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November 27, 2017

Eric D. Hargan
Acting Secretary
Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20201

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS-9930-P – Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019
82 Fed. Reg. 51052 (November 2, 2017)

Dear Acting Secretary Hargan and Administrator Verma:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on the 2019 Notice of Benefit and Payment Parameters 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.

ACS CAN supports a robust marketplace from which consumers can choose a health plan that best meets their needs. Access to health care is paramount for persons with cancer as well as survivors. In the United States, there are more than 1.7 million Americans who will be diagnosed with cancer this year.[1] An additional 15.5 million Americans living today have a history of cancer.[2] For these Americans access to affordable health insurance is a matter of life or death. Research from the American Cancer Society has shown that uninsured Americans are less likely to get screened for cancer and thus are more likely to have their cancer diagnosed at an advanced stage when survival is less likely and the cost of care more expensive.[3]

We offer comments on specific provisions of the proposed rule as follows:

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

2. Guaranteed Availability of Coverage (§ 147.104)

HHS proposes to exempt qualified individuals from the prior coverage requirement that applies to certain special enrollment periods (SEPs) if, for at least one of the 60 days prior to the date of their qualifying event, they lived in a service area without any qualified health plans (QHPs) offered through

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[1] American Cancer Society. *Cancer Facts & Figures 2017*. Atlanta, GA: American Cancer Society; 2017.
[2] Id.
[3] 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.

an Exchange. Under the proposed change, this exception for individuals would also apply to coverage purchased off the Exchange.

ACS CAN has closely monitored the status of issuers participating in the exchanges in states with low issuer participation. We are pleased that for the 2018 plan year, every county in the U.S. has at least one issuer selling an insurance plan through the state or federal exchange. This will help to ensure that every cancer patient, survivor and person at risk for cancer has access to an insurance option. However, we are aware that it is possible this will not always be the case, and we support this change. Individuals in the future who may live in a county where no issuer is offering coverage should not be penalized or blocked from enrolling in coverage when such coverage becomes available, either because the individual moved, or because an issuer entered the market.

ACS CAN also urges the administration to take steps to prevent counties from being left with no issuers offering coverage. The most important and urgent way to do this is to provide long-term funding for cost-sharing reduction subsidies.[4]

C. Part 154 – Health Insurance Issuer Rate Increases: Disclosure and Review Requirements

2. Rate Increases Subject to Review (§ 154.200)

HHS proposes 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 also proposes to eliminate the existing requirement that it publish a notice each year indicating which threshold applies to each state. Rather, states that choose to impose a threshold other than the federal minimum standard would be responsible for communicating that information.

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.

In addition, we urge HHS to continue its practice of providing notice of rate filing thresholds for all states. This practice makes it easier for stakeholders to monitor rate review filings. This information would be helpful to HHS as it would allow the Department the ability to monitor state activity to determine whether future threshold decreases may be warranted.

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

1. Standardized Options (§ 155.20)

In 2017 and 2018, HHS provided for standardized plan designs that issuers could choose to offer and that were developed to be similar to the most popular QHPs in the federally-facilitated exchange (FFE) markets based on enrollment. HHS also encouraged the differential display of those options, labeling them "Simple Choice" plans on healthcare.gov. In the 2019 proposed Payment Notice, HHS declines to specify standardized options nor to provide for differential display of such options, citing their desire to

[4] For more information, see ACS CAN's factsheet on The Need to Fund Cost-Sharing Reduction Subsidies at https://www.acscan.org/policy-resources/need-fund-cost-sharing-reduction-csr-subsidies.

"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."

ACS CAN opposes the decision to discontinue the standardized plan designs. We have historically supported the prior decision to offer such plans, because these policies helped to address the challenges of individuals who may be overwhelmed with plan options when shopping for health insurance coverage in the exchanges. The American Cancer Society operates a specialized Health Insurance Assistance Service (HIAS) which provides cancer patients information about health insurance options that may be available to them in their area. HIAS representatives often hear from individuals with cancer about how overwhelming it can be to choose among too many health insurance plans.

We believed that standardized benefit packages could be beneficial to individuals as they shop for health insurance coverage. 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.

The HHS-published landscape file for individual medical QHPs shows that there are 3,052 standardized plans being offered in multiple states through the FFM in 2018. The data.healthcare.gov website no longer includes data from the 2017 plan year, so we are unaware of whether this number has increased since standardized plans were created. These and other data are important in evaluating whether such a program should be maintained. ACS CAN encourages HHS to release more data on the standardized plans for plan years 2017-2018 so that all stakeholders can accurately evaluate the success of the program. Before HHS proceeds with its decision to discontinue standardized plan options, it should conduct research to determine the extent to which the program was successful in accomplishing its goals. The lack of standardized plans, combined with the relaxing of the meaningful difference standards contained elsewhere in this proposal, will make it harder for consumers to compare and shop for health plans during open enrollment 2019. This accomplishes the opposite of one of HHS' stated goals, to "empower consumers."

2. General Standards Related to the Establishment of an Exchange

c. Additional required benefits (§ 155.170)

Under existing rules, state mandated benefits enacted prior to December 31, 2011, are considered part of the state's essential health benefit (EHB) requirements. Mandates enacted after this date are outside the EHB and the state must make payments, either to the enrollee or to the health plan, to defray the cost of these additional benefits. The preamble makes clear that HHS is not proposing changes to the state mandate policy at this time, but rather seeks comments on different applications of the State mandate policy that would allow for greater flexibility.

ACS CAN has been supportive of the EHB benchmark policy, which serves as a reference point regarding coverage of essential health benefits. We are also pleased that the EHB-benchmark policy incorporates state mandates enacted prior to December 31, 2011. Many of these state mandates provide coverage related to cancer care or preventive screenings.

3. General Functions of an Exchange

a. Functions of an Exchange (§ 155.200)

HHS proposes to eliminate the requirements for state-based exchanges on the federal platform (SBE-FPs) to enforce the FFE standards for network adequacy and essential community providers (ECPs), leaving SBE-FPs with the sole discretion on enforcing the network adequacy and ECP requirements. HHS is also proposing to remove the requirement that SBE-FPs comply with the Federal meaningful differences standard.

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. Federal oversight ensures that states are enforcing these vital consumer protections, particularly in cases where states are not sufficiently resourced to be able to conduct this oversight. In addition, federal oversight ensures that states are enforcing these requirements in a consistent manner. We urge HHS not to finalize this policy.

b. Navigator program standards (§ 155.210)

Under current law, each Exchange is required to have a Navigator program. Existing rules require each Exchange to have at least two Navigator grantees. One must be a community and consumer-focused nonprofit group and at least one other grantee must fall under one of the other categories established in regulation. In this proposal, HHS proposes to eliminate several requirements related to Navigators: (1) the requirement that an Exchange have at least two Navigators; (2) that at least one Navigator must be a community and consumer-focused nonprofit group; and (3) that each Navigator maintains a physical presence in the Exchange service area to provide face-to-face assistance. HHS notes in its Regulatory Impact Statement that to the extent that Exchanges take advantage of the new flexibilities around Navigators, consumers could have fewer options for Navigation assistance.

ACS CAN was deeply concerned when HHS announced it was drastically cutting outreach and enrollment funding for the marketplaces in September 2017.[5] The changes proposed in this rule, which further scale back and weaken the navigator program, are even more alarming. Outreach and enrollment efforts help to reduce public confusion over the law and ensure more people who need health coverage – including cancer patients and survivors – get it. The navigator and certified application counselor programs are a major part of these outreach and enrollment efforts, and continued investment is critical to promoting a healthy risk pool and ensuring that consumers, especially those who are low-income or have health literacy or other access challenges, enroll in a plan that suits their needs – including coverage of preventive services and cancer care should they need it.

The American Cancer Society and ACS CAN often hear from individuals with cancer about how overwhelming it can be to choose among many health insurance plans. For patients with cancer and cancer survivors, it is crucial to choose a health insurance plan that provides coverage for their unique needs. Cancer patients and survivors must pay particular attention to whether a plan covers the medications they need, whether their (often multiple) physicians are in-network, whether their treatment center is in-network, and the cost-sharing that will be required of them. Weighing all these factors with premium prices, tax credits and subsidies can be daunting for even the most educated

[5] Center for Consumer Information and Insurance Oversight, CMS Announcement on ACA Navigator Program and Promotion for Upcoming Open Enrollment Period (Aug. 31, 2017).

consumer, while we know that many individuals enrolling in the exchanges may have health literacy challenges or be inexperienced with health insurance and are almost guaranteed to have trouble.

The American Cancer Society's HIAS program combined with ACS CAN's efforts to educate consumers about their health insurance options[6] are helpful to address the specific needs of cancer patients and survivors. However, our efforts, are intended to supplement, and not replace, the education and outreach programs sponsored and supported by HHS. We note that the Medicare program has almost universal enrollment and beneficiaries report high satisfaction. Much of this is due to the Administration's significant education and outreach to beneficiaries regarding their plan choices. Consumers using the exchanges need to have enrollment assistance available and accessible to them, just like many other Americans have when enrolling in insurance through their employers or Medicare.

We are concerned that, if implemented, these proposed changes would inhibit consumer access to the mode of assistance they need – and in many cases, to which they have become accustomed. Grants to more than one navigator entity and at least one community and consumer-focused nonprofit entity are critical to helping cancer patients and other consumers, many of whom may not be reached by only one navigator entity. We share HHS' stated goal of ensuring that the strongest applicants are selected to serve as navigators but we believe that community and consumer-focused nonprofit groups and groups that are physically located in the state to provide in-person support is necessary to the enrollment process. In the midst of the fifth open enrollment period, we cannot understate the value and importance of supporting and working with trusted community nonprofit organizations who have conducted in-person outreach, educated consumers, and assisted with enrollment since 2013.

HHS notes in the preamble that its changes could result in fewer navigator options and potentially no in-person enrollment assistance from a navigator or certified application counselor; it also notes that entities with a physical presence and strong local community relationships "tend to deliver the most effective outreach and enrollment results." Giving states the "flexibility" proposed in this rule will also exacerbate health disparities across the country, as some states may choose to maintain a focus on outreach and enrollment, while others drastically cut back their navigator programs. These changes are even more alarming because they follow HHS' significant cut in funding to navigators, which has limited these organizations' operations in a number of states for the 2018 plan year. In South Carolina, for example, navigator funding was cut by two-thirds for 2018, resulting in the loss of navigator services in about two-thirds of the state's counties and potentially leaving consumers without access.[7] Given this impact and the potential to leave so many consumers without assistance – likely leading some to become uninsured or underinsured – we strongly urge HHS to not implement these proposed changes.

d. Standards for third-party entities to perform audits of agents, brokers, and issuers participating in direct enrollment (§ 155.221)

HHS proposes to let QHP insurers, agents, and brokers participating in direct enrollment to select their own third-party entities for annual reviews and audits.

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[6] American Cancer Society Cancer Action Network, "Tips for Getting Help Affording Your Health Insurance," (Oct. 2017), available at https://www.acscan.org/policy-resources/tips-getting-help-affording-your-health-insurance-0 and "Tips for Choosing the Right Health Insurance Plan" (Oct. 2017), available at https://www.acscan.org/policy-resources/tips-choosing-right-health-insurance-plan.

[7] Alex Olgin, "Reductions in Federal Funding for Health Law Navigators Cut Unevenly," *NPR* (Oct. 26, 2017).

ACS CAN urges HHS not to implement these changes. We encourage HHS to continue federal oversight of direct enrollment and not implement these proposed changes. 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 HHS is also proposing to allow insurers, brokers, and agents to access more and more consumer personal and financial information.

4. Exchange Functions in the Individual Market: Eligibility Determinations for Exchange Participation and Insurance Affordability Programs

a. Eligibility standards (§ 155.305)

Currently, Exchanges must provide notification to the enrollee before discontinuing the premium tax credit when the enrollee failed to file taxes and reconcile their income for the relevant year. Exchanges cannot discontinue advanced premium tax credits (APTCs) when the enrollee fails to reconcile unless it provides direct notification to the enrollee that her APTC will be discontinued for failure to comply with the file and reconcile requirements. HHS proposes to remove the direct notification requirement.

ACS CAN urges HHS to not adopt this proposal. HHS says that it will continue to notify noncompliant tax filers through practices that were in place prior to the direct notification process. However, as the preamble notes, the direct notification policy has resulted in 60 percent of households taking action and filing a tax return and reconciling APTCs. Contrary to HHS' suggestion, the fact that 40 percent of households who received direct notification did not take action is insufficient evidence to suggest the policy should be revoked. APTCs enable individuals who qualify the ability to afford their Exchange coverage and thus enrollees should be provided sufficient notice before their APTCs are discontinued.

b. Verification process related to eligibility for insurance affordability programs (§ 155.320)

Under current rules, when a person attests that their income is above the amount indicated from electronic data sources, the Exchange is instructed to accept the lower amount. HHS proposes to add an additional verification requirement in such cases. Specifically, HHS is proposing additional document and income verification for enrollees who attest to income between 100 percent and 400 percent of the federal poverty level (FPL), but where Internal Revenue Service (IRS) and Social Security Administration (SSA) data indicates the enrollee's income is below 100 percent FPL.

ACS CAN is concerned this policy is overly burdensome and urges HHS to withdraw the proposal. We are concerned that if an enrollee fails to comply with this additional income verification process, her eligibility for premium tax credits and cost-sharing reductions could be discontinued. Many low-income individuals may experience changes in their income throughout the year. The enrollee would be better situated to anticipate changes in her income in the year; SSA and IRS data are more likely to be retrospective. We are concerned that these additional verification requirements would deter low-income individuals who may qualify for subsidies from enrolling in coverage.

c. Eligibility redetermination during a benefit year (§ 155.330)

HHS seeks comment on ways to better encourage enrollees to report changes in circumstances during the benefit year that could impact eligibility for Exchange coverage or for APTCs or cost-sharing

reduction subsidies (CSRs), noting that many individual changes in circumstance, such as changes in household income or size, are unknown by the Exchanges until reported by the enrollee. HHS does not make any concrete proposals at this time.

ACS CAN recognizes that it is important for Exchanges to have accurate information about enrollees, particularly related to their continued eligibility for coverage, tax credits and subsidies. This benefits HHS and the Exchange in regards to program integrity. It also benefits enrollees, who may become responsible for paying back tax credits or subsidies upon filing taxes if their eligibility for such benefits changed. It is very likely that a low-income individual or family – even if they increased their income to the point of changing their eligibility for APTCs or CSRs – would find it very difficult to pay a tax bill that is unexpectedly large. This kind of surprise also might discourage them from enrolling in the Exchange, or health insurance of any kind, in the future. Therefore, ACS CAN supports the intent of HHS requesting comments on this issue, and hope it will find a reasonable solution.

However, in finding solutions to this problem, ACS CAN encourages HHS to seriously consider potential consequences for patients. We would be very concerned, for example, if HHS proposed very onerous, frequent reporting requirements, as they would likely make it difficult for enrollees to comply. We would be further concerned if the consequence of not meeting such requirements would be immediate disenrollment, as this would severely impact a patient's access to care – particularly patients in active cancer treatment. We note that fear of this consequence may be one reason enrollees fail to report changes to their income or other circumstances, and note that the severe cuts to enrollment assistance and navigator programs in this proposal will exacerbate this problem. Such changes, if adopted, would disproportionately impact low-income consumers, those with limited English proficiency, and those living in rural areas without internet access.

5. Exchange Functions in the Individual Market: Enrollment in Qualified Health Plans

a. Special enrollment periods (§ 155.420)

ii. *Exception to prior coverage requirement for qualified individuals who have lived in service areas where no QHP is offered through an Exchange*

In the 2018 Payment Notice, HHS added a prior coverage requirement for people to access two special enrollment periods: permanent move, and gaining or becoming a dependent through marriage. In this proposed rule, HHS adds an exception to the prior coverage requirement for people in areas in which no QHP was available.

As previously discussed, ACS CAN has closely monitored the status of issuers participating in the exchanges in states with low issuer participating. We are pleased that for the 2018 plan year, every county in the U.S. has at least one issuer selling an insurance plan through the state or federal exchange. This will help to ensure that every cancer patient, survivor and person at risk for cancer has access to an insurance option. However, we are aware that it is possible this will not always be the case, and we support this change. Individuals in the future who may live in a county where no issuer is offering coverage should not be penalized or blocked from enrolling in coverage when such coverage becomes available, either because the individual moved, or because an issuer entered the market. ACS CAN also urges the administration to take steps to prevent counties from being left with no issuers offering

coverage. The most important and urgent way to do this is to provide long-term funding for cost-sharing reduction subsidies.[8]

iv. *Loss of coverage SEP (§155.420(d)(1)(iii))*

HHS proposes to add another item to the list of coverage losses that would qualify an individual for the loss of coverage SEP. Under the proposed rule, women who lose access to healthcare services that they were receiving through Children's Health Insurance Program (CHIP) coverage for their unborn child would qualify for special QHP enrollment.

ACS CAN supports this change, which will increase access to health insurance options for certain women who are likely to qualify for APTCs and CSRs and benefit from enrolling through the exchanges.

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

2. Essential Health Benefit Package

Federal default EHB-benchmark: The preamble notes that in the future HHS is considering creating a Federal default definition of EHB "that would better align medical risk in insurance products by balancing costs and scope of benefits." The preamble notes that as part of this approach, HHS could establish a national prescription drug benefit standard under a Federal default EHB definition.

ACS CAN urges HHS not to create a federal default definition of EHB services at this time. It is unclear the extent to which a federal default standard would incorporate state mandates, which provide enrollees access to important services. If a federal standard were to no longer maintain the current state mandate policy, we are concerned that enrollees would lose access to vital services provided under state mandates. It is also unclear whether states would be responsible for the review and certification of these functions (as provided under this proposed rule and the 2018 Market Stabilization rule) or whether the federal government would regain this authority.

National Prescription Drug Standard: We are also concerned with the proposal to create a national prescription drug benchmark standard. For example, it is unclear whether the federal prescription drug standard would apply to outpatient prescription drugs or whether it would apply to all prescription drugs covered by the plan, such as drugs covered under a plan's medical benefit (as many chemotherapy drugs are). We also question the extent to which a federal prescription drug benchmark will be able to incorporate new therapies, thus ensuring enrollees have access to the latest treatments.

Timing: HHS proposes several policy changes to allow states greater flexibility in their selection of an EHB-benchmark plan beginning in 2019 and later plan years. In the preamble, HHS seeks comment on timing of the proposal and asks for comments on whether the policy should begin with the 2019 plan year or with the 2020 plan year.

As discussed in more detail below, ACS CAN urges HHS to refrain from adopting these proposed policies in any year. With respect to timing, we note that plan bids are due to states and/or CMS by early March 2018, which would not allow states sufficient time to provide meaningful analysis of any EHB-benchmark changes (and issuers appropriate time to develop products) by this deadline. We urge HHS

[8] For more information, see ACS CAN's factsheet on The Need to Fund Cost-Sharing Reduction Subsidies at https://www.acscan.org/policy-resources/need-fund-cost-sharing-reduction-csr-subsidies.

to proceed with caution and urge that any changes to the EHB-benchmark, if at all, be for the 2020 plan year.

b. State selection of EHB-benchmark plan for plan years beginning on or after January 1, 2019 (§ 156.111)

i. States' EHB-benchmark plan options (§ 156.111(a))

HHS proposes new policies to allow states to update their EHB-benchmark plans more frequently and to provide more options. The preamble offers three different options states may consider in setting their EHB-benchmark plans (as discussed in detail below). HHS justifies these proposed changes on the basis of providing states with additional choices with respect to benefits and affordable coverage.

Option 1: Selection Another State's EHB-Benchmark Plan: Under this proposal, HHS would permit a state to select an EHB-benchmark plan used for the 2017 plan year by another state. HHS contends that this policy would benefit the states in that they would not have to conduct extensive analysis given that state EHB-benchmark plans are publicly available.

Option 2: Replace Category or Categories From Another State's EHB-Benchmark Plan: This proposal would allow a state to partially replace its current EHB-benchmark with a benchmark from a plan used by other states for the 2017 plan year. States would be permitted to replace any EHB category or categories of benefits in its EHB-benchmark plan from the 10 statutorily mandated benefit categories with the same category or categories of benefits from another state's 2017 plan year EHB-benchmark plan.

Option 3: Select a Set of Benefits To Become the State's EHB-Benchmark Plan: Under this option HHS would permit states to select a new set of benefits that would become its EHB-benchmark plan so long as the new EHB-benchmark does not exceed the generosity of the most generous among a set of comparison options including the state's 2017 EHB-benchmark or one of the other base benchmark options.[9]

ACS CAN urges HHS not to adopt any changes to the EHB-benchmark standard. In the implementing rule creating the EHB-benchmark standard HHS noted the state EHB-benchmark selection would allow states to build on coverage that is already widely available, minimize market disruption, and provide consumers with familiar products. We are concerned that allowing a state to set a plan that has never been offered within the state as an EHB-benchmark plan could cause significant consumer confusion, particularly to the extent that the chosen EHB-benchmark plan is less generous than that offered by the state.

In the preamble, HHS notes the intention of this proposal is to provide flexibility and the option for stability. However, this proposal is not necessary to accomplish this stated goal. Indeed, to the extent that a state desires flexibility in establishing a state EHB-benchmark plan, such flexibility already exists

[9] These options include (1) the largest health plan by enrollment in any of the three largest small group insurance product by enrollment in the state's small group market; (2) any of the largest three employee health benefit plan options by enrollment offered and generally available to state employees; (3) any of the largest three national Federal Employees Health Benefit Program (FEHBP) plan options; and (4) the coverage plan with the largest insured commercial non-Medicaid enrollment offered by a health maintenance organization operating in the State.

under current law. State EHB-benchmarks provide consumers within a state access to coverage that reflects that coverage historically provided to residents of the state.

In addition, we note that in creating the EHB-benchmark standard, CMS stated that a "major advantage of the benchmark approach is that it recognizes that issuers make a holistic decision in constructing a package of benefits and adopt packages they believe balance consumers' needs for comprehensiveness and affordability."[10] We are concerned that allowing a state to pick-and-choose the benchmark standard for each EHB category is antithetical to the need to look at benefit packages in a holistic manner.

Less generous coverage: We are concerned that allowing a state to choose a benchmark plan from another state – particularly under the guise of additional state flexibility for coverage and affordability – will encourage states to adopt EHB-benchmark plans that are less generous than those currently offered to consumers. Were a state to adopt a less generous EHB-benchmark plan, consumers may find that services that were previously covered under their plan are no longer covered, thus forcing consumers to pay out-of-pocket for these services.

We are also concerned about this proposed policy's impact on large employer plans, who are currently permitted to choose any state's EHB-benchmark plan and thus could choose to adopt the skimpiest state's EHB-benchmark plan by which to compare its employer plan. As a result, enrollees would receive less generous coverage and would be exposed to more out-of-pocket costs.

This outcome would be particularly harmful to individuals with serious or complex health care needs, such as cancer patients, who benefit the most from these coverage standards that do not allow caps on essential health benefits. ACS CAN's Costs of Cancer report showed that under current law, cancer patients already typically pay multiple thousands of dollars in the first 1-3 months after a positive screening or diagnosis. Weakening coverage standards so that plans do not have to cover some elements of cancer care, or are allowed to cap their coverage of cancer care, would leave cancer patients vulnerable to higher and unexpected costs even after they have paid their deductible and met their out-of-pocket maximum for the year.

We further note that important consumer protections – such as the prohibition on annual and lifetime limits and the annual maximum out-of-pocket cap – are tied to EHB services. If a State adopts a less generous EHB-benchmark then consumers will find that some of the benefits and services that previously were subject to the patient spending caps may no longer be subject, thus forcing consumers to pay more out of pocket for their care.

State resources: Specifically, with respect to *Option 3*, we are concerned that this option is the most resource intensive for the state. As noted by the preamble, were a state to adopt this approach it would have to have a formulary drug list and would require an actuarial certification as to the generosity of the plan's benefit.

ACS CAN is concerned that this option could prove too onerous on state regulators. Under this option, a state would need to utilize resources to ensure that the prescription drugs provided under the EHB-benchmark plan satisfied the requirements of § 156.122(a)(1), regarding the prescription drug count. This analysis must be conducted by individuals that have medical expertise. In addition, a state must also use resources for actuarial certification, which must be conducted by an actuary who is a member of the

[10] Center for Consumer Information and Insurance Oversight, "Essential Health Benefits Bulletin" (Dec. 16, 2011).

American Academy of Actuaries and whose analysis is in accordance with generally accepted actuarial principles and methodologies. We strongly encourage HHS to retain the current EHB-benchmark standards.

State mandates: The preamble makes clear that HHS is not proposing to change the current state mandate policy, which requires a state to defray the costs of any state mandates enacted after December 31, 2011.

ACS CAN is pleased that HHS recognizes the importance of ensuring the continuation of state mandates, a number of which ensure that individuals have access to specific benefits to detect and treat cancer.[11] However, we are concerned that there are several benefit options that are included in an EHB-benchmark plan that may not necessarily be state mandates and thus could no longer be covered services if a state chooses a less generous EHB-benchmark standard.

ii. The requirements for States' EHB-benchmark plans (§ 156.111(b)-(d))

HHS proposes to define the scope of benefits provided by an EHB-benchmark plan to be equal in scope to benefits provided under a typical employer plan, which HHS proposes to define as an employer plan of at least 5,000 enrollees sold in the small group or large group market in one or more states or a self-insured group health plan with enrollment of at least 5,000 enrollees in one or more states.

ACS CAN urges HHS to rescind this proposal and use the existing definition of typical employer plan. Because some employer plans are not required to cover EHB-services, they can impose limits on the benefits they provide. For example, a plan could cap the number of physician services that it covers, could provide a very limited prescription drug formulary in which it only covers generic drugs, or could cap the number of hospital visits per year. As the preamble notes, the state would be required to add benefit requirements but only if the benchmark plan does not provide coverage of a given EHB category. If the typical employer plan provides coverage of an EHB-benchmark category – however, limited that coverage may be – the supplemental coverage is not required.

We are concerned that allowing a skimpier plan to be used as an EHB-benchmark would increase out-of-pocket costs for consumers. As discussed in more detail above, important consumer protections such as prohibitions on lifetime and annual limits and the annual maximum out-of-pocket cap, only apply to EHB services. Thus, if a less generous EHB-benchmark were to be used, consumers would not only experience reduced coverage of certain items and services, but would be less protected by the caps on out-of-pocket costs.

c. Provision of EHB (§ 156.115)

Under current rules, EHB-compliant plans are required to provide benefits that are substantially equivalent to the EHB-benchmark plan. Plans are permitted to substitute benefits within categories provided the benefit is actuarially equivalent to the benefit being replaced (except prescription drug benefits which cannot be substituted). HHS proposes to allow substitution both within the same EHB category and between EHB categories, as long as the benefit is actuarily equivalent to the EHB-benchmark. The preamble notes that substitutions must still provide "substantially equal" benefits and that benefit substitutions may not be unduly weighed towards any category and must provide benefits

[11] Karmen Hanson and Erik Bondurant, Cancer Insurance Mandates and Exceptions, National Conference of State Legislatures (Aug. 2009).

for diverse segments of the population. States will make the determination of whether EHB-compliant plans adhere to these requirements.

ACS CAN urges HHS to withdraw this policy proposal. Under this proposal, an issuer could provide more generous coverage in one EHB category and less generous coverage in another category provided that the whole product offered to consumers is actuarially equivalent to the EHB-benchmark. We are concerned that the policy would incentivize an issuer to provide greater coverage of low-cost services, while decreasing coverage of high-cost services. For example, an issuer could reduce coverage of hospitalizations, but increase coverage of preventive services or physician services and still meet an equivalent actuarial value. Under this example, individuals who require hospitalization would face significantly more out-of-pocket costs.

We are concerned that this policy change allows an issuer to intentionally reduce coverage of services utilized by individuals with serious or chronic illnesses to the point that such individuals would be discouraged from choosing the issuer's plan. This may conflict with current anti-discrimination policies like ACA section 1557 which prohibits a benefit design from discriminating against an enrollee on the basis of her medical condition, among other factors. Additionally, if most or all issuers engaged in such practices, individuals with serious or chronic illness would be left with few or no plans to choose from that actually cover the services they need.

In addition, we are concerned that this policy would make it almost impossible for individuals to be able to compare plan choices, particularly given that the changes may be nuanced and not necessarily reflected in the Summary of Benefits and Coverage.

3. Qualified Health Plan Minimum Certification Standards

a. Qualified health plan certification (Subpart C)

In the 2017 Market Stabilization rule, HHS announced that for plan year 2018 it would discontinue plan review and certification functions at the federal level and instead rely on States to oversee these functions. In the proposed rule, HHS proposes to continue these policies for plan year 2019 and beyond.

Network Adequacy: HHS proposes to continue to defer to the states in the determination on whether coverage is at least equal to the "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' (NAIC's) 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. 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.[12]

[12] 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).

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

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.

Essential Community Providers (ECPs): 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.

d. Meaningful difference standard for qualified health plans in the Federally-facilitated Exchanges (§ 156.298)

HHS proposes to eliminate the requirement that issuers only offer QHPs that are meaningfully different from its other QHP offerings. HHS notes that the standard was created to make it easier for consumers to choose the plan option that was right for them but because fewer insurers are participating in Exchanges, this standard is no longer necessary. HHS also indicates that the absence of the meaningful difference standard will allow more flexibility and innovation and will result in increased offerings and choice for consumers.

ACS CAN opposes this change and strongly encourages HHS to continue enforcing the meaningful difference 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.[13] The standard helps ensure that marketplace plans reflect substantive distinctions between benefit design features, such as cost-sharing levels. We are particularly

[13] Sarah Dash et al., Implementing the Affordable Care Act: Key Design Decisions for State-Based Exchanges, Commonwealth Fund (Jul. 2013).

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.

The American Cancer Society and ACS CAN often hear from individuals with cancer about how overwhelming it can be to choose among many health insurance plans. For patients with cancer and cancer survivors, it is crucial to choose a health insurance plan that provides coverage for their unique needs. Cancer patients and survivors must pay particular attention to whether a plan covers the medications they need, whether their (often multiple) physicians are in network, whether their treatment center is in network, and the cost-sharing that will be required of them. Weighing all these factors with premium prices, tax credits and subsidies can be daunting for even the most educated consumer, while we know that many individuals enrolling in the exchanges may have health literacy challenges or be inexperienced with health insurance. We believe potential enrollees with a history of cancer would continue to benefit from the standard limiting the number of plans displayed during this important decision process.

e. Other considerations

HHS seeks comments on how it can foster more market-driven programs; on whether there are additional regulations and policies that could be modified to better achieve affordability, quality and access to care; and how to encourage value based insurance designs and high deductible health plans (HDHPs) coupled with health savings accounts (HSAs). HHS asks for comments on how it can use plan display options on HealthCare.gov to promote the availability of HDHPs. With respect to value based insurance designs, HHS is particularly interested in those focused on drug tiering structures; that address overuse and higher cost health services; that provide innovative network designs that incentivize enrollees to use higher quality care; and that promote use of preventive care and wellness services.

ACS CAN welcomes the opportunity to give feedback on these ideas before a formal proposal is offered. First, we believe that market-driven programs, HDHPs and value-based insurance designs only work for patients and the healthcare system if they are coupled with transparency in quality of care, quality metrics and patient costs. In order to be an informed consumer in a "market-driven program," patients must have access to information on the quality of providers. The information provided should be what is most relevant to the patient, so we encourage a focus on patient experience measures and outcomes measures in these efforts. We also encourage HHS to engage in consumer testing to ensure that the information that is provided to consumers is easily understood, and delivered at the right time and in the right format for the consumer to meaningfully use.

Additionally, ACS CAN has long supported policies that make more transparent the costs and prices paid by consumers; and we believe this type of transparency is also necessary to create successful market-driven programs. Patients must be able to easily find information about their copays, coinsurance and deductibles, and how much a particular treatment or medication is expected to cost them. This transparency must be provided to consumers as they are making choices about their insurance coverage so they are enrolled in coverage that is right for them. If carefully implemented, this transparency may also assist patients in making choices between treatments, providers, or medications (to the extent that a patient has multiple choices for treatment given her disease or condition). In February 2017, ACS CAN released its third report showing the need for more transparency in patient cost-sharing for

chemotherapy and in QHP coverage of intravenous chemotherapy medications.[14] ACS CAN urges HHS to focus on transparency efforts before exploring any market-based strategies.

We also caution HHS that pursuing market-based programs cannot simply mean finding ways to shift more upfront costs onto beneficiaries. ACS CAN is very concerned about HHS' promotion of HDHPs. HDHPs – even when accompanied by a health savings account – are not appropriate for everyone. While some preventive services and cancer screenings are currently required to be exempt from deductibles in private plans, some HDHP enrollees still assume they will be charged in full for their preventive services and are discouraged from seeking care. One study showed that switching to an HDHP was associated with a downward trend in overall colorectal cancer screening rates after two years.[15]

HDHPs are even more concerning for cancer patients and survivors. Once a patient is suspected of having cancer, he or she undergoes many tests that are not considered preventive services and therefore are subject to the deductible. Costs continue after the patient is diagnosed and undergoes surgery, radiation and/or chemotherapy. These costs are high and immediate – many cancer patients face paying their whole deductible in the first month or two after diagnosis.[16] Being required to pay for these high costs up-front can cause delays in treatment, especially for low-income patients. Research is starting to show the negative consequences of HDHPs to cancer treatment and outcomes. One study showed that HDHP enrollment was associated with a decrease in imaging tests[17]– the tests a patient needs if she has a positive screening test for suspected cancer. ACS CAN is very concerned about the prospect of HHS encouraging all enrollees to choose HDHPs, as this type of plan is not the right choice for everyone. This proposal is especially concerning in light of the other rollbacks on outreach and enrollment help contained in this proposal.

ACS CAN would welcome the opportunity to work with HHS to create value-based insurance designs that benefit cancer constituencies and promote value in healthcare. ACS CAN would evaluate any value-based insurance design, as well as other types of innovative models, based on whether it contains the following patient protections:

- Access to Innovative Treatments: Cancer patients need to have access to the latest and most effective cancer treatments. Safeguards must be in place to ensure that a value-based insurance design or model does not create a disincentive for the provider to use or the plan to cover the most effective treatments.
- Structure Considering Risk: Value-based insurance designs and models must be risk adjusted so that there are no disincentives for providers to accept higher-costs patients or for plans to enroll such patients.

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[14] American Cancer Society Cancer Action Network. ACS CAN Examination of Cancer Drug Coverage and Transparency in the Health Insurance Marketplaces. February 2017.

[15] Wharam JF[1], Graves AJ, Landon BE, Zhang F, Soumerai SB, Ross-Degnan D. Two-year trends in colorectal cancer screening after switch to a high-deductible health plan. Med Care. 2011 Sep;49(9):865-71. doi: 10.1097/MLR.0b013e31821b35d8.

[16] ACS CAN. The Costs of Cancer: Addressing Patient Costs. April 2017. www.acscan.org/costsofcancer.

[17] Zheng, S; Ren, ZJ; Heineke, J; Geissler, KH. Reductions in Diagnostic Imaging with High Deductible Health Plans. Medical Care. February 2016 - Volume 54 - Issue 2 - p 110–117. doi: 10.1097/MLR.0000000000000472.

- Ability to Appeal: If, as a result of a requirement of the benefit design, a patient is denied a drug or treatment that she needs or was already receiving, the patient must have the ability to appeal the decision.
- Transparency: Patients need to know specifically what items, services and prescription drugs are included in their plan design as well as their total out-of-pocket liability.
- Measuring Impact: Any model or value-based insurance design effort should use metrics – including patient experience metrics – that measure the overall effectiveness of the program on both reducing costs for patients and payors as well as improving quality.

We are encouraged by the reference in the proposed rule to value-based insurance design that promotes the use of preventive care. In 2017, an estimated 600,920 Americans are expected to die from cancer – about 1,650 people per day.[18] Yet up to half of all cancers can be prevented. ACS CAN would welcome the opportunity to work with HHS to develop programs that promote the use of all evidence-based cancer screenings, and/or preventive services that reduce the risk for cancer.

Lastly, ACS CAN cautions HHS that as it considers methods to promote use of preventive care and wellness services, that these methods are focused on encouraging such care rather than punishing enrollees who do not meet health outcomes. Punishing enrollees who do not, for example, lose enough weight or succeed in quitting tobacco, can have unintentional consequences – particularly if punishment is in the form of charging surcharges or extra fees, or limiting access to enhanced health services.

G. Part 158 – Issuer Use of Premium Revenue: Reporting and Rebate Requirements

3. Formula for Calculating an Issuer's Medical Loss Ratio (§ 158.221)

HHS proposes to change the medical loss ratio (MLR) formula to permit issuers the option to report quality improvement activity (QIA) expenses as a single fixed percentage of the premium. The preamble proposes the fixed percentage of QIA expenses to be 0.8 percent of the earned premium. Issuers who spend more than 0.8 percent of the earned premium on QIA expenses have the option to report the actual amount spent.

ACS CAN urges HHS to withdraw this proposal. The MLR is an important tool to ensure that enrollees and businesses receive fair value for their premium dollar. We are concerned that if the proposed policy were implemented, it would discourage issuers from devoting significant resources to quality improvement activities. The proposed policy will allow issuers to increase their MLR, regardless of whether the issuer is actually providing significant quality improvement activities.

In addition, we note that the ACA tasked the National Association of Insurance Commissioners (NAIC) with establishing definitions and methodologies for calculating the MLR, subject to the certification by the Secretary of HHS. Thus, we believe that before HHS implements a change to the MLR formula it should engage the NAIC prior to making a proposed change. We note that the NAIC recently discussed whether changes were warranted to the definition of "quality improvement activities" and declined to make changes to the existing rule at this time.

[18] American Cancer Society. *Cancer Facts & Figures 2017*. Atlanta, GA: American Cancer Society; 2017.

4. Potential Adjustment to the MLR for a State's Individual Market (Subpart C)

Under the ACA, the Secretary may adjust the MLR standard in the individual market if necessary due to the volatility of the individual market resulting from the establishment of the Exchanges. HHS proposes a number of changes to allow for adjustments to the individual market MLR standard in any State that demonstrates that a lower MLR standard could help stabilize its individual market.

Currently issuers in the individual market must comply with the 80 percent MLR standard. HHS proposes to amend this requirement to permit the Secretary to adjust the individual MLR standard in any State if the Secretary determines that there is a reasonable likelihood that an adjustment to the MLR standard would help stabilize the individual market.

ACS CAN strongly urges HHS to withdraw this proposal. The MLR standard is an important tool to ensure that enrollees and businesses receive value for their premium dollar. Allowing a State to reduce the MLR standard would reduce the value of the health insurance coverage to enrollees and enrollees would likely have to pay more out-of-pocket to access services.

Furthermore, we do not believe that reducing the MLR standard is an appropriate response to stabilize a State's individual market. Rather, we believe that other policies – such as permanent funding of cost-sharing reduction subsidies, devoting significant resources into outreach and education, supporting state reinsurance programs, and other policies – are more appropriate to help stabilize a State's individual market.

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 and Quality of Care at Anna.Howard@cancer.org or 202-585-3261.

Sincerely,

Kirsten Sloan
Vice President, Public Policy
American Cancer Society Cancer Action Network