

December 20, 2012

Steve Larsen
Deputy Administrator and Director
Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Ave., S.W.
Washington, DC 20201

RE: Proposed Rule for the Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation [CMS-9980-P]

Dear Mr. Larsen:

The Children's Defense Fund (CDF) appreciates the opportunity to submit comments in response to the Proposed Rule for the Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation (as published in the *Federal Register* on Monday, November 26, 2012, 45 CFR Parts, 147, 155, and 156). 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.

CDF has worked for many years, in collaboration with others, to expand health coverage that is comprehensive, accessible and affordable for children and youth. We believe the landmark Affordable Care Act (ACA) moves us closer to that goal, particularly with the original promise of a strong single essential health benefits (EHB) package. As we expressed in our January 31, 2012 written comments in response to the "Essential Health Benefits Bulletin" (the Bulletin), we were very disappointed in the approach taken that allows states to create their own variations of the EHB package. We believe this undermines the intent of the ACA to create the comprehensive and national standard for health insurance coverage for all children that is needed to help level the playing field for children. We remain very concerned that the proposed rule moves us even further from this goal and will not result in access to the appropriate health benefits package children need to survive, thrive and drive the economy of tomorrow.

In our comments submitted in response to the Bulletin, we encouraged you to ensure the promise of the ACA was realized with a clear definition by the Secretary of essential health benefits *for children* to help ensure that all children, regardless of where they live, get the comprehensive health and mental health services they need. We also asked that you take the unique health care needs of children into account, as required by the ACA, and guarantee every child access to all medically necessary services, while limiting the ability of insurers to circumvent the requirement to cover the full range of pediatric services. In subsequent communications and meetings with officials at The Department of Health and Human Services (HHS) and The Center for Consumer Information and Insurance Oversight (CCIIO), we offered further suggestions as to how to improve the essential health benefits for children, including adding state

CHIP plans as a benchmark option, and requiring states to assess their benchmark to identify which pediatric benefits are included and which are not. We proposed that in the case of deficiencies in children's services in the benchmark plans, states should be permitted to use their CHIP benefits to supplement the benchmark.

CDF is concerned that the proposed rule does not address any of our earlier suggestions about the benchmark, and as a result, many children will not have access to critical health and mental health services that would help them grow and develop to their full potential. Therefore, we again make recommendations for changes to the benefit package. Our comments below go beyond those issues about which you have requested comments in hopes they will be instructive to you as you reevaluate your approach to the essential health benefits for 2016. The timing is fortuitous; benefits for children in the exchange must be evaluated by 2015 in order to meet the ACA's requirement that the Secretary certify that coverage for children in the exchange is at least comparable to CHIP before children can be moved from CHIP to the exchange. We believe the necessary steps must have been taken prior to 2016 to ensure the exchanges will offer comparable, if not better, coverage and cost-sharing for children. To meet this standard will require significant changes to the benchmark approach in the proposed rule. To ensure this standard can be met, we offer the following comments and recommendations, which are expanded upon below:

1. The proposed rule leaves children's health coverage up to the whims of a 50 state "lottery of geography" by leaving the choice of an essential health benefits package to the states.

2. The proposed rule does not offer a child-appropriate benchmark option.

3. HHS must provide a strong federal definition of habilitation benefits.

4. Any essential health benefits package must limit the ability of insurers to circumvent the requirement to cover the full range of pediatric services.

5. A child-only policy must offer a child-specific benefit package.

6. HHS must increase the age limit for pediatric services to 21 in order to align with the existing Medicaid standards for pediatric benefits.

7. The rule's proposed extra cost-sharing requirements to the stand-alone pediatric dental plans undermines the intent of the law and must be eliminated.

8. HHS must have in place a mechanism for monitoring, oversight and data collection to ensure the essential health benefits package can be accurately reevaluated in 2016.

<u>The proposed rule leaves children's health coverage up to the whims of a 50 state "lottery of geography" by leaving the choice of an essential health benefits package to the states.</u>

First and foremost, as we noted in our January 2012 comments on the Essential Health Benefits Bulletin, we firmly believe that in passing the ACA, **Congress clearly intended and required in the ACA that the Secretary must design a standard essential health benefits package *to be applied across the nation*,** and required a number of considerations be taken into account in that development (ACA, Secs. 1302(a); (b)(1); (b)(2)(A), (B); (b)(3); and (b)(4)). The move toward one national essential health benefits

package to be established by the Secretary was a hallmark of the ACA. The ACA's definition of the essential health benefits at Sec.1302(b) states that "…the Secretary ***shall*** define the essential health benefits…." (emphasis added). We continue to believe that there is no authority in the ACA for the Secretary to delegate the development of the EHB to states or to insurers, nor does the ACA authorize states or health plans to define the EHB standards. Numerous provisions of the ACA presume that the Secretary will establish a single national EHB standard for the nation. The proposed rule, however, rejects the requirement for a single EHB standard and instead perpetuates a 50 state "lottery of geography," when instead, every child, no matter where he or she lives, should have the same opportunity to grow up healthy.

As you develop a means to evaluate the state-selected benchmark approach, we urge you to consider establishing a standard essential health benefits package to be applied across the nation beginning in 2016, if not for all, then **at least for children**. This will ensure all children, no matter where they live, are given the opportunity to have the health coverage they need when they need it.

<u>The proposed rule does not offer a child-appropriate benchmark option.</u>

Section 1302(b)(4) of the ACA clearly states that children's specific needs should be taken into account in the EHB package. **However, the benchmark options in the proposed rule do not provide adequate benefits for children or pregnant women.** Generally developed for working age adult employees, some of these plans may not even address dependent coverage, much less the full range of medically necessary screenings, diagnosis and treatment to meet the developmental needs of children. Given the wide range of coverage between benchmarks that have been identified to date and the clear deficits in coverage for children (particularly around habilitative services), it seems clear that the only way for an EHB package to meet the needs of children is for the Secretary to clearly define EHB for children. Because of the critical importance of maximizing health and development for children, this approach of a federally defined floor of benefits could be adopted for children's pediatric services even if it is not adopted for adults.

We strongly believe the EHB should include the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit—the true gold standard for pediatric coverage. However, if that is not possible, we urge you at a minimum to: 1) add state CHIP plans as a benchmark option for states, and 2) require states to assess and report the pediatric benefits (including habilitation, maternity and newborn services) that are included *and excluded* from their selected benchmark.

The addition of CHIP plans as a benchmark option and the requirement that states assess and address pediatric benefit gaps would provide the appropriate protection to ensure that children receive the comprehensive benefits necessary to address their full spectrum of health and mental health care needs. The addition of CHIP as an Exchange benchmark option would accomplish four important goals. It would: 1) enable a state to select a benchmark that has already been shown to work well for children, including benefits specifically designed for children; 2) provide the Secretary a path to certify CHIP-comparable coverage for children in the Exchange in 2015; 3) resolve the problem of a lack of a required child-only option with child-appropriate benefits and; 4) help ensure a seamless transition for children who may move back and forth between the Exchange and CHIP coverage.

Furthermore, requiring states to assess their benchmark to identify which pediatric benefits, including habilitation, maternity and newborn services, are included (with limits noted) and importantly, which ones are excluded, would make clear to parents and states how the selected benchmark falls short of comprehensive coverage and would provide data for evaluation and assessment of the benchmark

approach prior to 2016. In doing this analysis, the selected benchmark should be compared against EPSDT, the American Academy of Pediatrics (AAP) recommended scope of benefits for children, and the American Congress of Obstetricians and Gynecologists (ACOG) and AAP recommended services for maternity care. If there are deficiencies between the benchmark and these widely recognized standards of coverage for children, states could then use their CHIP benefits to supplement the benchmark, similar to the way states must supplement deficiencies in other areas.

A recent study commissioned by the AAP demonstrates that CHIP plans provide a better benefit packages for children and their unique health care needs. The study compared plan options from which states may choose their benchmark, to benefits offered in Medicaid and CHIP programs in five states, and found that CHIP plans cover the benefits that children need more appropriately than FEHBP plans, state employee health plans, and especially the large small group health plans. These available benchmark options all fell significantly short of providing children the health and mental health services they need when they need them. For example, the commercial plans in those states did not cover or impose durational limits on home and private day nursing, durable medical equipment, speech, occupational and physical therapy, among other vital services needed by children with chronic or complex medical conditions. The AAP report found the state CHIP plans were the next best option outside of EPSDT to meet the comprehensive health care needs of children.[1]

Pediatric services should be explicitly defined and reflect the full range of children's needs.

It is CDF's position as mentioned earlier, that the Secretary should adopt EPSDT as the essential health benefit for children. Alternatively, if you will not do that, we recommend, as we did in our January 2012 comments on the Bulletin, that at a minimum, HHS should provide further definition of the ten categories of services that must be part of the EHB. A prescriptive, uniform EHB "floor" would ensure that the millions of children across the country who will enroll in coverage through the exchanges would at least receive a minimum level of coverage regardless of their state of residence or insurer. We do not believe that the approach in the proposed rule accomplishes that. States could always add additional coverage options to the standard core benefits.

Given the need and benefit for children from the full range of pediatric services, we are concerned that like the Bulletin, the proposed rule references only oral and vision care, when clearly the legislative intent was for pediatric care to be much broader. Basic rules of statutory construction suggest that pediatric coverage, including *but not limited to,* oral and vision care was intended to be the tenth category, distinct from the other adult categories of services (ACA, Sec. 1302(b)(J)). From the state EHB selections, it appears that the proposed rule was not interpreted this way. Virtually all states supplemented only pediatric dental and vision, except for two that also supplemented mental health. We recommend the proposed rule be clarified to ensure the full range of pediatric services are included, not only oral and vision care.

We also remain concerned that the remaining nine of the ten benchmark options proposed in the Bulletin were designed for working-age adults, not for children. A strong EHB designed for children should not, for example, have the same limits imposed on adults for certain services (e.g., durable medical equipment), and would cover child-specific services that adults do not need, such as anticipatory guidance for parents, developmental screenings and certain counseling services. By including pediatric services as

[1] McManus, Peggy (for the American Academy of Pediatrics). A Comparative Review of Essential Health Benefits Pertinent to Children in Large Federal, State, and Small Group Health Insurance Plans: Implications for Selecting State Benchmark Plans. July 2012. http://www.aap.org/en-us/about-the-aap/aap-press-room/Documents/AAP_EHB_Report_FinalPress.pdf.

a required category of benefits, Congress clearly signaled its intent in the ACA that children should receive an additional set of benefits beyond that provided in the nine other categories.

Children require unique pediatric services that do not fall into the other nine required categories to optimize their health and development, and help them become healthy, productive members of society. As they grow and develop, children's health and mental health care needs differ from those of older health care consumers, making it unlikely that children will be well served by a standard designed to meet the needs of adult populations. For instance, a growing child may require a new wheelchair or other durable medical equipment on a much more frequent schedule than is provided in an adult benefit package—a new wheelchair every five years may be adequate for an adult, but it certainly is not for a growing child. As children develop, they also need preventive and supportive services, such as speech therapy, more frequently to ensure they have the tools to maintain or improve their health well into adulthood. Other examples of supportive services include developmental assessments and screenings, education, counseling, and services such as anticipatory guidance, nutritional counseling and treatment of pediatric obesity. Pediatric services must be interpreted to include this full continuum of care, as is required in the EPSDT benefit.

<u>HHS must provide a strong federal definition of habilitation benefits.</u>

We are pleased the proposed rule provided more authority for a state to define habilitiative services if its benchmark plan lacks coverage for habilitation. However, the proposed rule leaves it up to states to define habilitation if they choose. If the selected benchmark is entirely lacking in habilitative services coverage, the state may draw up its own definition to apply across the individual and small group market, or the state can leave it to insurers to define the category themselves. This approach will result in many children—particularly those who are disabled or those with special health care needs—not getting the critical habilitative services and devices they need. We urge you to establish a federally defined set of habilitative services that must be included in every plan that is subject to the EHB requirement and not permit insurance plans to determine their own habilitation benefits packages, even by providing coverage on par with rehabilitative services. We also urge you to require states to assess coverage of habilitation services and devices in their selected benchmark to ensure that children and adults are able to access the habilitation services and devices they need.

The set of habilitative services to be included in the EHB package must specify the types of services to be provided (e.g., OT, PT, speech-language therapy), as well as any limitations or exclusions. To ensure that children have the opportunity to reach their full potential, the habilitation benefit must not be subject to age restrictions or arbitrary limits, such as number of visits per year. Instead, the provision of services should be based on medical necessity. Medicaid's EPSDT program is an appropriate model for children.

In addition, plans subject to the EHB requirement must cover habilitative devices, such as durable medical equipment (e.g., wheelchairs), orthotics, prosthetics, low vision aids, hearing aids, augmentative communication devices that aid in hearing and speech, and other assistive technologies and supplies. For children, it is critical that there be no arbitrary restrictions on the coverage of devices. As they grow, children will need frequent replacements of devices such as wheelchairs, glasses, orthotics and prosthetics, and as their skills develop, they may need new augmentative communications devices.

As a first step, HHS should require states and plans to adopt the definition of habilitative services put forth by the National Association of Insurance Commissioners (NAIC), which was included in the

Department's proposed regulations defining medical and insurance terminology.[2] According to the NAIC definition, habilitative services are: "Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings." (NAIC Glossary of Terms for the Affordable Care Act.)

An alternative definition that HHS might consider is provided in the Medicaid law, which defines "habilitation services" as "…services designed to assist individuals in acquiring, retaining and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings." (Social Security Act, Section 1915 (c)(5)(A).)

If HHS does decide to provide state flexibility in the design of the habilitative services benefit—which is an approach that we do not support—it is imperative that states be required to comply with strong federal standards in the determination of the habilitative services in their EHB benchmark plans. Under this approach, we strongly recommend supplementation of their base-benchmark plans with habilitative benefits from another benchmark option, including CHIP and Medicaid.[3]

A strong HHS standard for the coverage of habilitative services and devices is 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. Some children will need habilitative services only for a short time, while others will need them on an ongoing basis to ensure that hard-earned skills are not lost or, in the case of children with cerebral palsy, for example, so their muscles function as well as possible.

The proposed rule does not ensure that children with special health care needs will have access to the habilitative services they need. In fact, the preamble to the proposed rule acknowledges the limitations of the proposed benchmark approach: "many health insurance plans do not identify habilitative services as a distinct group of services." In reality, some plans specifically exclude habilitative benefits.[4] Furthermore, as referenced above, the proposed rule does not give states any parameters for determining habilitative services. Moreover, no mechanism is proposed for evaluating a state's package of habilitative services or requiring that it be amended if found to be inadequate.

We also have serious concerns regarding the "parity with rehabilitation" option because we believe that it is unlikely to result in an adequate package of habilitative services. Habilitation benefits should receive parity with rehabilitation benefits in that both should cover the same *types* of services, regardless of whether the services are needed to *acquire* or *restore* function or skills. With respect to amount, duration

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[2] See, 76 Fed. Reg. 52,442; 76 Fed. Reg. 52,475

[3] Supplementation would be required regardless of the level of habilitative services in the base-benchmark plan if that plan did not meet HHS standards. Under the proposed rule, a health insurance plan could interpret the regulation as requiring coverage of only a single habilitative service, as defined by the issuer, or by the state in the case of state-required benefits enacted prior to December 31, 2011. This should not be considered adequate coverage of habilitative services and would not meet our recommended HHS standard.

[4] McManus, Peggy (for the American Academy of Pediatrics). A Comparative Review of Essential Health Benefits Pertinent to Children in Large Federal, State, and Small Group Health Insurance Plans: Implications for Selecting State Benchmark Plans. July 2012. http://www.aap.org/en-us/about-the-aap/aap-press-room/Documents/AAP_EHB_Report_FinalPress.pdf.

and scope however, parity with rehabilitative services is not adequate for habilitative services, particularly for children. Habilitative services may be needed for a longer period of time than rehabilitative services, and it may be difficult to measure progress for a child who is developing a skill for the first time. Furthermore, it may not be possible to determine with certainty the limits of the child's capacity – whether, for example, more speech therapy will enable the child to develop stronger verbal skills.[5]

Any essential health benefits package must limit the ability of insurers to circumvent the requirement to cover the full range of pediatric services.

The proposed rule clarifies that states can limit or prohibit insurers' ability to make substitutions within the EHB categories, but suggests states can only supplement benefits when an entire category is missing. Under this approach, a category would only have to cover one service, treatment, etc. to be considered adequate, and the state would be *unable* to make substitutions to ensure an acceptable benefit package. This will result in inadequate pediatric and habilitation benefits for our nation's most vulnerable children. For example, it would appear that if the base-benchmark plan offers even a single benefit that is considered "habilitative," the issuer would not need to supplement the category with any other habilitative services. Accordingly, a plan would be in compliance with the ACA's EHB requirements if it covered speech and language therapy, but not physical therapy. Under such a scenario, a child with cerebral palsy, for example, could be deprived of the opportunity to learn to walk. The deeply flawed approach outlined in the proposed rule will perpetuate or worsen inequities bertween children in different states and different health plans in a way that surely runs counter to the intent of the ACA.

Allowing insurers to differ the benefits provided in their plans will make it difficult for families to make "apples to apples" comparisons between health insurance products when faced with the decision and will increase the likelihood that a plan will not meet the needs of their children. Risks are great when insurers are allowed to make substitutions in benefits even though they are required to be "substantially equal" to the benefits of the benchmarked plans. When choosing plans, consumers will already face differences among the plans' provider networks, premiums, and cost-sharing charges and have to make tradeoffs. Allowing insurers to offer different sets of essential health benefits will introduce another level of complexity, leaving many consumers uncertain as to what benefits they are entitled to when they purchase a plan.

It is impossible to predict exactly what health care needs a child will have as he or she grows and develops. No child should be denied necessary services because their parent or guardian did not anticipate the services he or she would need, or chose the "wrong" health insurance plan.

A "child-only policy" must offer a child-specific benefit package.

The purpose of the ACA's child-only provision was two-fold: to ensure that coverage is available for children who may not be afforded coverage through their families, and to ensure that these children are able to access pediatric appropriate coverage that is able to meet their needs. By definition, child-only plans should have a child-specific benefit package that is comprehensive and affordable. We are deeply

[5] Even if parity with rehabilitative benefits were appropriate for habilitative services, the proposed rule provides no mechanism for determining whether that parity is achieved. It would be incumbent upon HHS to state whether the state insurance commissioner makes that assessment and have the authority to require changes to a plan if the parity standard were not met.

concerned that the proposed rules suggests that an insurer could satisfy the ACA's requirement that child-only plans be available in state exchanges (ACA, Sec. 2707(c)) by offering the same product to children that it offers to applicants seeking coverage for adults or for families including both adults and children, as long as the child-only coverage is priced in accordance with the applicable rating rules.

A clearly-defined, strong pediatric benchmark would ensure that children's needs are adequately met by the child-only plans that insurers will be required to offer if they plan to participate in the exchanges. We recommend that you consider the inclusion of CHIP as a plan option in the exchange. Given CHIP's track-record of success, states' familiarity with CHIP, and the child-specific design of CHIP plans, this approach would ensure that there is a child-only coverage option available that focuses on children, including access to the providers and services they need to meet their unique health and developmental needs. Furthermore, as you know, by 2016, the Secretary must certify that the benefits and cost-sharing for children in the exchange are at least as comparable to those in CHIP before children can be moved from CHIP to the exchange. We are deeply concerned that, given the current benchmark approach for the determination of the EHB and the value of the plans as outlined by the ACA, there will not be a comparable option for children in the exchange. As we mentioned earlier, the inclusion of CHIP as an Exchange benchmark option would accomplish four important goals: 1) enable a state to select a benchmark that has already been shown to work well for children, including benefits specifically designed for children; 2) provide the Secretary a path to certify CHIP-comparable coverage for children in the Exchange in 2015; 3) resolve the problem of a lack of a required child-only option with child-appropriate benefits and; 4) help ensure a seamless transition for children who may move back and forth between the Exchange and CHIP coverage.

The proposed rule does not define the categories of children who are eligible for child-only coverage when no other option is available. In defining who might be eligible for child-only coverage, we urge you to adopt an expansive definition of the children who would be eligible. All children who are unable to get coverage through their parents' insurance should be able to access a comprehensive affordable child-only plan when no other option is available. We believe Congress intended to make sure that child-only coverage is available for the millions of children who may not be able to get coverage as part of a family plan. The Urban Institute estimates that at least 20 million children live in "non-traditional family" situations, with nearly 28 million children living apart from at least one of their parents.[6] Children who live in so-called "non-traditional" families including those being cared for by grandparents who likely get their coverage through the Medicare program; children aging out of foster care who are under the age of 21; children with parents whose employers do not offer dependent coverage; citizen children in mixed immigrant-status households; and other citizen children, including homeless or runaway children, children with parents in prison, and those with parents who live overseas, among others. Some of these are children who should be eligible for child-only coverage.

<u>HHS must increase the age limit for pediatric services to 21 in order to align with the existing Medicaid standards for pediatric benefits.</u>

The proposed rule establishes the age limit for pediatric services as 19. However, because many families will be transitioning between public insurance and exchange coverage, we strongly encourage efforts to ensure consistency in coverage options, especially for low-income families. Therefore, we recommend

[6] McMorrow S,; Kenney G,; Coyer C . Addressing coverage challenges for children under the Affordable Care Act. Washington (DC): Urban Institute; 2010.

that HHS increase the age limit to 21 in order to align with the existing Medicaid standards for pediatric benefits.

The rule's proposed extra cost-sharing requirements to the stand-alone pediatric dental plans undermine the intent of the law and must be eliminated.

CDF commends HHS for adding the option to supplement pediatric vision care with the state's separate CHIP plan when the CHIP plan includes vision services, and appreciates the opportunity provided by the proposed rule to offer comment on cost-sharing rules, as we are concerned about their impact on pediatric dental care.

The cost-sharing limits established in the ACA (156.130) are a critical benefit for American families. Congress established these limits in the context of the other provisions of the ACA to ensure that families covered in the individual and small group markets have affordable access to essential benefits. Like the EHBs, the cost-sharing regulations outlined in the proposed rule also apply in the individual and small group markets beginning in 2014.

The proposed rule notes that for family plans, the cost-sharing limits will be double the limits for single coverage. This limit will work well for larger families, since cost-sharing limits will be no higher for families of 3, 4, or 5 or more people than they are for families of 2. However, we are concerned that the rule proposes a separate cost-sharing (out-of-pocket) limit for stand-alone dental plans but only specifies that this limit be "reasonable." Without further clarification, this proposal is problematic for two reasons. First, it creates a separate out-of-pocket limit for services provided through a stand-alone dental plan in addition to the "medical" out-of-pocket limits already established by the law, but it also does not set a clear limit, leaving the definition of "reasonable" to be determined by each state. Requiring families to meet a separate out-of-pocket limit for expenses related to their children's dental care will increase their costs and could create significant barriers to access, thereby breaking the fundamental promise of the underlying law. Second, complicating this proposed requirement further is the fact that states are permitted to operate exchanges in which families are required to purchase their dental benefits separately; this could result in families being forced to purchase an essential health benefit when it may not be affordable. We strongly urge you to require that the out-of-pocket maximums established by the statute be applied to costs related to all essential health benefits – including those services covered by stand-alone dental plans – and to require that costs be tracked and coordinated among all insurance carriers for a family.

HHS should also amend the proposed rule to include an exception that keeps the cost-sharing limit in place for out-of-network services for children that are not reasonably available in-network.

Children may have health needs that cannot be served adequately by any in-network provider, even if the network meets applicable network adequacy standards. Children who need complex subspecialty pediatric care are most likely to fall into this category. When medically necessary services are not available in-network, a family should not be required to exceed the ACA's limits on cost-sharing when seeking services out-of-network. Therefore, the final rule should contain an exception that keeps the cost-sharing limit in place for out-of-network services for children that are not reasonably available in-network.

HHS must have in place a mechanism for monitoring, oversight and data collection to ensure the essential health benefits package can be accurately reevaluated in 2016.

The proposed rule makes no mention of oversight and evaluation measures HHS must implement in advance of 2016, the deadline established in the ACA (§ 1302(b)(4)(G)) and corresponding HHS Bulletin for the EHB to be reevaluated (HHS Essential Health Bulletin, page 9). CDF believes it is critical for HHS to develop strong requirements for states to collect and report data on their EHB benchmark packages in order to evaluate the impact of their respective choices, particularly whether the benchmark plans are serving the needs of children and what refinements are necessary. While the Information Collection Request on EHB approved as OMB Control Number 0938-1174 provides a useful starting point for collection of data regarding essential health benefits in the benchmark plans, we urge HHS to require each issuer to report its definition of medical necessity; to collect information on rider policies; and to collect data elements related to network adequacy. Each of these has critical implications for the care provided to children.

Thank you for the opportunity to comment on the Proposed Rule for the Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation. Ensuring comprehensive health and mental health coverage for all children is critical to their future lives and health and the future prosperity of our nation. CDF strongly recommends that you amend the benchmark options for states to include the use of their CHIP plans as a benchmark for children. Additionally, at a minimum, we ask that in your monitoring and oversight of the EHB implementation during 2014 and 2015, you construct a way to consider our concerns so that in 2016 when the EHB approach is reevaluated, you are able to define and guarantee a strong federal floor of benefits for children. It is critically important that children be better – and certainly no worse – off than before passage of the ACA. We look forward to working with you to ensure that all children realize the promise of the ACA. We appreciate your consideration of our comments and would be pleased to discuss them with you further.

Sincerely yours,



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