



August 7, 2017

Doug Ommen
Insurance Commissioner
Iowa Insurance Division
ATTN: Public Comments
601 Locust Street
Fourth Floor
Des Moines, Iowa 50309

Re: ACS CAN Iowa's Comments on Iowa Stopgap Measure

Dear Commissioner Ommen:

The American Cancer Society Cancer Action Network (ACS CAN) Iowa appreciates the opportunity to comment on the request for comment on the Iowa Insurance Division's Draft Iowa Stopgap Measure (Iowa's 1332 waiver request), released for public comment July 13, 2017. 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 and 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 In Iowa alone, an estimated 17,230 Iowans are expected to be diagnosed with cancer this year and an estimated 172,030 Iowans are cancer survivors.³ 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.⁴

¹ American Cancer Society, *Cancer Facts & Figures 2017*, available at <https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2017/cancer-facts-and-figures-2017.pdf>.

² *Id.*

³ *Id.*

⁴ 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>.

ACS CAN Iowa appreciates your willingness to meet with groups as you developed policies to be included in the 1332 Waiver application. We recognize that at the time these discussions were ongoing, it appeared as though Iowa would have no health insurance issuer participating in the Marketplace in any of the state's 99 counties. We share your concern that without issuer participation in the Marketplace, individuals – particularly those who qualify for Advance Premium Tax Credits (APTCs) and/or Cost-Sharing Reduction (CSR) subsidies – would not be able to purchase health insurance coverage in the individual market.

Fortunately, last month Medica announced its intention to participate in all 99 Iowa counties for plan year 2018. We understand that Medica has requested an average rate increase of 43 percent in premiums for plan year 2018. Nationally many health insurance premiums are expected to rise given the lack of permanent funding for the CSRs and uncertainty regarding Congressional and/or federal administrative changes to the marketplace.⁵

ACS CAN Iowa urges you to work with Medica to mitigate any premium increases. We recognize that a majority of Iowans in the individual market – 44,193 Iowans (85.7 percent) – qualify for APTCs and 26,848 Iowans (52.1 percent) – qualify for plans with reduced cost-sharing. Thus, the proposed premium increases will be somewhat mitigated for these Iowans. But for individuals who do not qualify for APTCs or CSRs, a 43 percent increase will most certainly make insurance unaffordable.

Medica's announced market entry obviates the need to enact a 1332 waiver that would likely result in decreased access to care for many Iowans and, given the ambitious timeframe for implementation provided under the waiver application, would likely result in significant consumer confusion and market disruption for plan year 2018.

Further, many of the proposals put forth in the 1332 waiver request fail to meet the guardrails established under the statute and thus cannot be waived by federal administrators. We are particularly concerned that the waiver's provisions to eliminate additional cost-sharing subsidies for those who qualify violates the statutory requirement to ensure that any waiver provides coverage at least as affordable as exists under current law.⁶

Therefore, we strongly urge the Department to withdraw its 1332 waiver request and consider submitting a waiver solely to implement its reinsurance program. We note that earlier this year Alaska successfully completed a 1332 waiver to implement a reinsurance program and rates, while not yet finalized, are expected to decrease by 20 percent.⁷

We strongly urge the Department to continue to meet with stakeholders to begin more extensive discussions regarding what policies changes should be considered and a reasonable

⁵ Beth Fritchen and Kurt Giesa, *New Survey: CSR Uncertainty Looms Large Over Payers*, Oliver Wyman. June 2017. Available from http://health.oliverwyman.com/transform-care/2017/06/ACA_rate_survey.html.

⁶ Affordable Care Act section 1332(b)(1).

⁷ Alaska Dispatch News, "Insurance Premiums on Alaska's Individual Market," August 2, 2017.

<https://www.adn.com/alaska-news/health/2017/08/01/premera-expects-a-21-6-percent-decrease-in-individual-market-premiums-for-2018/>.

implementation timeframe for such changes. As a precursor to potential future discussions, we offer the following comments on the draft 1332 waiver proposal:

A. Implementation of a Standard Plan

i. Standard Plan Benefits

Under the proposed 1332 waiver, only one plan – a silver level plan with an actuarial value requirement between 68 to 72 percent – would be available in the market. According to the proposed 1332 waiver, this plan would cover all essential health benefits (EHBs) as well as Iowa state mandates.

While we are pleased that the proposal would ensure that silver level coverage is available, we are concerned about what specific products and services will be offered by the plan. Cancer patients' treatment generally involves several different types of specialists, including medical oncologists, radiation oncologists, surgeons, palliative care specialists, and specialties related to tumor sites and we urge the Department to ensure that the plan provides coverage for the full range of products and services needed by cancer patients.

Patient Choice: It is unclear from the proposed waiver whether the Department intends for only one plan to be offered to individuals or whether consumers will have a choice of multiple plan offerings (all of which will be Silver-level plans). We urge the Department to provide clarification. To the extent that multiple plan offerings – with different benefit designs – will be permitted, we strongly urge the Department to develop a consumer education tool to ensure that consumers are able to compare options and chose a plan that best meets their needs.

Formularies: We are concerned that the proposed 1332 waiver provides scant information regarding the prescription drug formulary provided by the standard plan. For example, it is unclear whether if multiple issuers offer products, each issuer would be required to offer the same prescription drug formulary or whether the formularies could differ, provided the EHB and state mandate requirements are met. If Iowa only allows one formulary to be used, we strongly urge that consumers and stakeholders have an opportunity to engage in an open and transparent process to ensure that the formulary is robust enough to cover the prescription drugs consumers need, including those with cancer and other serious conditions for which robust prescription drug coverage is required. If, on the other hand, the Department permits issuers to vary their prescription drug formularies (again, as long as EHB standards and state mandates are met), it is unclear to what extent the Department will provide oversight and active monitoring to ensure that the plan formularies meet these requirements. For example, it is unclear whether the Department intends to conduct pre-approval of a formulary before the plan can be marketed to consumers, and if so, what additional resources the Department intends to use to conduct this analysis. We strongly urge the Department to provide oversight to ensure the formulary design would not be considered discriminatory on the basis of health status, as provided under federal requirements.

We note that under Section B, the proposed waiver seems to suggest that there would be standard cost-sharing (the amount of which is not yet proposed). It is unclear whether the

copays referenced on page 12 of the proposal refer to prescription drug copays or copays associated with the use of medical benefits. We urge the Department to provide greater clarification as to the amount of the cost-sharing that would be applicable for each service.

We also note that the proposed 1332 waiver is silent regarding the extent to which issuers offering a standard benefit plan will be required to adhere to a standardization of the number of prescription drug tiers. If the stated objective of standardized plan offerings is to allow consumers to better compare plans across issuers, then having a standardized number of tiers would be concordant to that outcome.

Network Adequacy: We are concerned the proposed 1332 waiver is silent regarding requirements for determination of the adequacy of a standard plan's network. For example, it is unknown what standards, if any, an issuer would have to meet in order to be able to offer a standard plan benefit. Cancer treatments can be varied depending on the type of cancer and stage of diagnosis and thus individuals with cancer often require an array of specialists – such as oncologists, surgeons, radiologists, and palliative care specialists – to be able to treat their disease. We urge the Department to ensure that any issuer operating a standard benefit plan provides access to specialists – including not only physicians, but facilities in which these practitioners serve their patients as well. The importance of network adequacy standards increases even more if the intent of the proposal (as discussed above) is for only one plan to be offered.

ii. Eligibility Requirements and Verification

Open enrollment period: Under the proposal, Iowans who wish to purchase the plan must do so during the open enrollment period of November 1, 2017 to December 15, 2017 and must do so directly from the participating insurance carrier.

While we are pleased the 1332 waiver includes an intention by the Department to develop a standard application, we are concerned that given the time constraints, such application may not be completed in time for the open enrollment period. It is also not clear what information will be required to be provided on the application and the extent to which the application will be designed to accommodate individuals with disabilities and those with limited English proficiency.

Direct submission to carriers: While we recognize that requiring applications to be submitted directly to the carriers provides a certain amount of administrative ease, we are concerned that this proposed policy has potential unintended consequences. It is unclear what, if any, mechanism would be implemented to mediate any issues that may arise regarding lost or incomplete applications. For example, if an individual were to submit an application to a carrier and that application were lost – whether intentional or inadvertently – would the individual be permitted a special enrollment period in order to file an application with another carrier (if applicable)?

We note that specific information regarding data-sharing among agencies and carriers has not been finalized. We urge the Department to provide the opportunity for public review and

comment regarding this proposal in order to determine that such data-sharing protects the privacy of information provided by the consumer in the application and also provides a mechanism for appeals in the event that there are discrepancies in the data-sharing arrangements.

Public education and outreach: The 1332 waiver states that the Iowa Insurance Division and the Association, through the Iowa Comprehensive Health Association (HIPIOWA), will provide information directly to consumers regarding the carriers that are participating in the marketplace. While we very much appreciate this education and outreach to consumers, we are concerned that the significant changes to the marketplace provided under this proposed waiver will require extensive education and outreach within the state to inform individuals about the new system, how it differs from the plans provided under the exchange in the past, and how the enrollment process has changed. We note that for years many consumers have enrolled in coverage through the healthcare.gov platform and eliminating this as an option for consumers to enroll would cause unnecessary consumer confusion.

We are particularly concerned that such education and outreach activities would be hampered by the fact that the proposal differs from current law. For example, Iowans who had been eligible for CSRs – including 26,848 Iowans – would no longer be provided these benefits and will need additional information about how this changes their plan options and potential affordability of using their coverage.

Education of enrollees and potential enrollees would be challenging and would also require coordination with the federal government. For example, the material they make available to consumers – through healthcare.gov and other efforts – would have to provide notice to individuals in Iowa of the differences in plan offerings and benefits. We strongly urge the Department to work with the Centers for Medicare and Medicaid Services (CMS) to ensure that there exists a federal commitment of significant resources to fund an education and outreach campaign. Even if CMS were unable to provide such commitment, it would need to tailor its own education and outreach materials – particularly to markets/areas that border other states – to minimize confusion as Iowa's proposal calls for significant changes to the Iowa insurance market. Furthermore, it is unclear whether the healthcare.gov platform will allow consumers in Iowa the ability to access information on plan choices – regardless of whether enrollment can be conducted through this platform. We strongly urge the Department to work with CMS to ensure that plan information is available on the healthcare.gov platform.

iii. Special Enrollment Period Eligibility

The proposed waiver would permit an Iowan to obtain a special enrollment period (SEP) only if the individual met one of eight specified requirements, which mirror the SEPs defined by CMS for federally facilitated marketplaces. 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 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.

However, in addition to meeting the eligibility requirements of SEPs, Iowans under this proposal will also have to prove they have had continuous coverage for the last 12 months. We are extremely concerned that this proposal is based on false assumptions that individuals are enrolling illegitimately via SEPs, and could make it harder for consumers to enroll in coverage through an SEP. There is limited credible evidence that enrollees are inappropriately using SEPs. Making it harder for individuals to enroll via SEP can lead to gaps in insurance coverage, which can be detrimental to cancer patients.⁸ 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 initiation of a treatment protocol. Recent research shows that delays in the initiation of chemotherapy for breast cancer patients result in adverse health outcomes.⁹

We are particularly concerned with the proposal that individuals who seek an SEP must apply directly to one of the insurance carriers offering coverage. It is unclear who makes the determination regarding whether an individual qualifies for an SEP. Such determination must rest solely with the Department and cannot be abdicated to the carrier, because the carrier has an incentive to deny coverage to individuals who are older, sicker, or who they think may be more expensive to insure. Allowing carriers to make this determination opens up the possibility for discrimination against individuals, as well as delays in coverage.

Continuous Coverage Requirement: ACS CAN Iowa also has serious concerns about the continuous coverage requirements in the proposal. Under the waiver application any individual who wished to purchase coverage outside the annual enrollment period must show proof that she has not been without minimum essential coverage (MEC) for more than 63 days in the immediately preceding 12 months. We are concerned this policy is overly punitive. We would welcome the opportunity to work with the Department to ensure policy changes do not impact a patient's uninterrupted access to health insurance coverage and necessary treatment.

⁸ 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>.

⁹ 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.

A one-size-fits-all approach that imposes penalties for any interruption in coverage fails to recognize the many legitimate reasons that patients have coverage gaps, including the following scenarios:

- 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 months depending on the treatment.¹⁰ While this transition would constitute a SEP for the enrollee, it is unclear what, if any, requirements would be imposed on employers to provide documentation of prior MEC coverage and whether such documentation would be standardized in some way.
- 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.
- While individuals who move into the area would be permitted an SEP, an individual who may be coming from a state with less stringent SEP policy may be unaware of the limited SEP options in Iowa. If the individual fails to enroll in coverage within 63 days, she would be locked out of enrolling until the next annual election period.
- Moreover, even if an individual tried to enroll during this timeframe and was unable to successfully complete the process (because, for example, she failed to have the necessary paperwork from her former employer) absent clarification to the contrary, it appears as though the individual would be locked out of coverage and unable to enroll until the next annual enrollment period.
- If the individual was not able to afford COBRA or marketplace premiums, but earned too much income to qualify for Medicaid. Because all insurance options were unaffordable, this individual would be forced to go uninsured for a period of time. If the individual later experiences a positive change in income – thus allowing her to afford her health care premiums – she would still be unable to enroll due to the continuous coverage requirement and would have to wait until the next annual enrollment period to sign up for coverage.

All of these examples – and many others – are common reasons why a person may have an unexpected gap in coverage. Penalties 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.

We are concerned that the only open enrollment period defined in the proposal is for November 1, 2017 through December 15, 2017. The proposal indicates that any individual seeking enrollment outside of these dates would have to qualify for an SEP. It is unclear whether the proposal intends for there to be subsequent annual open enrollment periods if the waiver is approved for subsequent years. ACS CAN urges the Department to clarify this, and hold an open enrollment period every year at the same time.

¹⁰ Scott Ramsey, et al, "Washington State Cancer Patients Found to be at Greater Risk for Bankruptcy than People Without a Cancer Diagnosis," *Health Affairs*, 32, no. 6, (2013): 1143-1152.

We are also concerned that the proposal would require an individual to show proof of coverage before she is allowed to enroll in coverage. We are concerned that the result of this seemingly minor change in policy could be cancer patients failing to access health coverage and treatment in a timely way. The 1332 waiver application is silent regarding what standards of proof must be provided in determining proof of coverage, how those standards will be enforced on the carriers who are approving and implementing SEPs, or whether the carriers will have deadlines on how quickly they must decide on SEP applications. Restricting SEPs and requiring enrollees to document their eligibility prior to coverage will lead to gaps in coverage, which can be detrimental to an individual who needs access to cancer treatment immediately. If the Department were to consider such rules, the policy should provide a review process by which an individual could obtain expedited coverage when medically necessary.

We also urge the Department to create a mechanism whereby individuals can appeal an adverse determination regarding imposition of the continuous coverage requirement and/or request extenuating circumstances that warrant an exception to the continuous coverage requirement.

B. Age and Income-based Premium Credits

The 1332 waiver application proposes to use its share of federal expenditures originally designated for advance premium tax credits (APTCs) and cost-sharing reduction subsidies (CSRs) to provide premium tax subsidies that would differ from those provided under the Affordable Care Act.

Additional assistance needed for low-income individuals: While we appreciate that the apparent goal of the proposal is to provide additional financial assistance to individuals above 400 percent of the federal poverty level (FPL), we are concerned that as we read the proposal the CSRs would no longer be available to individuals who qualify on the basis of income. The CSRs help to ensure that lower-income Americans can afford the cost-sharing associated with their plan. ACS CAN Iowa is concerned that eliminating the CSRs – without providing comparable assistance for low-income individuals – will result in these individuals being unable to afford health insurance coverage and thus become uninsured.

We strongly urge the Department to ensure that low-income individuals at or under 250 percent FPL continue to have access to CSR plans, either by redirecting funds in the proposal to ensure this financial support, or by simply allowing plans to be sold as they would have, absent this proposal. In addition, we note that at this time Congress and the Administration have not provided continuous funding for the CSRs and the funding is the subject of litigation. ACS CAN fully supports permanent CSR funding. However, until that funding is provided, it is unclear how the 1332 waiver can proceed given that CSRs are a major funding source and there appears to be no back-up plan in the proposal if the administration does not provide CSR funding.

We also note that ensuring affordability is a key requirement to be able to obtain a waiver under section 1332. Absent additional policies to ensure that low-income individuals will have

access to affordable coverage options, we fail to see how the proposed waiver will meet this key requirement.

Adequacy of subsidies: It is unclear from the proposed waiver what assumptions were made to determine the adequacy of the premium subsidies provided under the waiver. This is concerning because the proposed waiver seeks to delink the amount of the subsidy a person receives from the amount of that individual's premiums, thus leaving individuals who may have little choice but to enroll in a higher than average premium vulnerable to incurring additional out-of-pocket costs. We urge the Department to couple the value of the subsidy to the premiums offered in a given region, as currently exists under current law.

Income determination: Under the proposed waiver, the income used to determine tax credit eligibility would be based on 2017 household income. ACS CAN Iowa is concerned about the use of this metric for eligibility determinations. We know that individuals' income can change throughout the year. For example, as discussed above, an individual may lose her job when her cancer treatment becomes too burdensome. We strongly urge the Department to include mechanisms to allow individuals who experience a change in income to report that change to the Department to ensure that eligibility and the amount of tax credits are based on actual, current income.

C. Reinsurance

The waiver proposes to implement a reinsurance program that will reimburse carriers for high cost individuals whose claims exceed \$100,000 on an annual basis. A well-designed reinsurance program can help to lower premiums and mitigate plans' risk associated with high-cost enrollees. As noted previously, Alaska's 1332 waiver is expected to result in significant premium decreases. A well-designed reinsurance program can also be relatively easy to implement, and could be implemented in time for the beginning of plan year 2018. We also note that a successful reinsurance program should reduce premiums for all enrollees – including those above the APTC threshold.

We are concerned that the proposed waiver seeks to fund the reinsurance program in part through expected CSR funding. We strongly urge the Department to remove CSRs as a funding mechanism for its reinsurance program. Any CSR funding should be dedicated to reducing cost-sharing specifically for low-income individuals (the subsidies for which are significantly reduced under this waiver compared to the subsidies provided under current law).

Conclusion

On behalf of the American Cancer Society Cancer Action Network Iowa we thank you for the opportunity to comment on the proposed section 1332 waiver. In light of the comments raised above, we believe the current waiver should undergo a significant redraft before the proposal is submitted to CMS. We stand ready to work with you and other stakeholders to ensure that the Iowa 1332 waiver is designed in a manner that provides the long-term viability of the individual market. If you have any questions, please feel free to contact me at noah.tabor@cancer.org or 319-480-0810.

Sincerely,



Noah Jensen Tabor, Esq.
Government Relations Director
Iowa American Cancer Society Cancer Action Network