Submitted electronically

July 3, 2012

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Washington, D.C.

Attention: CMS 9965-P

To whom it may concern:

The American Cancer Society Cancer Action Network ("ACS CAN") is the advocacy affiliate of the American Cancer Society (the "Society"). The Society is a nationwide, community-based, voluntary health organization dedicated to eliminating cancer as a major health problem by preventing cancer, saving lives, and diminishing suffering from cancer, through research, education, advocacy, and service. The American Cancer Society, operating through its national office and 13 chartered, geographic division affiliates throughout the United States is the largest voluntary health organization in the United States.

ACS CAN appreciates the opportunity to provide comments to the U.S. Department of Health and Human Services on the proposed rule, Data Collection to Support Standards Related to the Collection of Data for Essential Health Benefits.

We want to thank the Department for issuing the Proposed Rule regarding data collection to support standards related to Essential Health Benefits (EHB). Robust data on the potential benchmark plans is vital to better understanding how the Department's intended approach to defining the Essential Health Benefits would impact the cancer population we represent. Robust data collection requirements for states and carriers will help HHS ensure it has the data needed to accurately assess the impact of the benchmark approach on consumers. This data will be necessary to meet the Secretary's statutory obligation to periodically review and update the essential health benefits to address any gaps in access to coverage or changes in medical evidence or scientific advancement. It will also be necessary to inform HHS's evaluation of the benchmark approach for the calendar year 2016 and to assess whether an alternative approach, such as a federally defined EHB, would better address access to care, consumer choice, risk selection, and the ACA's goal of establishing a minimum level of uniform benefits.

Gathering Data on Limits on Potential Benchmark Plans

We and other consumer groups have previously expressed concerns about the lack of information available on limits in the potential benchmark plans and that limits could impede access to the essential health benefits. Information about quantitative and non-quantitative limits is not easily available and without it, consumers cannot be assured that all benchmarks will have reasonable, non-discriminatory limits that are truly within the scope of the typical employer plan. We are glad to see that the information is being collected and hope it will be used to ensure consumers have access to the entire scope of essential health benefits.

While we believe the information is important to have, we want to make certain that its collection is not an indication that these limits will be incorporated wholesale into the essential health benefits. We reiterate our concern that arbitrary and unreasonable limits could be used to restrict needed care or steer consumers into or away from certain plans offered on the exchange and may be inconsistent with the ACA's clear intention to guarantee that at least the 10 benefit categories are covered. In some instances, arbitrary service limits could seriously interfere with necessary care. For example, we know of a cancer patient who had a limit of 30 physician visits per year, even though she required chemotherapy once a week for 52 weeks and she required other physician visits. These limits are arbitrary and inhibit efforts to move toward greater reliance and utilization of evidence-based medicine in treating complicated chronic conditions like cancer. For these reasons, HHS should prohibit some limits or exclusions even if they are found in a proposed state benchmark plan.

There are some concerns we have specific to the request for information on non-quantitative limits, such as step-therapy and prior authorization. It is important that the use of non-quantitative limits be restricted so that they do not prevent access to the essential health benefits. We have particular concern for non-quantitative limits that are not based on the best medical evidence or are being applied to situations outside the applicability of the medical evidence.

In addition to our concerns about the impact of non-quantitative limits, we are also concerned that it will not be possible to verify the actuarial equivalence of treatment limits, and particularly non-quantitative limits. This could result in some plans using non-quantitative limits to reduce access to benefits while still appearing to be actuarially equivalent to the benchmark plan. If there is no clear way to determine and verify the actuarial value of specific plan limits, then we do not see how they can be incorporated into the essential health benefits. We recommend that the Department use the data collected to understand non-quantitative limits and how they may be discriminatory and/or limit access to essential health benefits. We specifically encourage the Department to recognize any gaps in medical evidence that supposedly support non-quantitative limits and issue regulations that restrict the use of non-quantitative limits in essential health benefits.

Additionally, given the Secretary's obligation to ensure that the EHB package does not discriminate and to comply with the requirements in § 1302 and § 1557, we believe this data

should be used to identify any quantitative or non-quantitative limits that might be discriminatory and ensure that they do not become part of the Essential Health Benefits.

Prescription Drug Data Should Help Direct a Robust Definition of Prescription Drug Coverage

We are glad to see that detailed information will be requested on prescription drug coverage. Hopefully this data will help the Department issue regulations on the prescription drug category that ensures the essential health benefits include prescription drug coverage that is comparable to a typical employer plan. This means that the essential health benefits will require a broad range of drugs covered within each category or class. All of our concerns on the use of limits we discuss above apply to prescription drug coverage.

HHS Should Collect Data on Rider Policies

The Department of Health and Human Services (HHS) has provided inconsistent guidance on the issue of whether rider policies will be considered as part of the benchmark for determining Essential Health Benefits (EHB). HHS stated in a Frequently Asked Questions (FAQ) document, "For purposes of identifying the benchmark plan, we identify the plan as the benefits covered by the product excluding all riders. HHS intends to propose that if benefits in a statutory category are offered only through the purchase of riders in a benchmark plan, that required EHB category would need to be supplemented by reference to another benchmark."[1] Yet, a footnote in the HHS Bulletin states, "Nomenclature used in HealthCare.gov describes 'products' as the services covered as a package by an issuer, which may have several cost-sharing options and riders as options. A 'plan' refers to the specific benefits and cost-sharing provisions available to an enrolled consumer. For example, multiple plans with different cost-sharing structures and rider options may derive from a single product."[2] If a plan is, in fact, a product that is supplemented by optional rider policies as described in the HHS Bulletin, then it is very confusing for Centers for Medicare and Medicaid Services (CMS) to define a plan in its FAQ as a product without riders. Individual plans that emerge from a single product are, by definition, distinguished by the availability of rider policies.

As proposed, HHS intends to collect data from the issuers of the largest three products in each state based on the plan with the highest enrollment within the product. We urge HHS to require the collection of data related to the rider policies made available by that plan. High enrollment in a plan can be attributed, at least in part, to the availability of rider policies. Moreover, in some states riders are very common forms of coverage for certain categories of benefits like

[1] http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf
[2] http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf, page 4.

prescription drugs. Therefore, information that HHS must have in order to develop a policy that reflects the statute's requirement that the scope of benefits reflect a "typical employer plan."[3]

Further Clarification on Supplementing a Benchmark Plan, including the Alternate Approach mentioned in Appendix G: Benchmark Plan Data Requirements

This appendix mentions an alternate approach that states may use when providing data on the selected benchmark plan. It notes that if the state chooses the alternate option, HHS will ensure coverage in all ten statutorily required categories. We assume that HHS will fill in the required categories in a robust way that ensures plan enrollees receive the comprehensive benefits intended by the ACA. However, as this alternate approach appears to be a new idea, we request further clarification on how HHS would supplement the ten categories to ensure access to all essential health benefits. The approach should use a transparent process when supplementing the ten categories under this approach with an opportunity for stakeholder input. We also request clarification on whether there will be any action taken by HHS to verify coverage of all ten categories when states DO NOT choose the alternate approach.

Question About Wellness Programs Mentioned in Appendix H-1: Medical Benefits Template for Individual Family Plan (IFP)

We were concerned to see that the Medical Benefits Template for Individual Family Plan included a question concerning Diabetes Wellness Plans. We want to ensure that wellness programs which are not actually benefits are not included in the EHB. Many wellness programs, such as those that provide discounts to enrollees who reach certain goals (such a specific blood glucose level, in the case of diabetes) are not actually benefits and should not be taken into account in determining the Essential Health Benefits. Furthermore, we are concerned that wellness programs could be used as a way to circumvent other features of the Affordable Care Act, such as the end to discrimination based on health status and gender, and that wellness programs could be discriminatory towards women, low-income people, and minorities who may have more barriers to participating in these programs and are more likely to have chronic conditions or poor health to begin with.

Additional Data

This data is an important step in helping states make informed decisions when choosing a benchmark plan and will also provide important information about coverage available in insurance markets across states. In order for states and other parties working on state implementation to be fully informed, they need information on how limits actually work. We therefore recommend the following additions be added to the data request.

<u>Exceptions and Numbers of People Reaching Limits</u>

[3] Section 1302(b)(2) of the Affordable Care Act

We recommend the final recommendation request, from each plan, data on how both quantitative and non-quantitative limits function including any exception process and the number s of people reaching each limit. Specifically, we suggest adding, for each limit:

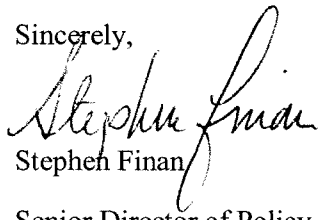
- Is there an exception process for the limit? If yes: what is the exception? How many enrollees requested an exception in the last plan year? How many enrollees were granted an exception during the same period?
- How many people hit the limit in the last plan year? How many people hit the limit in each of the last two plan years?

Medical Necessity

This information request provides an important opportunity to gather information on how plans will administer the essential health benefits. We therefore recommend the final recommendation request the definition of medical necessity used by each plan. Medical necessity determination processes appear to vary widely among plans and are often not transparent. However, they can be critical in deciding care for some patients, particularly those with complex medical conditions like cancer. Colleting this additional information will allow the Department to have an understanding of how plans in various markets define medical necessity and should help the Department determine when certain definitions may be discriminatory and/or unreasonably limit access to the essential health benefits.

If you need any further information, I can be contacted at SFinan@cancer.org.

Sincerely,



Stephen Finan

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