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March 7, 2017

The Honorable Tom Price
Secretary
Department of Health and Human Services
Attention: CMS-9929-P
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

Re: Patient Protection and Affordable Care Act; Market Stabilization
82 Fed. Reg. 10980 (February 17, 2017)

Dear Secretary Price:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on the market stabilization proposed rule. ACS CAN, the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society, supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. As the nation's leading advocate for public policies that are helping to defeat cancer, ACS CAN ensures that cancer patients, survivors, and their families have a voice in public policy matters at all levels of government.

Access to health care is paramount for persons with cancer and survivors. ACS CAN supports a robust marketplace from which consumers can choose a health plan that best meets their needs. We appreciate the need to ensure that issuers will participate in the plan year 2018, however, we are concerned that some of the policies that are proposed will actually impede a consumer's ability to obtain health insurance coverage. Specifically, we are concerned with the following proposals:

- *Special Enrollment Periods*: ACS CAN urges HHS not to adopt the proposed changes to the special enrollment periods. The proposed changes will make it harder for individuals who are legitimately eligible to obtain insurance outside of open enrollment, and could cause cancer patients and survivors to have coverage gaps that can be detrimental to their health.
- *Actuarial Value*: ACS CAN urges HHS not to adopt changes to the actuarial value standards, which would result in an increase in out-of-pocket costs to consumers.
- *Network Adequacy*: ACS CAN urges HHS not to adopt the proposed requirements. We believe the determination of the adequacy of a health plan's network should be based on open and transparent standards that rely on quantitative standards to make a determination about the adequacy of a plan's network.

- *Essential Community Providers (ECPs)*: ASC CAN urges HHS to retain the current requirement that qualified health plans must contract with at least 30 percent of the essential community providers within a plan's service area. We are concerned that lowering the standard would result in fewer plans contracting with cancer hospitals and children's hospitals, which provide vitally important oncology services.
- *Annual Enrollment Period*: ACS CAN is concerned that 2018 is too soon to implement a shortened open enrollment period. We strongly urge HHS to retain the current open enrollment timeframe.

We are disappointed with the amount of time provided to stakeholders to review and comment on the proposed rule. Many of the issues raised in the proposed rule could impact an individual's opportunity to access health insurance coverage. For a cancer patient, access to health insurance coverage is vitally important to their likelihood of surviving cancer.[1] The proposed rule was released by HHS on Wednesday, February 15, 2017, with comments due on March 7, 2017. The 20-day comment period fails to allow sufficient opportunity for all stakeholders to provide sufficient input on these proposals. In the future, we strongly urge the Department to provide a longer comment period.

A. Part 147 – Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets

1. Guaranteed Availability of Coverage (§147.104)

HHS proposes to modify its previous guidance to allow issuers to require an enrollee in the individual or group market, whose coverage is terminated for non-payment of premiums within the last 12 months, to pay all past due premiums owed to the issuer in order to resume coverage from that issuer. This policy would be permitted assuming it was not prohibited under state law. Issuers would be allowed the option to enforce this policy, but they must apply the policy uniformly to all employers and individuals, consistent with the non-discrimination provisions. The preamble notes that this policy would not prevent an individual or employer from enrolling in coverage from a different issuer.

ACS CAN is concerned that the proposal is potentially harmful to low- and moderate-income individuals who experience a sudden or unexpected financial burden associated with a serious disease like cancer. An individual in active treatment for cancer usually incurs significant out-of-pocket costs for required deductibles, copayments and coinsurance, as well as costs for services not covered by insurance. For instance, some standard insurance plans have deductibles of $2,500 or more. These additional costs may make it even more difficult for a cancer patient to pay their insurance premiums. Nearly half of all American adults report being unable to cover an emergency

[1] E Ward et al, "Association of Insurance with Cancer Care Utilization and Outcomes, *CA: A Cancer Journal for Clinicians* 58:1 (Jan./Feb. 2008), http://www.cancer.org/cancer/news/report-links-health-insurance-status-with-cancer-care.

expense costing $400 without having to borrow or sell something to do so.[2] Individuals often need additional time in order to try to obtain funds to cover these unexpected medical costs.

The proposed policy could also result in discrimination depending on the number of issuers participating in the marketplace in a given area. For example, if an enrollee who qualifies for advance premium tax credits (APTCs) and owes past-due premiums to her plan resides in an area where there is only one issuer, and that issuer chooses to enforce the policy provided under the proposed rule, the enrollee would be prohibited from enrolling in the only plan which would accept her APTC. This individual would be denied coverage in the individual market. This result is antithetical to the statutory intent.

We recognize that enrollees have a responsibility to pay premiums. However, it is imperative to remember that life circumstances for individuals with serious illness could negatively impact patients' ability to pay their monthly premium when they need access to their coverage the most. In lieu of adopting policies that restrict enrollment, we urge HHS to first require plans to contact the enrollee and provide specific notice regarding the amount of past-due premiums and offer to work through a payment option before the plan denies the individual the opportunity to enroll in coverage. This requirement would help to ensure that the enrollee maintains coverage consistent with the guarantee availability of coverage requirements provided under the statute.

B. Part 155 – Exchange Establishment Standards and Other Related Standards under the Affordable Care Act

1. Initial and Annual Open Enrollment Periods (§155.410)

HHS proposes to change the open enrollment period for plan year 2018 to begin on November 1, 2017, and end on December 15, 2017. The preamble notes that HHS "originally included a longer transition period" before shortening the open enrollment period.[3]

ACS CAN urges HHS not to adopt the shortened open enrollment period for plan year 2018. Given the uncertainty regarding Congressional and future administrative changes to the Affordable Care Act, we are concerned that shortening the open enrollment period will have a chilling effect on the number of individuals who enroll in marketplace coverage. In addition, the open enrollment period also offers individuals an opportunity to change their qualified health plan (QHP) selection and we are concerned that this shortened period will provide an insufficient opportunity in which consumers can make an informed choice about their health care plans options.

We note that the administration recently extended the timeframe by which plans are to submit bids for the 2018 plan year.[4] While we appreciate that this additional time allows plans the opportunity

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[2] Board of Governors of the Federal Reserve, Report on the Economic Well-Being of U.S. Households in 2015, May 2016, available at https://www.federalreserve.gov/2015-report-economic-well-being-us-households-201605.pdf.
[3] 82 Fed. Reg. at 10984.
[4] Center for Consumer Information and Insurance Oversight, DRAFT Bulletin: Revised Timing of Submission and Posting of Rate Filing Justifications for the 2017 Filing Year for Single Risk Pool Coverage; Revised Timing of

to prepare for the 2018 plan year, we are concerned that this extension will reduce the amount of time plans have to ensure the accuracy of their marketing materials and for CMS to ensure that plan information is properly reflected in marketplace materials.

In addition, we note that historically younger individuals tend to enroll at the end of the open enrollment period. We are concerned that by shortening the annual enrollment period – absent a robust education campaign – younger enrollees may miss out on their opportunity to enroll in the program.

If HHS intends to make any changes that would shorten the open enrollment period, we strongly urge the Department to conduct extensive education and outreach to consumers to make them aware of their limited opportunity to enroll in a plan and change plans as well as the ramifications of failing to enroll and/or review their plan options. We note that the preamble suggests that HHS will conduct outreach to consumers but is silent with respect to the extent to which it plans to conduct such outreach. ACS CAN would suggest that any consumer education and outreach will require an extensive investment of resources including the implementation of a well-designed multimedia campaign with a particular emphasis on specific populations that are historically harder to reach.

In addition, HHS will need to provide additional and significant funding for patient navigators who can provide one-on-one counseling to individuals. Past experience with Navigators and in-person assisters demonstrates that the annual enrollment period can be a challenging time with many being stretched to capacity and having to turn consumers away during peak times.[5] We urge HHS to provide Navigator grant funding at or above the current level given that consumers who enroll in marketplace coverage with Navigator assistance are almost twice as likely to successfully enroll as individuals who enroll on-line without additional assistance.[6]

2. Special Enrollment Periods (§155.420)

Special enrollment periods (SEPs) allow individuals with qualifying life changes – like divorce, marriage, birth, a permanent move, or loss of employer-sponsored health insurance – to enroll in a plan that best meets their needs. These SEPs are vital for individuals with cancer who may often experience a job loss (and subsequent loss of employer-sponsored health insurance) if their cancer and/or cancer treatment leaves them unable to work. In addition, some individuals with cancer may

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Submission for Qualified Health Plan Certification Application, Feb. 17, 2017, available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Revised-2017-filing-timeline-bulletin-2-17-17.pdf.

[5] Karen Pollitz, Jennifer Tolbert, and Rosa Ma, *2015 Survey of Health Insurance Marketplace Assister Programs and Brokers*, (Washington: Kaiser Family Foundation, August 2015), available at: http://files.kff.org/attachment/report-2015-survey-of-health-insurance-marketplace-assister-programs-and-brokers.

[6] Zach Baron, *In Person Assistance Maximizes Enrollment Success*, (Washington: Enroll America, March 2014), available at https://s3amazonaws.com/assets.enrollamerica.org/wp-content/uploads/2013/12/In-Person-Assistance-Success.pdf.

have to move to a different location in order to be closer to family members who can provide necessary caregiving and/or to be closer to specialized treatment facilities to treat their specific form of cancer.

HHS proposes several changes to SEPs that could make it harder for consumers to enroll in coverage through an SEP. ACS CAN has repeatedly expressed concern about restricting eligibility for SEPs[7] for two main reasons:

- **Abuse of SEPs has not been documented.** Many of HHS' changes to SEPs since 2014 have been based on the perception that enrollees are using SEPs to "game the system" and enroll in insurance only when they get sick. Yet there is no credible evidence that enrollees are inappropriately using SEPs. According to the Urban Institute, an estimated 5 percent of eligible people elect to use an SEP to enroll in a health plan.[8] While an industry report indicates that individuals who enroll in health plans through an SEP have higher health care costs compared to individuals who enroll during an open enrollment period, the report does not provide data on how the individuals qualified for their SEPs.[9] For instance, it is unknown how many of these additional costs were due to newborn babies. SEP-qualifying individuals are naturally going to generate new costs, but it does not mean they are intentionally abusing the SEP system, or do not have legitimate life changes that qualify them for an SEP.

- **Restricting access to SEPs will negatively affect cancer patients and their families.** Making it harder for individuals to enroll via SEP can lead to gaps in insurance coverage, which can be detrimental to cancer patients.[10] Individuals in active cancer treatment need regular access to care and services and, when that access is disrupted, the effectiveness of the treatment could be jeopardized and the individual's chance of survival could be significantly reduced. Evidence-based protocols for chemotherapy and other cancer treatments often require treatment delivery on a prescribed timeline. Interruptions to this timeline because of coverage gaps can be detrimental. A gap in coverage can also cause a fatal delay in

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[7] See American Cancer Society Cancer Action Network. June 23, 2016 comments on Amendments to Special Enrollment Periods, available at https://www.acscan.org/sites/default/files/National%20Documents/FINAL%20ACS%20CAN%20Comments%20on%20SEP%20Interim%20Final%20Rule%206-23-16.pdf) and September 20, 2016 comments on Frequently Asked Questions Regarding Special Enrollment Period Verification, available at https://www.acscan.org/sites/default/files/National%20Documents/ACS%20CAN%20Comments%20on%20SEP%20Pilot%20Project%209-19-16%20Final.pdf.

[8] Stan Dorn. *Making Special Enrollment Periods Work under the Affordable Care Act*. Urban Institute, June 2016, available at http://www.urban.org/sites/default/files/publication/81806/2000834-Helping-Special-Enrollment-Periods-Work-Under-the-Affordable-Care-Act.pdf.

[9] Carlson C, Giesa K, "Special Enrollment Periods and the Non-Group, ACA-Compliance Market," Washington: Oliver Wyman, Feb 2016, available at https://www.ahip.org/Wyman-SEP-Enrollment/.

[10] See American Cancer Society Cancer Action Network. Gaps in Coverage Are Detrimental to Cancer Patients & Survivors. Fact Sheet. January 10, 2017. https://www.acscan.org/policy-resources/gaps-coverage-are-detrimental-cancer-patients-survivors-0.

initiation of a treatment protocol. Recent research shows that delays in the initiation of chemotherapy for breast cancer patients result in adverse health outcomes.[11]

It is vital that cancer patients are able to enroll in health insurance without experiencing any coverage gaps. We are concerned that the specific changes to SEPs in the proposed rule will make it harder for cancer patients to avoid gaps in coverage. We outline our concerns about the specific proposals as follows:

Pre-enrollment verification: HHS proposes to expand its pre-enrollment verification pilot program to all categories of special enrollment periods for all new consumers in all states served by the HealthCare.gov platform. The pre-enrollment verification pilot program was designed by the previous administration to sample 50 percent of consumers who were attempting to enroll via SEP and require these consumers to submit documentation of their eligibility before their coverage became effective. The pilot program was slated to begin in June 2017.

Under this proposal, all consumers applying for coverage through an SEP in a marketplace using the HealthCare.gov platform would be able to select a plan upon applying, but their coverage would not take effect until verification of SEP eligibility is completed. The proposal notes that "consumers would be given 30 days to provide documentation, and would be able to upload documents into their account on HealthCare.gov or send their documents in the mail."[12] HHS intends to make "every effort" to verify eligibility through automated electronic means where possible.

ACS CAN expressed concern when the pre-enrollment verification pilot program was originally proposed in September 2016,[13] and we remain very concerned that this process will cause gaps in coverage for cancer patients and survivors.

We urge HHS to clarify in the final rule whether the enrollment verification process will apply to "all categories of special enrollment periods for all new consumers in all states served by the HealthCare.gov platform," or whether HHS will "verify eligibility for certain special enrollment period categories".[14] These two sentences – located on the same page in the proposal – appear to be contradictory. If not clarified in the final rule, this could cause severe confusion among consumers and enrollment assistors.

ACS CAN is also concerned that some consumers may find it challenging to provide required documentation within 30 days of applying for coverage. For example, employers are no longer required to automatically provide employees or former employees with certificates of creditable

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[11] Chavez-MacGregor M, Clarke CA, Lichtensztajn DY, Giordano SH. Delayed Initiation of Adjuvant Chemotherapy Among Patients With Breast Cancer. *JAMA Oncol.* 2016;2(3):322-329. doi:10.1001/jamaoncol.2015.3856.

[12] 82 Fed. Reg. at 10985.

[13] See American Cancer Society Cancer Action Network. September 20, 2016 comments on Frequently Asked Questions Regarding Special Enrollment Period Verification, available at https://www.acscan.org/sites/default/files/National%20Documents/ACS%20CAN%20Comments%20on%20SEP%20Pilot%20Project%209-19-16%20Final.pdf.

[14] 82 Fed. Reg. at 10985 (emphasis added).

coverage, which documents the loss of minimum essential coverage (MEC). It could be very challenging to obtain and send this documentation within 30 days. Separately, it could be very challenging to obtain documentation of a permanent move within 30 days, as it takes some time to transfer mail and get paperwork organized when moving.

Additionally, ACS CAN urges HHS to clarify how changing the enrollment process to be dependent on document verification will change the assignment of coverage dates. Presumably individuals whose SEP eligibility cannot be instantly confirmed via automatic electronic sources will be given 30 days to submit documentation. What is less clear, however, is how and when the effective coverage date is assigned for an individual who enrolls through an SEP, and whether the coverage date is affected by the 30-day period for submission of documentation. The addition of a 30-day waiting period for processing paperwork may cause coverage gaps and delays in care, and ACS CAN urges HHS to clarify this timeline.

It is important to note that granting coverage retroactively once an enrollee's documentation has been processed may create burdens on the consumer and/or provider. Patients granted retroactive coverage will likely have to resubmit medical claims to the plan which may delay treatment. For cancer patients, treatment interruptions may seriously jeopardize their outcomes.

HHS implies in its proposal that this new documentation requirement will not be any more burdensome on consumers because the Department already requests or requires documentation for certain SEPs and has a verification process in place. HHS is underestimating the impact of these changes on its ability to process paper and electronic verifying documents. The previous plan (which was not yet implemented) required documentation for 50 percent of all individuals applying with an SEP. This proposal would double this amount – requiring 100 percent documentation.

If HHS is unable to process documentation in a timely manner, it will cause gaps in coverage for individuals who are transitioning from other insurance with set end-dates. The proposal notes that upon selection of a plan, a consumer's plan selection and coverage date information would be pended until SEP eligibility is confirmed. While the consumer is given a deadline of 30 days to submit documentation, the proposal does not impose a deadline on HHS to process and respond to the documentation. It is not clear from the proposal what will happen if the original coverage date given to the consumer passes before HHS confirms documentation (the preamble only states that the consumer would be able to delay their coverage date for one month).

ACS CAN also questions why CMS would proceed with this proposal without fully implementing and evaluating an existing a pilot program – before any testing has actually taken place. The previous administration intended to compare the experience of individuals required to submit documentation with the experience of individuals not required to submit documentation. This kind of testing would allow HHS to determine whether requiring documentation leads to lower claims costs – as the industry hopes – and/or if it leads to younger individuals not completing enrollment, and therefore negatively affecting the risk pool. In fact, preliminary HHS data showed that only 55 percent of younger enrollees were able to submit verifying documentation, while 73 percent of an

older cohort completed the process.[15] ACS CAN urges HHS to conduct testing to answer these questions before expanding this requirement to all enrollees.

If HHS finalizes the proposal to implement pre-enrollment verification documentation for all – or even most – SEP enrollees, ACS CAN strongly urges HHS to:

- Include a required timeframe by which HHS must process and respond to submitted documentation. This timeframe must allow individuals who are required to submit additional justification to do so before the expiration of the SEP.
- Include a plan for HHS/marketplace communication with the enrollee if their documentation is not verified within the set timeframe. This is crucial to helping enrollees avoid coverage gaps or deal with gaps if and when they happen. This communication plan must require that HHS make multiple attempts to contact the consumer.
- Include an expedited timeframe and appeals process for patients who:
    - are in active treatment for a serious or life-threatening illness (such as cancer) and for whom a slower enrollment process will cause a coverage gap.
    - have applied for coverage, are waiting for their documentation to be approved and coverage to be effective, and are being denied treatment for a life-threatening illness because of their uninsured status.
- Re-institute the requirement for employers to automatically provide employees and former employees with a certificate of creditable coverage.
- Provide training to enrollment assistors so they can help enrollees submit their documentation.
- Conduct testing on the HealthCare.gov website to determine the best way to allow for easy submission of documentation.

It is important to note that determination of eligibility for an SEP must be made by the marketplace. Issuers are not able to be impartial in this matter, because they have an incentive to protect their risk pool and may selectively approve only healthy individuals, or delay approval of less desirable enrollees. If HHS moves forward with pre-enrollment verification, ACS CAN urges all further regulations and sub-regulatory guidance to keep the decision-making power for SEP eligibility with the marketplace.

State-Based Marketplaces: HHS asks for comments on whether the proposed changes to SEPs should be required of state-based marketplaces.

ACS CAN urges HHS to grant continued flexibility to state-based marketplaces to decide whether to adopt pre-enrollment SEP verification requirements and any other changes to the SEP process. State-based marketplaces should retain discretion and not be required to adopt SEP changes if they do not wish to do so for policy or practical reasons. Already, some state-based marketplaces have

[15] Centers for Medicare and Medicaid Services. Pre-Enrollment Verification for Special Enrollment Periods. https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/pre-enrollment-sep-fact-sheet-final.pdf.

taken different approaches that they have found to be far less burdensome for consumers, while also supporting a well-balanced risk pool and robust enrollment of eligible people.[16]

Restricting plan choice for SEP enrollees: HHS proposes that individuals who are already enrolled in a QHP and apply to change their coverage through an SEP only be allowed to enroll in a plan in the same QHP or change to another QHP within the same metal level of coverage. This restriction is intended to ensure that consumers are not using SEPs simply to switch levels of coverage during the coverage year – in other words, to buy more generous coverage when they get sick. This restriction would apply to most SEPs, including the permanent move SEP. HHS also proposes that when a new individual is added through an SEP for marriage or addition of a dependent, the new individual only be allowed to enroll in the QHP in which their spouse/parent is enrolled (with some exceptions). HHS intends to enforce these restrictions by making changes to HealthCare.gov that would only show the consumer enrolling in coverage via an SEP those plans for which he/she is eligible.

ACS CAN is very concerned that these restrictions – particularly when applied to the permanent move SEP – will adversely impact cancer patients. It is critical for cancer patients in active treatment to have continuity of care during coverage transitions. Being forced to change a health care provider or lose coverage for a medication during active treatment can be detrimental to cancer patients. If a patient has a rarer form of cancer, a complex situation, or a complication to their treatment, there may not be many providers in the country able to treat her.

The proposed changes that limit plan choice for SEP enrollees could seriously impede a cancer patient's continuity of care. For instance, a cancer patient using the permanent move SEP has no guarantee that her current health plan or other plans in her metal level, will cover the providers and treatments she needs once she moves to her new community. Additionally, there is no guarantee that a new spouse or dependent enrolling via the marriage or dependent SEP will have similar needs in a health plan to their spouse or parent. For example, enrollee A might have picked a particular plan because his cardiologist was in-network. His wife needs to choose a plan that covers her oncologist because she is in active cancer treatment. The fact that they are marrying has absolutely no bearing on whether enrollee A's plan will be the best choice for his wife's cancer treatment.

If HHS finalizes these proposals, ACS CAN strongly encourages HHS to exempt the permanent move SEP from the restriction. Additionally, we urge HHS to institute an appeals process for patients in active treatment whose continuity of care would be affected by the restriction. We also urge HHS to implement a clear notification on HealthCare.gov that enrollees are not actually seeing all plans offered through the marketplace when enrolling through SEPs restricted in this way, with instructions on how to submit an appeal to see all plans available.

[16] See, for example, "Appendix IV: Comments from the DC Health Benefit Exchange Authority," in Results of Enrollment Testing for the 2016 Special Enrollment Period, GAO-17-78, U.S. Government Accountability Office, November 2016.

Requiring couples that use the marriage SEP to prove at least one spouse had minimum essential coverage (MEC): HHS proposes to add a new requirement for consumers enrolling in a QHP through the SEP for marriage – at least one spouse must demonstrate having had MEC for one or more days during the 60 days prior to the date of the marriage (unless at least one spouse lived outside the U.S.). This proposal is in response to concerns that consumers are using the marriage SEP to game the system and enroll in coverage mid-year after they get sick.

ACS CAN opposes the proposed limitations to the availability of the SEP for marriage. We believe that before CMS acts to restrict access to insurance coverage, it should first provide evidence that individuals are misusing the SEP and that it is destabilizing the market.

We are also concerned that the proposed new requirement will make it harder for individuals who are not abusing the system to gain access to insurance coverage. For example, there is no exemption for couples who were uninsured because they fell into the Medicaid expansion gap in a state that has not expanded. Marriage may make a couple newly eligible for tax credits and therefore want to apply through the marketplace via this SEP, but they would be barred from doing so because they had both been uninsured.

In addition, this new requirement will make it harder for enrollees – and those assisting enrollees in choosing a health plan – to understand whether they are entitled to an SEP. The American Cancer Society operates a specialized Health Insurance Assistance Service (HIAS) which provides cancer patients information about health insurance and access to care. HIAS staff regularly interact with cancer patients who need health insurance coverage, are confused about whether they qualify for an SEP, and/or have difficulty applying for coverage through an SEP. This unnecessary requirement will prove overly burdensome and could have the chilling effect of discouraging individuals to seek coverage through an SEP.

Differing requirements for small group market: HHS notes that its proposed changes to SEPs in the individual market differ from existing rules in the group market. HHS states that the differences in markets and the impacts of those differences on the risk pools warrant this approach.

As ACS CAN objects to many of the additional limits placed on SEPs in the individual market in this proposal, we agree that these restrictions should not be implemented in the group market. However, we encourage HHS to be cautious about having two entirely different sets of rules. This can cause confusion for consumers – particularly for a consumer who is familiar with the rules in the group market and might assume she is eligible for an SEP in the individual market when in fact those rules are different. Different rules can also cause confusion for enrollment assistors. Therefore, we urge HHS to carefully educate assistors on these differences, and work to make materials and HealthCare.gov very clear about the rules for SEPs in each market.

Required documentation for the SEP for permanent moves: Current regulations require individuals applying for coverage under the SEP for permanent moves to submit documentation showing that a move occurred, and attest to having had prior MEC for at least one day in the last 60 days (or having lived outside the U.S.). HHS proposes to now require the applicant to prove both her

previous and new addresses and evidence of prior MEC through the pre-enrollment verification process.

ACS CAN continues to oppose the requirement of having had prior MEC to enroll via the permanent move SEP for reasons similar to those listed above regarding the marriage SEP: (1) there is not sufficient evidence that consumers are misusing this SEP; (2) we are concerned the requirement will cause coverage gaps; and (3) we are concerned the requirement will cause confusion and have a chilling event on applications for insurance.

This requirement gets even more onerous in a system (proposed in this same rule) that requires pre-enrollment verification for all SEP enrollees. Requiring documentation of both a consumer's previous address and new address almost ensures that consumers will have coverage gaps. Many consumers will find it very challenging to obtain documentation of a new address until after they have actually moved – and having just moved, will have to find documentation of their previous address and their previous insurance coverage. These are materials that may have just been thrown out or left behind during the process of moving.

It is not uncommon for cancer patients to permanently move while in active treatment to be closer to a treatment facility or a caregiver. It is also not uncommon for a caregiver to move to be closer to the recipient of their care. We are extremely concerned that the documentation requirements for these enrollees are too onerous for families who are dealing with a cancer diagnosis, and that it will result in coverage gaps. If these requirements are implemented, we strongly urge HHS to increase its awareness and education efforts so enrollees can be prepared for the amount of documentation they will need to submit after their move. We also encourage HHS to implement an appeals process, as suggested in other sections of our comments, for patients whose health would be jeopardized by delays caused by these requirements.

Limiting the exceptional circumstances SEP: HHS proposes to "significantly limit" the use of SEPs granted for exceptional circumstances, which in the past have been used to address eligibility or enrollment issues that affect large cohorts of individuals where they had made reasonable efforts to enroll but were hindered by outside events. The proposal notes that HHS would apply a "more rigorous test" for future uses of the SEP, including requiring supporting documentation where practicable. The proposal notes that HHS will provide guidance on examples of situations that would require the more rigorous documentation test.

The exceptional circumstances SEP is used for a wide range of situations, including cases where consumers were misled to believe their coverage qualified as MEC, were victims of fraud, or were prohibited from enrolling during open enrollment by natural disasters. It is difficult to evaluate this proposal without more details about what the more rigorous test will be and to which situations it will apply.

ACS CAN encourages HHS to include more details in its final rule, rather than using sub-regulatory guidance to clarify. We strongly urge HHS to tailor documentation requirements carefully to the

specific exceptional circumstance. For example, a consumer who has just experienced a natural disaster will find it very difficult to provide any type of documentation.

Impact of proposed guaranteed availability of coverage policy: As discussed above, HHS is proposing to allow issuers to prohibit individuals who are delinquent in their premiums from enrolling in coverage until the debt has been repaid. We are concerned that if this proposal is adopted, it could deny individuals access to care. For example, if an issuer erroneously believed an enrollee were delinquent on her premiums, the issuer could refuse to allow the individual to enroll in the plan. If this issue was not resolved during the open enrollment period, an individual could be locked out from coverage due to circumstances beyond her control (e.g., error on the part of the issuer). Therefore, we urge HHS to consider granting an SEP in instances where a documented error has prevented the individual from enrolling in a health plan within the enrollment period provided (either an SEP or the annual enrollment period).

In conclusion, ACS CAN understands the need to ensure that the risk pools are balanced between healthy and sick individuals. However, we believe that the best way to achieve this goal is to invest in enrollment, education, and outreach activities, further reduce barriers to enrollment, and ensure a strong risk adjustment program — not to restrict access to SEPs or penalize consumers.

3. Continuous Coverage

In the preamble, HHS notes that it is "actively exploring additional policies in the individual market that would promote continuous coverage" and seeks "input on which policies would effectively do so consistent with existing legal authorities."[17] As an example, HHS notes that it is considering policies that would require individuals to show evidence of prior coverage for a longer "look back" period for individuals who seek to utilize a special enrollment period. HHS is soliciting feedback from stakeholders, but is not proposing specific policies.

ASC CAN notes that the statute's guaranteed availability requirements provide that issuers "must accept every employer and individual in the State that applies for coverage" during the open enrollment and special enrollment periods. Most individuals who lack health care coverage are already assessed a financial penalty through the individual mandate. We caution HHS against enacting policies that would penalize an individual from enrolling in health insurance if they experience a gap in coverage.

There are many legitimate reasons why an individual may experience a coverage gap.[18] For instance, many people may experience a gap in coverage when they lose their job and their employee coverage. Research suggests that between 40 and 85 percent of cancer patients stop working while receiving cancer treatment, with absences from work ranging from 45 days to 6

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[17] 82 Fed. Reg. at 10988.

[18] In 2014, almost one-quarter of people with pre-existing health conditions (approximately 31 million people) experienced at least one month without health coverage. Assistant Secretary for Planning and Evaluation. Health Insurance Coverage for Americans with Pre-existing Conditions: The Impact of the Affordable Care Act, Jan. 5, 2017, available at https://aspe.hhs.gov/system/files/pdf/255396/Pre-ExistingConditions.pdf.

months depending on the treatment.[19] Individuals with cancer may lose their job because their cancer and/or cancer treatment makes them unable to work. This also includes cancer survivors who are more likely to report being unable to work because of their health or having employment disability, including more missed work days or additional days spent in bed due to poor health.[20]

Gaps in coverage also occur as a result of a divorce or death of a spouse when one spouse is no longer covered on the other's health plan. Moving from one state to another may result in a gap in coverage. Penalties (including financial penalties and/or onerous restrictions to enroll in a health plan) imposed on people in these situations may adversely impact access to care, interrupt life-saving treatment and make insurance unaffordable when they attempt to regain coverage.

Gaps in coverage are detrimental to individuals in active cancer treatment, and ACS CAN shares HHS' desire to encourage individuals to avoid them. However, we are very concerned that the proposals cited here do not accomplish this goal. Imposing waiting periods before coverage begins or erecting barriers to accessing coverage can make health insurance permanently unaffordable for that individual. Alternatively, additional restrictions to SEPs can lock the individual out of coverage until open enrollment. Both policies actually serve to extend coverage gaps instead of discouraging them.

C. Part 156 – Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges

1. Levels of Coverage (Actuarial Value) (§156.140)

The statute provided that QHPs must adhere to certain actuarial value (AV) requirements depending on the metal level of the plan. Actuarial value requirements are determined based on the percentage of cost for which the health plan is responsible based on coverage of essential health benefits (EHBs) for a standard population. HHS proposes several changes to the AV requirements.

De Minimis Calculation: Through previous regulations, HHS promulgated a de minimis rule which allowed issuers some flexibility when determining the AV of their plan. Under this rule, plans (other than bronze level plans) were determined to meet the statutory AV requirements so long as their

[19] Scott Ramsey, et al, "Washington State Cancer Patients Found to be at Greater Risk for Bankruptcy then People Without a Cancer Diagnosis," Health Affairs, 32, no. 6, (2013): 1143-1152.

[20] Yabroff KR, Dowling EC, Guy GP, et al. Financial Hardship Associated With Cancer in the United States: Findings From a Population-Based Sample of Adult Cancer Survivors. Journal of Clinical Oncology. 2016;34(3):259-267. doi:10.1200/JCO.2015.62.0468; GP Guy Jr, DU Ekwueme, KR Yabroff, et al: Economic burden of cancer survivorship among adults in the United States J Clin Oncol 31:3749–3757,2013; EA Finkelstein, FK Tangka, JG Trogdon, et al: The personal financial burden of cancer for the working-aged population Am J Manag Care 15:801–806,2009; KR Yabroff, WF Lawrence, S Clauser, et al: Burden of illness in cancer survivors: Findings from a population-based national sample J Natl Cancer Inst 96:1322–1330,2004.

variation was +/- 2 percentage points. HHS proposes to expand these AV requirements to allow a variation of -4/+2 percentage points.[21]

ACS CAN opposes the change in actuarial value requirements. We are concerned that this change is designed to reduce the overall value of the benefit to consumers (as noted by the fact that the AV change allows for a greater deviation below the statutory actuarial value). By allowing issuers to offer a less generous silver plan, the proposed rule would force consumers to choose between a plan with lower premiums but higher out-of-pocket costs or a plan with higher premiums and lower out-of-pocket costs. The preamble suggests that this policy "could lead up to a 1 to 2 percent reduction in premiums."[22] But at the same time, HHS notes that by definition this policy will shift costs from plans to consumers:

> [T]he impact of this proposed change would be to generate a transfer from consumers to issuers. The proposed change in AV could reduce the value of coverage for consumers, which could lead to more consumers facing increases in out-of-pocket expenses, thus increasing their exposure to financial risks associated with high medical costs.[23]

While we appreciate HHS' attempt to lower plan premiums, for individuals who are high utilizers of health care services, such as those with cancer, the premium is but one aspect of enrollee cost-sharing. ACS CAN councils people to choose a plan based on coverage of products and services and the associative cost-sharing over a plan's premium.[24] Indeed, younger enrollees report being concerned about high cost-sharing associated with their plan.[25]

We are also opposed to the proposed policy because it will be harder for consumers to compare the value of plans within the same metal level. Under the proposal, a consumer could be offered a silver level plan with an AV of 66 percent and another plan with an AV of 72 percent. Both plans could technically be considered "silver level" plans, but the six percentage points of variation

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[21] HHS proposes to allow a variation of bronze plans of between -4 and +5 percentage points. Through previous regulation HHS had allowed a variation for bronze plans of -2/+5 percentage points for those plans that covers and pays for at least one major service other than preventive services before the deductible. HHS proposes to expand the AV requirements for bronze plans to +5/-4 to be consistent with the proposed policy.

[22] 82 Fed. Reg. at 10995.

[23] Id.

[24] American Cancer Society Cancer Action Network, Health Plan Worksheet: Tips for Choosing the Right Health Insurance Plan in the Market, available at https://www.acscan.org/policy-resources/tips-choosing-right-health-insurance-plan-marketplace. In addition to this worksheet, ASC CAN has a number of other tip sheets and fact sheets to educate individuals with cancer and survivors about key considerations to use when choosing a health plan. More information about those materials are available at https://www.acscan.org/policy-resources/access-health-care/health-care-delivery.

[25] Liz Hamel, Jamie Firth, Larry Levitt, Gary Claxton, and Mollyann Brodie, *Survey of Non-Group Health Insurance Enrollee, Wave 3*, (Washington, DC: Kaiser Family Foundation, May 20, 2016), available at http://kff.org/health-reform-poll-finding/survey-of-non-group-health-insurance-enrollees-wave-3/. Kara Brandeisky, *Why Millennials Hate Their Least Expensive Health Care Option*, Time Magazine (Dec. 8, 2014), available at http://time.com/money/3614626/millennials-health-insurance-high-deductible/.

between the plans would result in significant differences in coverage offered by the plan. Again, the point of the de minimis requirement was to allow some flexibility while at the same time allowing consumers the opportunity to shop among plans that offered essentially the same amount of coverage. We believe the proposed rule is antithetical to the statutory intent. We strongly urge HHS to retain the existing de minimis standard.

Impact on Advance Premium Tax Credits (APTCs): Under the ACA, the advance premium tax credit is the difference between the second-lowest-cost silver plan premium and the applicable percentage of the enrollee's income. Under the proposal, if the second-lowest cost-silver plan had an actuarial value of 66 percent (and thus, a lower premium) the total amount of the advance premium tax credit would be reduced. According to analysis from the Center for Budget and Policy Priorities, a family of four with an income of $65,000 would either pay $327 more a year in premiums or face a $550 increase in their deductible if they chose a 66 percent AV plan.[26]

Cost-Sharing Reduction Plans (CSRs): At the same time we are pleased that HHS does not intend to extend this proposed policy to the cost-sharing reduction plans (plans with an AV of 73, 87, and 94). Rather, HHS will continue to permit a single variation (-1/+1 percentage) for these plans. ACS CAN supports HHS' intention to not apply the policy for the CSR plans.

2. Network Adequacy (§156.230)

Beginning in plan year 2018, HHS will defer a determination of whether the QHP meets the network adequacy requirements to states that have authority to determine whether coverage is at least as good as the current "reasonable access standard." For States that don't have such authority or lack the means to conduct sufficient network adequacy reviews, HHS would accept an issuer's accreditation from an HHS-recognized accrediting entity (e.g., National Committee for Quality Assurance, URAC, and Accreditation Association for Ambulatory Health Care). Unaccredited issuers would be required to submit an access plan that is consistent with the National Association of Insurance Commissioners' Health Benefit Plan Network Access and Adequacy Model Act.

ACS CAN is concerned that the proposal fails to provide consumers with a comprehensive standard regarding the adequacy of their plan's network. The American Cancer Society operates a specialized Health Insurance Assistance Service (HIAS) at its National Cancer Information Center which provides cancer patients information about health insurance and access to care. HIAS frequently receives calls from patients who are in an insurance plan, yet unable to access oncology services because their plan's network is not robust enough to provide coverage of these specialized services. We have long advocated that the network adequacy requirements must ensure that individuals – including those with serious diseases like cancer – have access to the specialists needed for their care.

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[26] Center for Budget and Policy Priorities. *Trump Administration's New Health Rule Would Reduce Tax Credits, Raise Costs, For Millions Of Moderate-Income Families*. Feb 15, 2017, available at http://www.cbpp.org/sites/default/files/atoms/files/2-15-17health.pdf.

State Review: ACS CAN believes that state regulators should have certain flexibility to regulate their insurance markets. However, we are concerned that the proposal fails to provide adequate consumer protections. We strongly urge HHS to provide minimum federal standards to ensure that consumers receive comparable benefits with respect to the adequacy of their plan networks nationwide. Such federal standards must include quantitative standards (like time and distance standards). Using quantitative standards allows insurers to know the parameters by which they will be judged and lets consumers know that all plans are judged by the same standards. We also note that less than half the states have metrics in place to assess whether marketplace plans provide adequate networks.[27]

Accreditation: ACS CAN does not believe that accreditation by an external entity is sufficient oversight to determine whether a plan has met certain network adequacy requirements. Accreditation standards are not always readily accessible and therefore it can be impossible for consumers to know the extent to which their plan meets network adequacy requirements. Moreover, depending on the accrediting standards it may be possible for a health plan to fail the network adequacy requirements, yet still receive accreditation by the accrediting entity if the plan otherwise does well with respect to other areas of accreditation.

We would also note that the accrediting entities cited in the proposed rule may not accredit marketplace plans, but rather may provide accreditation of other types of plans such as Medicaid managed care plans, employer-sponsored coverage, etc. While accreditation of these types of plans is important, the populations served by Medicaid managed care plans and individual marketplace plans is different and thus the network adequacy requirements for these plans would differ.

National Association of Insurance Commissioners' (NAIC) Model Act: ACS CAN is pleased with HHS' recognition of the value of the NAIC's Health Benefit Plan Network Access and Adequacy Model Act. We believe this Model Act, when adopted by states with some modifications (including the imposition of quantitative standards) will serve as an important protection for consumers. Since the NAIC Model Act was adopted in November 2015, few states have enacted the model legislation. We urge HHS to postpone any requirement that the NAIC Network Adequacy Model Act serve as the basis for determining whether a plan's provider network is adequate until more states have had an opportunity to enact this Model Act.

3. Essential Community Providers (§156.235)

Under current regulations plans must contract with at least 30 percent of the available essential community providers (ECPs) in each plan's service area. Plans that are unable to meet this standard

[27] Justin Giovannelli, Kevin W. Lucia, and Sabrina Corlette, Implementing the Affordable Care Act: State Regulation of Marketplace Plan Provider Networks, (Washington, DC: Georgetown CHIR, May 20015), available at http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/may/1814_giovannelli_implementing_aca_state_reg_provider_networks_rb_v2.pdf.

must submit justification for why this standard cannot be met. HHS proposes to reduce this standard to 20 percent.

ACS CAN strongly urges HHS to retain the current 30 percent ECP requirement. A stronger ECP in-network threshold is a critical step to improving access to care, especially given that ECPs serve as an entry point into the broader health care system and serve as an ongoing source of care for millions of families.

We are particularly concerned about the ECP standards because cancer hospitals and children's hospitals (which are a primary provider of pediatric oncology services) are included within the ECP hospital category. We are concerned that by weakening the ECP standards, enrollees will have a harder time accessing these vital oncology services. We have long advocated for CMS to make modifications to the ECP standards so that cancer patients can have better access to these specialized facilities.

HHS seeks to justify its reduction of the ECP standard to 20 percent by stating that for plan year 2017, six percent of issuers were required to submit justification for why the 30 percent standard was not met. In all cases, the justification was deemed sufficient. HHS estimates that without the proposed change, "approximately 20 [qualified health plans] and stand-alone dental plans issuers would have spent 45 minutes on average to prepare an[d] submit a justification. The total reduction in burden for the 20 issuers would be 15 hours with an equivalent reduction in costs of $1,155."[28] HHS' proposed policy justification falls short on two counts:

First, HHS' rationale for its proposed policy fails to justify why the ECP standard must be weakened; rather, the rationale serves to support the current requirements. Plans that are unable to meet the ECP standard for whatever reason are permitted to seek a waiver from CMS provided they have a strong rationale for doing so. HHS fails to provide any evidence of why standards for all plans must be weakened (and thus decreasing consumer access to essential community providers) because six percent of plans were unable to meet a standard – particularly given that these plans' justifications for failing to meet the standard was deemed sufficient.

In addition, by its own estimation only 20 plans and stand-alone dental plans are unable to comply with the current 30 percent requirement. The fact that HHS fails to differentiate between the number of QHPs and the number of stand-alone dental plans who had to submit a justification is noteworthy, and we urge HHS to provide further information regarding how many of the 20 plans were QHPs versus stand-alone dental plans. It is also worth noting that the justification process does not appear to be too onerous if HHS estimates that a plan would spend less than one hour preparing a justification to CMS.

We are also concerned with HHS' recognition that the proposed policy would result in cost-shifting to consumers. As stated in the Regulatory Impact Analysis:

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[28] 82 Fed. Reg. at 10992.

> Less expansive requirements for network size would lead to both costs and cost savings. Costs count take the form of increased travel time and wait time for appointments or reductions in continuity of care for those patients whose providers have been removed from their insurance issuers' networks. Cost savings for issuers would be associated with reductions in administrative costs of arranging contracts and, if issuers focus their networks on relatively low-cost providers to the extent possible, reductions in the cost of health care provisions.[29]

This proposed justification is alarming for a number of reasons. Individuals in active cancer treatment and survivors rely on specialized oncology services (including cancer hospitals and/or children's hospitals in the case of pediatric cases). While it is true that eliminating these specialized facilities from a plan's network (or failing to contract with these facilities which are considered essential community providers) will reduce the cost to the insurer, it does not reduce a consumer's need to access these services.

Rather, individuals who require access to these specialized services will be forced to go outside the plan's network to obtain care. In 2014, ACS CAN examined the extent to which silver plans operating in the federally-facilitated marketplace, Covered California, and NY State Health offered out-of-network coverage. Our analysis determined that 43 percent of silver plans offered no out-of-network coverage. Even among those plans that offered some out-of-network coverage, the cost-sharing associated was often significant – with an average out-of-network deductible of $6,384, though some states, like Texas, had an out-of-network deductible in excess of $10,000.[30]

Conclusion

On behalf of the American Cancer Society Cancer Action Network we thank you for the opportunity to comment on the proposed rule. If you have any questions, please feel free to contact me or have your staff contact Anna Schwamlein Howard, Policy Principal, Access to and Quality of Care at Anna.Howard@cancer.org or 202-585-3261.

Sincerely,

Christopher W. Hansen
President,
American Cancer Society Cancer Action Network

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[29] 82 Fed. Reg. at 10996.

[30] American Cancer Society Cancer Action Network, Cancer Care and the Adequacy of Provider Networks Under ACA Marketplace Plans, Washington, DC: American Cancer Society Cancer Action Network; June 2014, available at: https://www.acscan.org/policy-resources/cancer-providers-and-qualified-health-plan-qhp-networks.