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December 7, 2017

Randy Pate
Deputy Administrator & Director
Center for Consumer Information and Insurance Oversight
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Re: DRAFT 2019 Letter to Issuers in the Federally-facilitated Marketplaces
(November 27, 2017)

Dear Director Pate:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on the draft 2019 Letter to Issuers in the Federally-facilitated Marketplaces (Draft FFM Letter). 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.

ACS CAN strongly supports the patient protections and additional options for accessing health insurance enacted as part of the Affordable Care Act (ACA). The ACA has decreased the number of uninsured in this country to record levels – and this is already proving beneficial for cancer patients and survivors as well as for individuals who need preventive services. Qualified Health Plans (QHPs) sold in federally-facilitated and state-based marketplaces are key to these developments, providing insurance coverage for individuals and families who cannot obtain or afford insurance through an employer or elsewhere. ACS CAN will continue to advocate for policies that ensure QHPs offer quality coverage to enrollees.

We note the Draft FFM Letter references several policies contained in the recent 2019 Notice of Benefit and Payment Parameters proposed rule[1] (proposed 2019 Payment Notice) and we refer CMS to our comments in response to that proposed rule.[2] Overall, we are extremely concerned by many of the major proposed changes in the proposed rule. Below are comments addressing specific sections of the Draft FFM Letter.

[1] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019, 82 Fed. Reg. 51052 (Oct. 27, 2017).
[2] ACS CAN's comments on the proposed rule are available at https://www.acscan.org/sites/default/files/ACS%20CAN%20Comments%202019%20NBPP%20FINAL.pdf.

Chapter 1: Certification Process for Qualified Health Plans

Section 7. Standardized Options

In the proposed 2019 Payment Notice, HHS declines to specify standardized options, citing their desire to "encourage free market principles in the individual market, and to maximize innovation by issuers in designing and offering a wide range of plans to consumers." In the Draft FFM Letter, HHS reiterates this proposal and states that if it is finalized, CMS will not provide differential display for standardized options on healthcare.gov.

ACS CAN opposes HHS' decision to not provide standardized plan options. As stated in our comments regarding the proposed 2019 Payment Notice, ACS CAN believes these standardized options helped to address the challenges of individuals who may be overwhelmed with plan options when shopping for health insurance coverage in the exchanges. This standardization allowed individuals shopping for coverage to focus on the aspects of their health insurance plan that matter most to them, such as plan provider networks, covered benefits, quality, and premiums.

ACS CAN is disappointed that HHS is proposing to not continue this program, but in light of that proposal, we encourage HHS to explore other ways to help users of healthcare.gov easily compare their plan options.

Chapter 2: Qualified Health Plan and Stand-Alone Dental Plan Certification Standards

Section 3. Network Adequacy

i. Network Adequacy Standard and Certification Review

CMS notes it intends to follow the approach provided in the 2019 proposed Payment Notice, e.g., to defer to the States in the determination on whether coverage is at least equal to the "reasonable access standard."

As noted in our comments on the proposed 2019 Payment Notice, ACS CAN is concerned that the proposal fails to provide consumers with a comprehensive standard regarding the adequacy of their plan's network. We believe 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 also note that less than half the states have metrics in place to assess whether marketplace plans provide adequate networks.[3]

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. 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 or employer-sponsored coverage, which serve different populations than

[3] 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).

those enrolled in the individual marketplace plans and thus the network adequacy requirements for these plans would differ.

ii. Provider Transitions and Out-of-Network Cost Sharing for In-Network Settings

CMS states that their approach for provider transitions and out-of-network cost sharing for in-network settings remains unchanged from 2018, and refers to the 2018 FFM Letter for more information. The 2018 FFM Letter to Issuers states that in the event of a provider leaving a QHP's network, CMS requires QHP issuers to make a good faith effort to provide written notice to affected enrollees 30 days prior to the provider leaving the plan's network. Additionally, when a provider's contract is terminated without cause, the QHP issuer should allow an enrollee in active treatment to continue treatment until completion or 90 days, whichever is shorter, at in-network cost-sharing rates.

ACS CAN appreciates CMS continuing to address provider changes in a plan's network. While the 90-day continuity of care provisions are an important first step it is important to note that 90 days may be an insufficient time for many patients with more complex cancers to complete an entire course of chemotherapy. We continue to urge CMS to clarify this provision to explicitly allow longer continuity of care periods in special circumstances, such as when the patient's cancer requires a longer course of treatment or when a patient has received prior authorization for a procedure or surgery by a provider who subsequently leaves the network.

iv. Network Transparency

CMS states that it plans to "continue to test patient use and experience on healthcare.gov to enhance and improve the display of QHP network breadth information," and refers to the 2018 Letter to Issuers for more information. In 2017, CMS created a pilot program to provide information on healthcare.gov displaying the relative size of the provider networks for plans in a limited number of states.[4] In the pilot states, CMS issues a rating based on access to hospitals, adult primary care, and pediatric primary care, with a separate classification for each of the three categories, and displays this rating on healthcare.gov. CMS most recently released an updated bulletin about this pilot program on June 9, 2017,[5] and presumably CMS intends to continue this program as specified in this update.

ACS CAN continues to support this program and encourages CMS to provide additional classifications for the most commonly used specialty physicians in 2019. We also encourage CMS to distinguish between hospital types. In addition, we recommend that CMS add the following categories of practitioner and hospital classifications:

- Emergency department physicians who practice at an in-network hospital;
- Adult physician specialists who practice at an in-network hospital (e.g., anesthesiologists, pathologists, etc.);
- Adult specialists who practice in office-based settings, such as oncologists and cardiologists;

[4] On September 30, 2016, CMS provided additional information on this pilot program. CMS, Updated CMS Bulletin on Network Breadth Information for Qualified Health Plans on Healthcare.gov, available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/NA-Pilot-Final-Guidance-Clean-093016.pdf.

[5] CMS. "Updated CMS Bulletin on Network Breadth Information for Qualified Health Plans on HealthCare.gov." June 9, 2017. Available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/NA-Pilot-Guidance.pdf

- Pediatric specialists; and
- Children's hospitals, cancer hospitals, and other specialty facilities.

It is crucial that CMS include specialists in its rating because otherwise a QHP whose network is composed primarily of primary care providers will receive a higher rating that a QHP with a broader network that covers specialty care. Individuals – like those with cancer or cancer survivors – who rely on access to specialists for their medical needs would be unfairly disadvantaged by such a system.

Specialty Access

We note that in the 2018 FFM Letter, CMS indicated it would "explore factors that contribute to enrollee access to specialty providers." ACS CAN strongly supported this plan, especially as it pertained to monitoring access to oncology and cancer treatment facilities. We believed that such an analysis would help ensure that cancer patients have access to providers and facilities necessary for their treatment, helping to reduce the need for individuals to have to seek care outside the plan's network, which can be prohibitively costly to the enrollee. We note that CMS is silent about this previous plan in the proposed 2019 FFM Letter. We encourage CMS to continue this monitoring and analysis.

Section 4. Essential Community Providers

CMS states that it intends to follow the policies outlined in the proposed 2019 Payment Notice related to Essential Community Providers (ECPs). CMS intends to require plans to adhere to the 20 percent general ECP standard.

ACS CAN opposes maintaining the 20 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 maintaining the 20 percent 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.

Section 9. Review of Rates

In its proposed 2019 Payment Notice, HHS proposed to change the federal threshold for review of annual premium increases from 10 percent to 15 percent. The preamble notes that this would be a minimum standard and that states can employ stricter rate review standards. HHS makes conforming changes in the proposed FFM Letter.

As stated in our comments regarding the proposed 2019 Payment Notice, ACS CAN urges HHS to retain the current 10 percent threshold. Congress adopted the rate review policy to monitor the extent to which a rate increase is justified by evidence. Increasing this threshold would allow plans to impose higher premium increases before additional justification would be required.

Section 10. Discriminatory Benefit Design

The Draft FFM Letter states that HHS' approach to discriminatory benefit design remains unchanged from 2018, and notes that CMS will not conduct active certification reviews for cost sharing outliers for States that perform plan management functions, and will instead defer to those State processes. CMS

will continue to review for cost sharing outliers in FFE States that do not perform plan management functions.

ACS CAN believes the non-discrimination provisions of the ACA are an important first step towards ensuring that health benefit designs cannot discriminate against patients in ways that deny them access to critical care. We are concerned, however, that HHS continues to not specifically define, illustrate, or address discriminatory practices in plan benefit designs, particularly as it relates to individuals with chronic or serious conditions like cancer. We urge CMS to provide additional, specific examples regarding what constitutes a discriminatory benefit design for individuals with chronic and serious illnesses like cancer.

Section 11. Prescription Drugs

The Draft FFM Letter states that HHS' approach to reviewing issuers' prescription drug benefit offerings remains unchanged from that used in 2018, and notes that CMS will not conduct active certification reviews for formulary outliers or for clinical appropriateness for States that perform plan management functions, and will instead defer to those State processes. CMS will continue to review for formulary outliers and for clinical appropriateness in FFE States that do not perform plan management functions.

ACS CAN believes it is important for CMS to review QHP formularies to ensure they are not discriminatory. CMS generally has more robust resources than may exist at the state level to conduct technical, clinical analysis to determine whether a QHP's formulary meets the appropriate standards.

In addition, we continue to be concerned that an outlier analysis may be insufficient to provide oversight for QHPs. CMS compares QHP plans to each other – therefore it is not a true test of discrimination, but rather a test to determine if a certain plan is being *more* discriminatory than other plans. For example, it is common for plans to require prior authorization for every covered tobacco cessation medication. Since this practice is common, a plan that did this would not be flagged in an outlier review – allowing this discriminatory practice against tobacco users to go on unchecked. Additionally, ACS CAN encourages CMS to add an examination of dosing restrictions to this outlier analysis, as it is another common utilization management technique used by plans that can create barriers for patients.

Section 12. Supporting Informed Consumer Choice/Meaningful Difference

In the proposed 2019 Payment Notice, HHS eliminates the requirement that issuers only offer QHPs that are meaningfully different from its other QHP offerings, and Draft FFMS Letter makes conforming changes to this proposal.

ACS CAN opposes this change and strongly encourages HHS to continue conducting meaningful difference reviews and enforcing this standard. We believe this standard makes the plan selection process easier for consumers, as it prevents issuers from flooding the market with multiple plans that have insignificant differences. The meaningful difference standard is designed to facilitate consumer comparison and choice by helping consumers differentiate among plan options. The standard helps ensure that marketplace plans reflect substantive distinctions between benefit design features, such as cost-sharing levels. We are particularly concerned that these changes will make the plan selection process much more difficult for consumers and could inadvertently discourage enrollment. The complexity of sorting through multiple plan options can often immobilize consumers and runs the risk that some people will decide to forgo picking a plan altogether.

Chapter 3: Consumer Support Tools and Public Information

CMS indicates its approach to consumer support tools and public information will remain unchanged from 2018.

ASC CAN applauds CMS for its work to ensure that plan coverage and formulary information is available to enrollees and potential enrollees as they search for a plan that best meets their needs. When choosing a health plan, ACS CAN urges individuals with cancer and survivors to choose a plan that covers the medical services and prescription drugs the individual needs.[6]

However, we note that it can be challenging for individuals to obtain information regarding their health plan's coverage of prescription drugs provided under the medical – not prescription drug – benefit. In a 2017 white paper,[7] ACS CAN analyzed coverage of cancer drugs in silver plan formularies in six states – Alabama, California, Colorado, Nevada, New Jersey and Texas – to determine the extent to which these plans covered certain cancer drugs and if plan coverage was transparent to the consumer. Our analysis determined that it was often challenging to determine from the plan websites whether they provided coverage for physician-administered intravenous (IV) medications, let alone what cost-sharing would be required. This makes it difficult for patients using these drugs to choose an appropriate health plan for their needs or predict their expenses. We urge CMS to require that plans list the cost-sharing associated with all drugs, including physician-administered drugs, regardless of whether the drug is covered under the medical or prescription drug benefit.

Chapter 5: Qualified Health Plan Performance and Oversight

Section 2. FFE Oversight of QHP Issuers and Web-brokers Using a Direct Enrollment Pathway

ii. Standards for Third-party Entities to Perform Audits of Agents, Brokers, and Issuers Participating in Direct Enrollment

In the proposed 2019 Payment Notice, CMS proposes to let QHP insurers, agents, and brokers participating in direct enrollment select their own third-party entities for annual reviews and audits. CMS indicates that this oversight process will serve as the basis for the oversight approach of any expansions of the direct enrollment pathway.

ACS CAN urges CMS not to implement the changes proposed in the 2019 Payment Notice, or use this approach as the basis for future expansion. We encourage CMS to continue federal oversight of direct enrollment. We are concerned that the third-party entities contracted by the QHP issuers, agents, and brokers would have a conflict of interest regarding the impartiality of the audits. QHPs would be permitted to choose an auditor with whom it has a financial conflict of interest provided the relationship is disclosed. This policy is particularly alarming given that CMS is also proposing to allow insurers, brokers, and agents to access more and more consumer personal and financial information.

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[6] More information on ACS CAN's consumer tip sheets can be available at www.acscan.org/healthcare/learn.
[7] American Cancer Society Cancer Action Network, ACS CAN Examination of Cancer Drug Coverage and Transparency in the Health Insurance Marketplaces, Washington, DC: American Cancer Society Cancer Action Network; February 22, 2017, available at: https://www.acscan.org/sites/default/files/QHP%20Formularies%20Analysis%20-%202017%20FINAL.pdf.

Chapter 7: Consumer Support and Related Issues

Section 3. Summary of Benefits and Coverage

CMS refers to the 2018 Issuer Letter for requirements regarding the Summary of Benefits and Coverage (SBC) except to note the new policy of not enforcing against an individual market issuer that omits the minimum value disclosure from its SBC. The minimum value disclosure indicates whether a plan includes minimum essential coverage – or is coverage that would satisfy the individual mandate. Since all QHPs by definition must meet this standard, CMS indicates it is not necessary to include this disclosure on SBCs for QHPs.

ACS CAN is concerned that allowing QHPs to omit this disclosure will result in confusion for consumers. We are particularly concerned that this will be the case if the number of short-term limited duration plans and/or association health plans increases in the coming years in response to the administration's executive order regarding these types of plans.[8] Short-term limited duration plans do not have to follow many of the requirements that consumers have come to expect in health insurance plans, and there is a potential for association health plans also having weaker coverage standards. It is important for consumers to be able to understand exactly what they are getting when they purchase health insurance coverage. We encourage CMS to pay careful attention to how their implementation of requirements for SBCs will affect consumer understanding of their health insurance benefits, and we urge CMS to enforce the minimum value disclosure requirements on all plans to minimize confusion.

Conclusion

On behalf of the American Cancer Society Cancer Action Network we thank you for the opportunity to comment on the Draft 2019 Letter to Issuers in Federally-facilitated Marketplaces. If you have any questions, please feel free to contact me or have your staff contact Jennifer Singleterry, Senior Analyst, at Jennifer.Singleterry@cancer.org or 202-585-3233.

Sincerely,

Kirsten Sloan
Vice President for Policy
American Cancer Society Cancer Action Network

[8] See Presidential Executive Order Promoting Healthcare Choice and Competition Across the United States. October 12, 2017. Available at https://www.whitehouse.gov/the-press-office/2017/10/12/presidential-executive-order-promoting-healthcare-choice-and-competition.