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February 25, 2014

Gary Cohen
Deputy Administrator & Director
Center for Consumer Information and Insurance Oversight
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

Re: Draft 2015 Letter to Issuers in the Federally-facilitated Marketplaces

Dear Deputy Administrator Cohen:

The American Cancer Society Cancer Action Network appreciates the opportunity to comment on the Draft 2015 Letter to Issuers in the Federally-facilitated Marketplaces. 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 is the largest public health organization in the United States.

We are pleased the Centers for Medicare and Medicaid Services (CMS) intends to strengthen the Qualified Health Plan (QHP) review and certification processes to increase transparency and improve oversight of network adequacy and prescription drug formularies. Without reliable and transparent information, consumers will not be able to make the necessary apples-to-apples comparison of plans to find the one that best meets their needs. Further, without the guarantee of an adequate provider network, many consumers who have longstanding relationships with providers – like persons with cancer – may face extraordinary costs. We strongly urge CMS to further strengthen plan requirements by adopting the following recommendations.

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

Section 3: Network Adequacy

We applaud CMS' recognition that access to oncologists and health systems, in particular, are at risk without strong network adequacy oversight. We support the proposal to collect provider lists and conduct network adequacy reviews during the QHP certification process, and we urge CMS to move forward with developing tools that will allow consumers to search for plans by covered providers. We also strongly urge CMS to require issuers to update provider directories on a timely basis, and we also urge CMS to provide the proposed provider directory tool for consumers when window shopping.

We strongly support CMS' proposal to pursue rulemaking with respect to time and distance standards. As part of that rule, we suggest that CMS also consider provider-to-patient ratios and appointment wait-time standards to help determine network adequacy.

Even with stronger network adequacy protections, some cancer patients may require highly specialized care that may not be available in a narrower network. We therefore recommend that CMS require a standardized exceptions process to allow enrollees to access out-of-network providers if no in-network provider is available, qualified, or within a reasonable distance.[1] We also recommend that CMS limit cost-sharing to in-network levels if an exception is granted and protect consumers from balance billing. We urge CMS to require that the exceptions process be at least as protective as that proposed in the Office of Personnel Management's Multi-State Plan Program Issuer Letter (see page 6 of http://www.opm.gov/media/4517978/2014-002_dms_.pdf).

Finally, we support the CMS proposal to increase the percentage of Essential Community Providers (ECP) that must be covered by Qualified Health Plans. We encourage CMS to clarify that the 30 percent requirement is a floor, and that states may choose to exceed, but not fall below, this requirement. We also suggest that, if CMS pursues rulemaking on the inclusion of ECPs in 2015, it increase the percentage of ECP providers that must be included over time.

Chapter 3: Qualified Health Plan and Stand-Alone Dental Plan Design

Section 1: Discriminatory Benefit Design: 2015 Approach

We appreciate efforts by CMS to review QHPs for discriminatory benefit designs, and we support outlier-based reviews that include cost-sharing, medical management practices, and exclusions and exceptions language.

[1] We note that, for preventive services, CMS clarified that patients must be allowed to access services without cost sharing from an out-of-network provider if no in-network provider can provide the service (see http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html). However, this guidance does not appear to apply to all Essential Health Benefits.

We understand that CMS will rely on states to enforce EHB non-discrimination standards as they apply both inside and outside the Marketplace. However, we urge CMS to provide guidance to states on minimum required non-discrimination review standards. Without this guidance, we are concerned the primary non-discrimination review conducted in some FFM states will be CMS' outlier-based review, which is insufficient to detect widespread discrimination against those with expensive conditions such as cancer.

For example, a recent report found that coinsurance is widely used for specialty medication, and that coinsurance rates often exceed 30 percent.[2] Outlier analysis is insufficient to determine whether this extensive use of coinsurance for specialty medications is discriminatory, because these practices are widespread. Therefore, we recommend that CMS provide guidance to states outlining non-discrimination reviews that take into account the extent of differences in cost-sharing and utilization management practices across patients with different diseases, disabilities, or expected length of life.

Section 2: Prescription Drugs

We strongly urge CMS to move forward with rulemaking for transition periods requiring coverage of non-formulary prescription drugs for new enrollees in the first 30 days of the plan year, as well as requirements for transition periods for access to specialists for patients undergoing cancer treatment. We recommend that CMS clarify these transition periods would apply whenever an enrollee changes health plans, not just when coverage begins January 1. Throughout the year, individuals and families will enroll in Marketplace plans through special enrollment periods, and the transition coverage protection should apply regardless of enrollment timing.

We further recommend that CMS require a standardized drug exceptions process similar to that used in Medicare Part D. CMS must also clarify that drugs covered under the exceptions or transition processes apply to the enrollee's in-network out-of-pocket maximum. If an exception is granted, plans should continue to provide coverage for the exception drug as long as the enrollee remains in the plan. It is crucial that CMS mandate an expedited internal and external review of exceptions process for requests in urgent situations. CMS should evaluate the prescription drug exception and claims denial appeals process as well as approval and denial rates as QHP certification and recertification criteria.

We appreciate CMS' emphasis on requiring direct links to up-to-date formularies, but we are concerned that this requirement does not go far enough in providing consumers with tools to easily compare plans. Many formularies posted by plans are incomplete and contain language indicating that the presence of a drug on the formulary does not guarantee coverage. In addition, issuers use a wide variety of organizational tools to display their formularies, making

[2] Avalere Health. *Consumers Likely Face High Out-of-Pocket Costs for Specialty Drugs in Exchange Plans.* February, 2014. Available at: http://avalerehealth.net/expertise/managed-care/insights/consumers-likely-face-high-out-of-pocket-costs-for-specialty-drugs-in-excha

comparisons difficult and inefficient. We therefore recommend that CMS use the data collected for the drug count service to create a tool that will allow consumers to search for plans that cover their prescription drugs. This type of tool has been implemented on the Nevada State-based Marketplace.

We support CMS' proposed collection of medical benefit drugs in addition to prescription drugs listed on formularies. There is currently no transparency into medical benefit drug coverage, which is an important consideration for cancer patients, so we urge CMS to publish the data it collects to help enrollees choose a plan. However, we are concerned with CMS including these drugs in the count service to determine if a plan meets the Essential Health Benefit requirements. These drugs may not have been systematically counted in the establishment of benchmarks. Therefore, inclusion of these drugs in the count service could allow issuers to reduce the number of cancer drugs covered, potentially harming cancer patients.

Finally, we note that the letter does not indicate whether CMS will use the United States Pharmacopeia Medicare Model Guidelines (USP MMG) version 5.0 or version 6.0 for the drug count service for the 2015 plan year, and the Essential Health Benefits regulation does not specify a particular version of the USP MMG. We strongly urge CMS to update to the USP MMG version 6.0 for the 2015 benefit year. The USP MMG version 6.0 includes an additional class of cancer drugs to treat prostate cancer, as well as over a dozen new drugs across cancer-related classes.[3] Many drugs used to treat cancer are targeted to specific cancer types, sites, or genetic variations, meaning they are not interchangeable. We are very concerned that failure to update to the USP MMG version 6.0 and count these new drugs as Essential Health Benefits will allow an erosion of cancer drug coverage and pose a significant risk to cancer patients relying on new, targeted therapies.

Section 7: Coverage of Primary Care: 2015 Approach

We encourage CMS to pursue rulemaking to require issuers to offer at least one plan at each metal level that covers three primary care visits before the deductible. As part of this rulemaking process, CMS should broadly define the term primary care.

Chapter 4: Qualified Health Plan Performance and Oversight

Section 3: QHP Issuer Compliance Reviews

We appreciate CMS' emphasis on review of complaint data to target compliance reviews and inform future policy. However, we note that most consumers do not file official complaints when faced with insurance coverage problems, as often they are unaware of how to file complaints with states or CMS. We therefore urge CMS to provide clear, prominent instructions for consumers on healthcare.gov describing how to file a complaint about an

[3] In total, the USP 6.0 includes 113 new drugs and 7 new classes. See Final Report, Summary of Methodology and Approach: USP Medicare Model Guidelines v 6.0, at 9, 15 (2014), *available at* http://www.usp.org/sites/default/files/usp_pdf/EN/healthcareProfessionals/uspmmg_v6_0_final_report.pdf.

insurance company. We also urge CMS to make aggregate complaint data available to the public, including the number and nature of complaints received about each QHP.

Chapter 6: Consumer Support and Related Issues

Section 1: Provider Directory

We support the requirement for issuers to provide a direct, up-to-date link to a provider directory, including information on whether each provider is accepting new patients. We encourage CMS to use provider lists collected for the purposes of network adequacy reviews to create a consumer-friendly tool on healthcare.gov, as provider links vary in quality and are inconsistent across issuers. We also urge CMS to hold issuers accountable for keeping provider lists up-to-date, and we suggest that CMS allow for a special enrollment period for consumers who enroll in a plan based on out-of-date provider information.

Section 6: Transparency

We appreciate CMS' steps to implement Section 1311(e)(3), and we strongly urge CMS to pursue rulemaking to implement this section and the parallel Section 2715a in a consistent manner across states and insurance markets. We encourage CMS to post all data publicly in a clear, comparable, comprehensive manner to allow consumers to use the information in the comparison of health plans.

Thank you for the opportunity to comment on the Draft 2015 Letter to Issuers in the Federally-facilitated Marketplaces. We look forward to continuing to work with you to ensure the new Marketplaces work for consumers. If you have any questions, please feel free to contact me directly or contact Laura Skopec, Senior Policy Analyst at 202-585-3260 or laura.skopec@cancer.org.

Sincerely,

Kirsten Sloan
Senior Policy Director
American Cancer Society Cancer Action Network