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January 8, 2019

The Honorable Alex Azar
Secretary
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

Re: CMS-9922-P – Patient Protection and Affordable Care Act; Exchange Program Integrity; Proposed Rule
83 Fed. Reg. 56015 (November 9, 2018)

Dear Secretary Azar:

The American Cancer Society Cancer Action Network (ACS CAN), appreciates the opportunity to comment on the proposed rule regarding Patient Protection and Affordable Care Act (ACA) exchange program integrity. 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. ACS CAN empowers advocates across the country to make their voices heard and influence evidence-based public policy change as well as legislative and regulatory solutions that will reduce the cancer burden.

The exchanges play an important role in helping Americans have access to quality, affordable health insurance coverage, and we share CMS' goal of ensuring the exchanges operate effectively, efficiently, and in a way that is well-integrated with other insurance coverage options. We appreciate CMS' efforts to improve this integration. However, we are concerned that a provision in this proposed rule could lead to a number of individuals becoming unintentionally uninsured or having gaps in insurance coverage. Following are our specific comments:

III. PROVISIONS OF THE PROPOSED REGULATIONS

A. Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act

CMS proposes to – beginning in plan year 2020 – give consumers the option of allowing health care exchanges to terminate their qualified health plan (QHP) coverage if they are dually enrolled in Medicare. A consumer could choose to authorize the exchange to access his/her Medicare information during the "periodic data matching" process. If that consumer is determined to be dually enrolled in Medicare and a QHP – and if the consumer authorizes it or does not respond to attempts at contact –

the exchange could automatically terminate QHP coverage. The proposal is designed to ensure the consumer is not liable for paying back any after-premium tax credits (APTCs) they were receiving to enroll in the QHP when they were also enrolled in Medicare.

We appreciate CMS' intent to prevent consumers from being accidentally enrolled in a QHP and Medicare, which would have implications for individuals who use APTCs and thus would face repayment. However, we urge CMS to implement this policy carefully, as we are cautious about any change that causes individuals to be automatically dropped from coverage. ACS CAN and the American Cancer Society regularly hear from cancer patients who are confused about their coverage options or are unable to understand notices or contact attempts from exchanges. In fact, we hear anecdotally that it is common for cancer patients to ignore their mail during the most grueling parts of treatment, which may cause them to miss contact attempts under this policy.

If CMS finalizes this policy, ACS CAN urges the Department to carefully monitor implementation of this provision in real time, conduct consumer testing on its notices to ensure they are effective, and seek feedback from consumers who were affected by this new policy so CMS can make any needed changes. We urge CMS to take every precaution in the use of these data so that an individual is not erroneously assumed to be enrolled in Medicare. We also encourage CMS to explore additional methods of contacting individuals who will be terminated. Finally, we recognize that some of the individuals affected by this policy may be enrolled in a QHP family policy – therefore, terminating their QHP policy may affect other family members. In the final rule we urge CMS to account for affected family members in the notice requirements, ensuring that other policy holders are also given notice and are held harmless.

B. Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges

Currently QHPs that cover certain services outlined in Section 1303 of the ACA[1] must not use federal exchange subsidies to fund such services. Applicable QHPs must collect premium funds that pay for these services separately, and keep these premium funds in a separate, specifically designated account. QHPs are still allowed, however, to give consumers a single bill for their entire premium. Under the proposed rule, CMS reverses its previous rules and guidance on this issue and proposes to now require applicable QHPs to send consumers two separate bills, requiring separate payments. CMS specifies that insurers must actually transmit the bills separately, in different envelopes or different e-mails. CMS maintains in the proposal that nonpayment of any premium, including the premium for the services detailed in Section 1303, could trigger a premium payment grace period and potentially result in termination of coverage.

ACS CAN is concerned that consumers will be confused by suddenly receiving two separate bills for their health insurance premiums, and that many will not understand that they must pay both bills to maintain their insurance coverage. Under CMS' proposal, if consumers are confused and pay one bill, but not the other, their coverage could be terminated for nonpayment.

ACS CAN is extremely concerned that if CMS finalizes this policy and QHP enrollees begin receiving two separate premium bills per month, some cancer patients, survivors, or those in need of preventive services and cancer screenings will unintentionally become uninsured.

Any gap in coverage can be especially problematic for cancer patients and survivors. Uninsured Americans are less likely to get screened for cancer, more likely to be diagnosed with cancer at an advanced stage, and less likely to survive that diagnosis than those with insurance. Conversely, individuals with health insurance are about twice as likely as those without it to have access to critical early detection cancer procedures.[2]

Evidence-based protocols for chemotherapy and other cancer therapies often require that treatments be administered on a prescribed timeline. Gaps in coverage may interrupt treatment schedules which could jeopardize outcomes. A gap in coverage can also delay initiation of treatment which could adversely affect outcomes. For example, research shows that delays in the initiation of chemotherapy for breast cancer patients result in adverse health outcomes.[3] Even gaps in coverage for a few years during young adulthood mean missing important cancer screenings and prevention – like the HPV vaccine, which must be administered by age 26.

Being told you have cancer is scary enough – finding out your coverage lapsed because you did not pay your premium bills correctly would be devastating for a patient facing tens or hundreds of thousands of dollars in cancer diagnosis and treatment costs. We urge CMS to withdraw this section of the proposal.

CONCLUSION

On behalf of the American Cancer Society Cancer Action Network we thank you for the opportunity to comment on proposed rule regarding the Patient Protection and Affordable Care Act (ACA) and exchange program integrity. We urge CMS to withdraw the portions of the rule referenced above to prevent consumers from falling into coverage gaps. If you have any questions, please feel free to contact me or have your staff contact Jennifer Singleterry at Jennifer.singleterry@cancer.org or 202-585-3233.

Sincerely,

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

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[1] 45 CFR 156.280.

[2] Ward E, Halpern M, Schrag N, Cokkinides V, et al. Association of Insurance with Cancer Care Utilization and Outcomes. CA: A Cancer Journal for Clinicians, 2008;58: 9–31. doi:10.3322/CA.2007.0011.

[3] 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.