization of pediatric specialty care.

Section 1332 Waivers
We strongly support your proposed rescission of the codification of the 2018 guidance related to the ACA’s statutory guardrails for Section 1332 state innovation waivers. We also support the statement in the rule that the secretaries have the right to further evaluate, suspend or terminate an approved waiver before its expiration for non-compliance with the original Section 1332 guardrails, laws and regulations, including any changes in federal law.

We agree that the 2018 guidance was wholly inconsistent with the statutory requirements of Section 1332 for affordability, comprehensiveness and coverage and would have far-reaching negative effects on children, pregnant women and families. We strongly believe that it is imperative that the affordability, comprehensiveness and coverage protections envisioned by Congress when it enacted Section 1332 are implemented in ways consistent with those statutory requirements. Without this rescission, Section 1332 waivers could be approved even though they might result in lower overall enrollment in ACA-compliant plans, more families that face higher out-of-pocket costs compared to those that face lower costs, and vulnerable populations—including those with low-incomes and children with serious health issues—worse off.

We are pleased that you will be encouraging states to develop waiver proposals that will specifically diminish barriers to coverage for people of color and other underserved groups, as well as those that increase access to comprehensive coverage, reduce premiums, improve affordability and address social determinants of health. We are also pleased that you will be assessing proposals based on their impact on vulnerable and underserved populations, including low-income individuals, those with serious health issues or who have a greater risk of developing serious health issues, and those who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. We urge you to incorporate a specific assessment of proposals’ impact on children and youth, including those with serious, chronic or complex conditions, who face poverty, inequality and lack of access to care into your standard review protocols. We look forward to working with you as you restore the critical guardrails for these state waivers and advance state delivery system reforms and health care quality improvement initiatives that will improve care for children and their families.

Non ACA-compliant coverage options
As you continue your work to strengthen health care coverage and access for children and families, we urge you to rescind the final rules that extended the availability of short-term limited duration insurance plans, association health plans and other non ACA-compliant plans, such as health care sharing ministries. These plans, which do not have to meet the ACA’s insurance consumer protections, such as the prohibition on medical underwriting and pre-existing conditions exclusions, can have serious negative implications for children’s health and health care. They can result in exposure to higher costs due to annual and/or service-specific limits, coverage denials, and limited access to appropriate pediatric providers. Family confusion about the difference between ACA-compliant plans and these other options may lead to the purchase of a plan that does not cover necessary pediatric services, including vision and dental, habilitation or mental health services as well as long-term gaps in coverage. We urge you to move forward as quickly as possible to limit access to these plan and to fully educate the public about their shortcomings.
In conclusion, we appreciate the opportunity to comment on the proposed rule and applaud you for your efforts to strengthen private coverage through the Exchanges. We look forward to working with you to ensure that those efforts strengthen children’s access to timely and appropriate quality health care and health care coverage. 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.

Sincerely,

American Academy of Pediatrics
Children’s Defense Fund
Children’s Hospital Association
Family Voices
First Focus on Children
Georgetown Center for Children and Families
National Association of Pediatric Nurse Practitioners