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Kevin Counihan
Director & Marketplace Chief Executive Officer
Center for Consumer Information and Insurance Oversight
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Re: DRAFT 2016 Letter to Issuers in the Federally-facilitated Marketplaces
(December 19, 2014)

Dear Director Counihan:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on the draft 2016 Letter to Issuers in the Federally-facilitated Marketplaces (FFM Letter). ACS CAN, the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society, supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. As the nation's leading advocate for public policies that are helping to defeat cancer, ACS CAN ensures that cancer patients, survivors, and their families have a voice in public policy matters at all levels of government.

We note the FFM Letter references several policies contained in the recent Notice of Benefit and Payment Parameters proposed rule[1] and we refer CMS to our comments in response to that proposed rule (NBPP comments).[2] Overall, we support many of the proposals included in the FFM Letter. With respect to the network adequacy provisions, we urge CMS to ensure that enrollees have sufficient access to a wide range of oncology services (e.g., oncologists, surgeons, and radiologists) and subspecialty providers.

As discussed in more detail in our NBPP comments, while we support many of CMS' proposals to ensure that issuers are complying with the ACA requirements as implemented in regulation and guidance, we are concerned that outlier based review is insufficient to detect instances of significant non-compliance, particularly as such violations may be directed against or have adverse effects on individuals with expensive conditions such as cancer.

We offer the following comments on specific portions of the FFM Letter:

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[1] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 79 Fed. Reg. 70674 (Nov. 26, 2014).

[2] ACS CAN's comments on the proposed rule are available at http://www.acscan.org/content/wp-content/uploads/2015/01/ACS-CAN-Comments-Notice-of-Benefit-and-Payment-Parameters.pdf.

Chapter 1: Certification Process for Qualified Health Plans

Section 1. QHP Application and Certification Process

vi. Sale of Ancillary Products in the FFM

The FFM Letter would prohibit ancillary insurance products and non-qualified health plans (QHPs) from being offered on the federally-facilitated marketplaces (FFMs). The FFM Letter makes clear that only QHPs and stand-alone dental plans (SADPs) would be permitted to be offered on the FFM.

ACS CAN strongly supports this provision. The FFM was created so that consumers have the opportunity to purchase QHPs, which offer consumers protections that are not required in non-QHPs. Issuers should not be permitted to offer non-QHP or non-SADP products on the FFM because the sale of such ancillary products could be confusing to consumers who are shopping for health insurance coverage.

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

Section 3. Network Adequacy

i. Network Adequacy Standard

CMS will require the submission of detailed network provider data in order to determine whether the issuer meets the "reasonable access" standard. CMS will analyze these data closely and intends to focus closely on areas that have historically raised network adequacy concerns – notably hospital systems, mental health providers, oncology providers, primary care providers, and dental providers, if applicable. If CMS determines the plan's network may be inadequate, it will request the issuer to submit a written justification explaining how it will provide reasonable access to enrollees in the identified area(s). CMS reminds issuers that they must maintain the network adequacy standards throughout the plan year – not just at certification – as providers enter and leave plan networks. CMS intends to monitor network adequacy via complaint tracking.

ACS CAN strongly supports CMS' efforts to ensure that plans meet minimum standards to ensure that individuals have adequate access to the providers (including hospitals, other facilities, physicians, and non-physician providers) and services needed to treat their diseases or conditions. We appreciate CMS' specific acknowledgement that network adequacy must be maintained throughout the plan year and not simply at the point of certification.

Oncology services: We applaud CMS for acknowledging that oncology services have historically been an area where some plan networks have been inadequate. We appreciate that CMS plans to review issuers' QHP networks to ensure that individuals have adequate access to oncology services. As CMS conducts its review, however, we note that simply counting the number of oncology providers will not provide sufficient information on whether a QHP's network is adequate. Cancer patients need access to different types of oncology providers depending on their specific form of cancer. For example, some cancers are treated with chemotherapy, whereas other forms of cancer may be treated through a combination of chemotherapy, surgery, and/or radiation. Some cancer patients – particularly those with rare cancers, those with certain comorbidities, and pediatric cancers – may need to receive treatment at specialized cancer facilities. We urge CMS to examine the totality of services offered by the plan – including whether providers are accepting new patients – as part of CMS' determination of whether the plan's network is adequate.

Exceptions process: Some cancer patients may need access to specialized services that may not be available in a QHP's provider network. For this reason, we urge CMS to create a standardized exceptions process so that individuals are able to access out-of-network services when no in-network provider is available, qualified, or within a reasonable time or distance from the enrollee/individual. We also recommend that for services provided through this exceptions process that CMS limit the enrollee's cost-sharing requirements to in-network levels and require that any cost-sharing accrue towards the individual's annual out-of-pocket maximum to ensure that access is not only available but affordable. We are very concerned that in the absence of such a policy, cancer patients who are enrolled in plans that only provide for in-network coverage will have no coverage for these specialized services or, if out-of-network coverage is available, that they are subject to prohibitively high cost—sharing requirements. We also urge CMS to adopt a policy that protects the enrollee in this situation from provider balance billing charges.

Review criteria: While we appreciate that CMS intends to assess the adequacy of a plan's network, we note that CMS has provided very little information on the specific criteria it intends to use to conduct this determination. As discussed above, simply counting the number of providers and hospitals included in a QHP network may not be an appropriate measure for determining whether its network is adequate. We strongly urge CMS to provide additional information on the specific criteria it intends to utilize for determining the adequacy of a plan's network. ACS CAN urges CMS to consider including standards that provide a minimum ratio of providers to covered persons for primary care physicians and specialists (including subspecialists); minimum number of full time providers to meet the needs of individuals with limited English proficiency; maximum travel time and distance standard; and, a maximum time and distance standard to access hospital, emergency care, diagnostic and ancillary services.

Oversight: The FFM Letter notes that CMS intends to monitor the adequacy of a QHP's network through complaint tracking. ACS CAN believes that compliant tracking is one – but not the only – important mechanism to assess the adequacy of a plan's network. We also believe that CMS should monitor appeals filed with the QHP to determine whether individuals are seeking out-of-network coverage for services that should have been available through an in-network provider. In addition, we urge CMS to require QHPs to post on their websites and through other consumer communications the application form for the appeal and information on where and how consumers can file a complaint and an appeal, if needed.

ii. Provider Directory Links

CMS will require QHPs to publish a current, accurate, and complete provider directory, including which providers are accepting new patients. This information must be made available to current and prospective enrollees as well as the general public.

ACS CAN supports CMS' proposal to make the provider directories more accurate, complete, and available to the public. We commented on these policies as part of our NBPP comments. In cases where an insurer offers multiple plans with different provider directories, we urge CMS to require the insurer to carefully note which provider directory is associated with which specific plan. We have heard from individuals who have been confused by the multiple plan directories and lack of clarity as to which directory applies to which plan, and, as a result, have erroneously enrolled in a plan that ultimately did not cover their provider.

Section 4. Essential Community Providers

i. Evaluation of Network Adequacy with respect to all ECPs

CMS notes that it will use an essential community provider (ECP) enforcement standard for 2016 similar to the standard used in 2015. One of the criteria of the ECP standard is that plans must contract with at least 30 percent of the available ECPs in each plan's service area to participate in the provider network. The FFM Letter indicates that if an issuer is unable to satisfy the 30 percent requirement, the issuer will be required to submit a narrative justification describing how the network provides an adequate level of service for low-income and medically-underserved individuals.

ACS CAN supports the requirement that plans must contract with ECPs. We encourage CMS to clarify that the 30 percent requirement is a floor, and that states may choose to exceed, but may not fall below, this threshold. We urge CMS to increase the percentage of ECP providers that must be included over time.

We urge CMS to scrutinize any and all written justifications for failure to meet the 30 percent requirement that may be submitted by an issuer. CMS should provide additional information on the criteria it will use to determine whether an issuer's written justification is sufficient to warrant an exception to the 30 percent ECP standard. In addition, we urge CMS over time to monitor issuers that consistently fail to meet the 30 percent ECP standard and include this as a factor in determining whether the plan should continue to be able to offer a QHP.

Section 9. Discriminatory Benefit Design

i. QHP Discriminatory Benefit Design

CMS will assess compliance with the non-discrimination standard by collecting an attestation that insurers' QHPs will not discriminate against individuals on the basis of health status, race, color, national origin, age, sex, gender identity, or sexual orientation. CMS will continue to assess issuer compliance through issuer monitoring and compliance reviews, including analysis of appeals and complaints. CMS will perform an outlier analysis on QHP cost-sharing and will compare benefit packages with comparable cost-sharing structures with respect to specific benefits. CMS also is considering conducting a review of each QHP to identify outliers based on estimated out-of-pocket costs associated with standard treatment protocols for specific medical conditions using nationally-recognized clinical guidelines.

ACS CAN appreciates CMS' efforts to ensure that issuers are complying with the non-discrimination standards with respect to their benefit design.

Outlier review: We support CMS' proposal to conduct an outlier analysis on QHP cost-sharing and urge CMS to provide additional information on the benchmark CMS plans to use as a comparison. We are concerned that if CMS simply compares QHPs within a given market against each other, the analysis may not accurately show discriminatory practices. In other words, such analysis would not reveal discriminatory practices if most or all plans were imposing significant cost-sharing on products to treat the same disease (like cancer).

We support CMS' proposal to conduct a specific review of each QHP to identify outliers based on out-of-pocket costs associated with standard treatments for specific conditions. We note the FFM Letter proposed that CMS identify five conditions (bipolar disease, diabetes, HIV, rheumatoid arthritis, and schizophrenia). We strongly urge CMS to include a cancer diagnosis, such as breast cancer, among the

list of conditions identified for specific review since cancer patients routinely faced discriminatory practices in the past. The National Comprehensive Cancer Center (NCCN) and the American Society of Clinical Oncology (ASCO) create well-known cancer screening treatment guidelines.

Monitoring: We support CMS' proposed policy to assess compliance through issuer monitoring and compliance reviews (including appeals and complaints). However, we urge CMS to provide additional information on the criteria it intends to use to determine whether issuers are compliant with this standard. For example, it is unclear whether compliance will be assessed based on the number or types of complaints issuers receive or whether certain complaints will warrant more immediate action from CMS. We urge CMS to publicly disclose plans that have been subject to this review, including the reasons for the review, along with a final disposition of the review. We note that similar requirements exist in the Medicare Part C and Part D programs.

Section 10. Prescription Drugs

ii. Review of Prescription Drugs Based Upon Clinical Appropriateness

CMS indicated it will review each QHP's prescription drug coverage for clinical appropriateness. CMS' review will analyze the availability of covered drugs used in the treatment of four medical conditions (bipolar disorder, diabetes, rheumatoid arthritis, and schizophrenia). The FFM Letter indicates the purpose of this review is to ensure issuers are offering a sufficient number of types of drugs needed to treat the condition and are not restricting access to first line therapies.

ACS CAN supports CMS' review of the QHP's prescription drug coverage. However, we urge CMS also to include at least one cancer diagnosis among the medical conditions CMS has identified for additional review. As discussed above, the NCCN and ASCO create well-known cancer screening treatment guidelines which can be used for the purpose of determining whether a QHP's prescription drug coverage is sufficient. Further, we also ask that CMS examine how plans tier drugs for these particulate conditions. Research conducted by ACS CAN found that cancer drugs are generally covered only on the most expensive specialty tiers.[3] This means that, while technically the plan is offering access to cancer drugs, the cost to the consumer may make these drugs out of reach.

Section 11. Supporting Informed Consumer Choice/Meaningful Difference

CMS proposes to continue its previous analysis to assess whether all plans proposed to be offered by potential QHP issuers are meaningfully different from other plans the issuer has submitted for certification.

ACS CAN strongly supports this policy, which is an important tool to help consumers sort through plan options. While enrollees should have a choice of marketplace plan options, too many options can hinder an enrollee's ability to make an informed choice. We support CMS' review to ensure that issuers offer meaningful differences between their plan offerings. Such differences should be made readily apparent so that enrollees and potential enrollees who search for plans can do an adequate comparison and easily ascertain which plan may best suit their needs.

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[3] American Cancer Society Cancer Action Network, Cancer Drug Coverage in Health Insurance Marketplace Plans, (March 2014), available at http://www.acscan.org/content/wp-content/uploads/2014/03/Marketplace_formularies_whitepaper.pdf.

Conclusion

On behalf of the American Cancer Society Cancer Action Network we thank you for the opportunity to comment on the draft 2016 Letter to Issuers in Federally-facilitated Marketplaces. 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
Senior Policy Director
American Cancer Society Cancer Action Network