

October 4, 2010

Mr. Jay Angoff, Director
Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Attention: OCIIO-9989-NC

Dear Mr. Angoff:

The Children's Defense Fund appreciates the opportunity to submit comments on the development of State Health Insurance Exchanges under the Patient Protection and Affordable Care Act (Affordable Care Act/ACA). CDF's Leave No Child Behind® mission is to ensure every child a *Healthy Start*, a *Head Start*, a *Fair Start*, a *Safe Start* and a *Moral Start* in life and successful passage to adulthood with the help of caring families and communities. CDF provides a strong, effective and independent voice for *all* the children of America who cannot vote, lobby or speak for themselves. We pay particular attention to the needs of poor and minority children and those with disabilities. CDF educates the nation about the needs of children and encourages preventive investments before they get sick, drop out of school, get into trouble or suffer family breakdown.

For years CDF has worked to ensure health coverage for all children that is comprehensive, accessible and affordable. We believe Secretary of Health and Human Services Kathleen Sebelius's (the Secretary) federal regulations and guidance for the development of the health insurance exchanges are key to ensuring that children and their families can receive quality coverage through the exchanges. The exchanges provide a critically important opportunity to ensure that all children will be able to get health coverage they are eligible for through Medicaid, CHIP or the exchange plans. Many of their parents will also be eligible for coverage for the first time as well, which will enhance children's chances of being covered. However, for these promises to be realized, it is especially important that these exchanges operate in a way that will fully recognize and accommodate the unique needs of children and low income individuals and families. As CDF made clear throughout the development of the ACA, we are especially concerned that children who are now eligible for Medicaid or the Children's Health Insurance Program (CHIP) not be transferred to exchange plans until they can all be guaranteed benefits and cost sharing protections that are better or at least comparable to what they are currently receiving or eligible for.

Efforts must be made to ensure that the children who come to the exchanges will receive quality health and mental health coverage that is comprehensive, accessible and affordable. It is especially important that exchanges operate in a way that can fully address the most vulnerable

populations including children and low income families. Our comments below focus on areas where we believe federal guidance through regulations and other issuances is necessary to help ensure that children and other vulnerable populations will be able to be directed to and receive the health coverage they need through the exchanges. It is critically important that families have access to all the information they need to make informed choices about the most comprehensive health coverage available to their children and to themselves. We also believe that the federal government and the exchanges are in a unique position to drive improvements in health plans to ensure coverage to children that is comprehensive, accessible and affordable regardless of whether the children are eligible for Medicaid, CHIP or the various exchange plans.

The promise of health reform for children will only be realized if federal guidance requires states to give child-specific attention to each of areas described below. Nearly one-third of all children are already receiving health coverage through Medicaid and CHIP and an additional five million children are eligible for one of these programs but not yet enrolled. It is important that coverage for these children be enhanced at the same time new coverage options are put in place in the exchange for children not eligible for Medicaid or CHIP. We offer the following recommendations:

- The governing advisory board for the exchanges must include experts in child health and mental health and advocates for children that are familiar with the children's health needs and both Medicaid and CHIP.
- A seamless system for eligibility determinations, enrollment, retention and renewal for Medicaid, CHIP and the exchange plans is needed to ensure that children get and keep coverage and must include the coordination necessary to ensure that children and families do not slip between the cracks of Medicaid, CHIP and the exchange plans as their circumstances change and they move from plan to plan.
- A comprehensive package of health and mental health benefits must be provided to all children in Medicaid, CHIP and the exchange plans that is comparable to the Early, Periodic, Screening Diagnostic and Treatment benefits now provided to all children in Medicaid and to children in CHIP in some states.
- Outreach to children and their families is needed so that they will know about children's continued eligibility for CHIP and Medicaid and other coverage options for children who are not eligible for these programs, including child-only plans provided through the exchanges.
- Federal reporting by state health insurance exchanges must be required so that the Secretary can be assured that the unique needs of children and their families are being addressed.

Each of our recommendations, with specific suggestions for federal guidance, is discussed below. Since a number responsive to several of the questions raised in the Department's request for comments on the development of State Health Insurance Exchanges, question references are included in parentheses, as appropriate.

Representation of those with expertise about children's health and mental health and child health coverage under Medicaid and CHIP on the governing boards for the exchanges (C.)

The Affordable Care Act recognizes the importance of exchanges reaching out to consumers, state Medicaid offices, and individuals and organizations working on behalf of hard-to reach populations or with experience in enrollment activities. In addition, it is important that the Secretary encourage exchanges to also include on their governing boards pediatricians and other professionals with expertise in child and adolescent health and mental health, child health advocates who are familiar with the operation of Medicaid and CHIP and community representatives who have been engaged in child health outreach all of whom can speak to the unique needs of children and how to address them. The inclusion of Medicaid and CHIP consumers and advocates is especially important as coordination of Medicaid and CHIP with the exchanges is key to their success.

A seamless system for eligibility determinations, enrollment, retention and renewal for children in Medicaid, CHIP and the exchange plans (G.)

It is critically important that state exchanges create a seamless system for eligibility determinations, enrollment, retention and renewal that will ensure that children get and keep coverage and do not slip between the cracks of Medicaid, CHIP and the exchange plans as their circumstances change and they move among programs and plans.

The "No Wrong Door" requirement established under the ACA is critically important to ensure that children can actually access and keep the health coverage they are eligible for. The strength of "No Wrong Door" is that a child and his or her parents will apply for coverage based on their income and other eligibility factors and the system will tell them what they are eligible for. The family will not have to apply to each program separately. The ACA explicitly requires that the enrollment and renewal processes for Medicaid and CHIP and the exchange subsidies be fully integrated. To ensure this happens, CDF recommends that the Secretary make clear to states that the exchanges must have the ability to conduct Medicaid and CHIP enrollment, and not just refer children and others who come to the exchange to Medicaid and CHIP. Similarly, if a mother takes her children to enroll in Medicaid or CHIP, she should be able to enroll in exchange coverage at the same time, if she herself is not eligible for Medicaid. Without such protection, it is easy to envision families being bounced back and forth between the exchanges, Medicaid and CHIP and the Basic Health Plan (BHP), if the state has established a BHP.

The Enrollment Period (G.1.) Critically important to getting children enrolled is the definition of the enrollment period. First, it must be made clear those children likely to be eligible for Medicaid and CHIP may apply for these programs at any time. CDF also recommends that the Secretary make clear, especially as the exchanges are first being implemented, that children and families should not be restricted by a defined open enrollment period. Families should be able to enroll prior to January 1, 2014 and at least during the first six months of the year, if not longer. Families will need time to learn about options under the new law and to enroll in plans that meet the needs of both children and parents and in some cases will only hear about the new options as outreach and publicity intensify. After the first year, enrollment periods should be established that are clearly announced and last for at least 90 days. Some have suggested September through

November. Making the enrollment period coincide with the beginning of the school year and running beyond that will help to ensure that parents have health coverage for their children as they begin school. There also must, of course, be opportunities for children and families to enroll when certain qualifying events occur, such as changes in family circumstances, pregnancy, loss of coverage or change of residence.

Enrollment Processes (G.2). The Secretary should encourage states to use the Medicaid agency to conduct eligibility and enrollment processes for the exchanges (as the Massachusetts Connector did), as it would make the "no wrong door" eligibility determinations easier to conduct. At a minimum, states should be required to document whether they considered using the Medicaid agency to conduct subsidy eligibility enrollment decisions for the exchange and why they decided against it.

Federal guidance should also make clear to states that they must have multiple methods in place to help families apply for coverage for their children. As online enrollment processes are developed, special accommodation must be made for families with low literacy or limited English proficiency, and parents with disabilities that limit their use of on line technologies. Any online system must be user friendly and accommodate the special needs above. There must also be recognition that computer and internet access is limited in many low income communities so that special efforts will have to be made to inform families how and where they can apply and what assistance will be available. Any materials about applying online should also include assurances about the privacy and security of the data that will be provided.

It should also be made clear to states that families can continue to apply through Medicaid and CHIP enrollment structures and by mail and phone as well as online. In addition, to assess the effectiveness of enrollment procedures, states must be required to assess the success of various enrollment strategies used and consumer satisfaction with them. Such information will help inform future improvements.

Availability of Child-Only Plan (G.3.) In creating a seamless system, it is important that the Secretary make clear to states that they must have a child-only option available through the exchange and should make that information available in outreach about the new coverage options. It is essential that children not eligible for CHIP or Medicaid be able to get coverage through the exchanges if their parents are covered through employers or other means or are not eligible for exchange plans, such as in the case of children of undocumented immigrants.

Consistency and Continuity of Coverage (G.3.) Given that it is not unusual for a family's eligibility for coverage to fluctuate, the Secretary must make clear the obligation on states in developing the exchanges to eliminate the need for frequent changes in coverage and to have a process in place for ensuring continuity of coverage and of care when changes do occur. To eliminate the need for frequent changes in coverage, the federal regulations should require states to provide continuous coverage for 12 months, including the ability to transfer to a more beneficial program if circumstances changed during the period. Families should not have to renew eligibility for their children any more often than every 12 months. The semi-annual reviews still required for many Medicaid and CHIP children not only threaten continuity of care for the child and are burdensome to the family, but they also are costly for the agencies. In some

cases, where children are eligible for Medicaid for example by virtue of their status as a child in foster care, it should be made clear to states that there should be no requirement at all for continuous eligibility until there is a time for a re-evaluation of eligibility when a child is ready to leave care. States also should be encouraged to explore ways to address other barriers that have made it difficult to enroll children in appropriate coverage in the past, such as eliminating face-to-face interviews and providing for automatic renewal.

To make any of this work for children, the exchanges must be required to coordinate closely with Medicaid and CHIP. Effective coordination requires a strong information technology infrastructure and interoperable system for eligibility determinations that allow linkages between the exchanges, Medicaid, and CHIP. The system must ensure real-time eligibility or presumptive determinations, databases that can be used to verify eligibility, information retained for renewal, and single client identifiers for tracking individuals across programs. States need extensive resources and technical assistance to build these systems. This will include establishment of a federal uniform platform or open source technology that states can adapt, funding through the exchange grants, and enhanced federal matching rate for Medicaid/CHIP system changes.

To ensure seamless navigation among the programs, federal guidance and technical assistance should speak to the following and states should be required to document in their exchange plans steps they have taken to respond to each:

- Develop simple and efficient procedures for families to report "change of circumstances" at the time of enrollment and during the enrollment year (if differences in income would affect eligibility and/or subsidy levels). When a person's eligibility changes, individuals should be automatically enrolled (with consent) in the appropriate program/subsidy level without requiring additional information from the consumer, though families should be clearly notified about how this change will affect them (i.e. differences in premiums, cost-sharing, provider networks, covered benefits, etc.).

- Build coordination between the delivery systems used by the exchange and Medicaid and CHIP plans to facilitate continuity of care when children move back and forth between Medicaid and CHIP and subsidized exchange coverage. The programs and plans should be required to help facilitate care and treatment transitions when they are needed.

- Establish Medicaid as the default coverage when there is a lack of clarity or a dispute about eligibility among the public programs or one of the exchange plans. This will help prevent children who get caught between Medicaid and CHIP and the exchange to keep coverage until eligibility can be resolved. Often it is the difference in how programs calculate and verify income and other eligibility data that can result in such a hiatus.

- Develop strategies to ensure that families with mixed immigration status apply for and obtain the coverage for which they are eligible. This includes ensuring that the eligibility questions are designed so that a citizen child or spouse of an undocumented immigrant is not mistakenly denied benefits based on the immigration status of the undocumented family member. The questions should also be minimized and clear information should be provided so that mixed status families are not afraid to apply to the programs for fear that

information they provide will be used by immigration officials.

Definition of the essential benefit package for children (D.)

The bottom line for children in assessing the success of the exchange will be whether children get enrolled in coverage that is comprehensive, accessible and affordable. It is critically important that the unique needs of children be protected and addressed as the benefit packages for the exchanges are developed. CDF recommends that the Secretary encourage states to establish the Early, Periodic, Screening, Diagnostic and Treatment (EPSDT) benefit, currently provided to all children in Medicaid and CHIP children in the 14 Medicaid expansion states (AK, AR, DC, LA, MD, MN, MO, NB, NM, OH, OK, RI, SC, WI) as the benefit package to be applied across Medicaid, CHIP and all of the exchange plans, including the BHP if a state chooses to develop one. The use of EPSDT will increase the likelihood of seamless coverage for children as they move from plan to plan and ensure each child the medically necessary care required to meet their individual needs.

EPSDT recognizes the importance for children of all ages to get regular and periodic screenings and assessments at various intervals throughout their lives, and is widely considered to be the best standard for quality age-appropriate child health coverage. Most importantly, it takes the next step to ensure that all eligible children are guaranteed the full range of comprehensive primary and preventive coverage they need and all medically necessary treatment to address health, mental health and developmental problems and chronic health problems identified through these screens. EPSDT includes unique features that are key to children receiving quality care:

- A guarantee of all medically necessary treatment, with no specific exclusions;
- A preventive and ameliorative pediatric medically necessary standard;
- No limits on scope and duration of services or treatment;
- Case management and personal attendant services to help ensure children benefit from the treatment they receive;
- Coverage of treatment in both traditional and non-traditional setting where children are; and
- Payment for transportation and specialized services as well as community health centers and other safety net providers that can help meet children's needs.

In considering the application of EPSDT across all plans, it is important to point out for states that the essential benefit package outlined in the ACA already requires specific services for children including pediatric oral and vision care, prenatal and postnatal care, and habilitative services. The ACA requirement that all exchange plans must also include Bright Futures with no cost sharing was an important step forward and will also help ensure that children receive preventive care services such as immunizations, well-child visits, vision and hearing tests, health and behavioral assessments, and developmental screenings. Some states also already have regulations in place that require health insurance plans to cover specific children's services and certainly should be required to retain them. EPSDT builds on these requirements already in place.

Outreach to children and families about their health coverage options (H.)

To help families make informed health care decisions for their children and ensure that maximum effort is made to reach as many eligible children and families as possible, the Secretary in regulations should require states to have consumer information mechanisms in place that will provide families with user-friendly information on Medicaid and CHIP, as well as exchange plans, so that they can determine the most comprehensive, accessible and affordable coverage for their children. It is also important that those engaged to do outreach understand the children, families and communities being reached and can communicate information about the new health coverage options in a way it will be heard. CDF recommends that federal guidance on outreach should suggest that states do the following when putting in place outreach methods to inform individuals about the health options available to them and assist with eligibility determinations and enrollment:

- Make clear up front in information campaigns that children eligible for Medicaid and CHIP will continue to be eligible even though parents can now access their coverage when renewal is necessary through the exchange. Without such clarity, it is very likely that publicity around the exchanges will be confusing to low income parents and may make them think that they must get new health coverage for their children.

- Use community-based organizations in the outreach efforts to increase the likelihood that families and individuals will learn about and trust the new systems put in place to help them obtain health coverage. Wherever possible, states should be encouraged to use individuals and organizations that have been assisting in the enrollment of children in CHIP and Medicaid over the years or other organizations that have good relationships in the community and knowledge about and experience with eligibility for public programs. In rural areas the U.S. Department of Agriculture Extension Service might be a useful resource for connecting families to enrollment opportunities in their regions. Community-based organizations engaged in outreach can also be helpful to individuals who need extra help in taking advantage of the new enrollment opportunities.

- Encourage organizations engaged in outreach to use a broad range of strategies in conducting the outreach – 2-1-1 referrals, application assistance hotlines, community dialogues, presentations at food banks, schools, faith organizations, and community centers, radio spots and billboards.

- Ensure that outreach efforts take into account the linguistic and cultural competencies of the communities where they are undertaken. Both written and electronic messaging must be made available in languages appropriate to the community. Bilingual and bicultural outreach workers will also help ensure that families and individuals know about the new resources available to them and understand their responsibility to get themselves and their children enrolled.

- Build upon the guidance already issued by the Secretary in her electronic enrollment standards that that suggest ways that technology can support third-party assistance in the enrollment process.

- States should be encouraged to create links between the Navigators and Community Health Workers established through the ACA. In considering appropriate funding for such assistance, it should be recognized that the support needed by Navigators is similar to the support needed by other organizations or individuals who are assisting with outreach and enrollment assistance. States should be encouraged to include specific attention to health coverage for children in both the Navigator and Community Health Worker program. Funding is also needed for outreach resources, such as materials, radio spots and others; pre-service and on-line training; reimbursement for hours spent by those facilitating enrollment; and support for the infrastructure necessary to enable communication among the network of outreach specialists.

- In considering an outreach plan and the costs to implement it, attention should also be given to the need to establish a system to track the status of children and families and other individuals who receive help from the enrollers and others to determine whether they in fact became enrolled and if not, why not. Identifying barriers to enrollment will help exchanges better respond to the barriers and prevent them from continuing to be barriers in the future.

Federal reporting by state health insurance exchanges so that the Secretary can be assured that the unique needs of children and their families are being addressed.

To ensure that the unique needs of children are being addressed by the exchanges, CDF recommends that the Secretary include in the regulations a series of questions about steps the state exchanges have taken to meet children's needs which the exchanges must answer annually in a report to the Department. Regardless of whether guidance encourages or requires specific actions, the snapshot states provide will present a picture of the types of activities underway and the impact of the strategies. Examples of questions might include:

1. How are children and their needs represented on the Governing Committee for the exchange?
2. How is the essential benefit package for children defined in the exchange? Does the state provide EPSDT to all children in Medicaid? CHIP? Exchange plans?
3. What outreach materials on children's coverage have the state used in announcing the exchange and new opportunities for coverage?
4. What barriers to children's enrollment have been addressed in the development of the exchange? Does the state have 12-month continuous enrollment for children in Medicaid, CHIP and the exchange plans?
5. What enrollment processes has the state put in place to encourage the enrollment of children and their parents in Medicaid, CHIP or the exchange plans? What successes have they had?
6. What processes are in place to ensure consistency of continuity of coverage for children who come to the exchanges?

Thank you for the opportunity to respond to the request for comments on exchange related provisions in the Affordable Care Act. The development of strong state-based health insurance exchanges is critical to ensuring children access to comprehensive quality care that is accessible and affordable. We appreciate your consideration of our comments and would be pleased to discuss them with you further. Thank you for your leadership in promoting quality, affordable health care for children.

Sincerely yours,



MaryLee Allen
Director, Child Welfare and Mental Health
mallen@childrensdefense.org; 202-662-3573



Kathleen King
Policy Associate, Child Health
kking@childrensdefense.org; 202-662-3576