January 30, 2023

Xavier Becerra
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-9899-P– Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024
87 Fed. Reg. 78206 (December 21, 2022)

Dear Secretary Becerra and Administrator Brooks-LaSure:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on the Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters (NBPP) for 2024. ACS CAN is making cancer a top priority for public officials and candidates at the federal, state, and local levels. 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. As the American Cancer Society's nonprofit, nonpartisan advocacy affiliate, ACS CAN is more determined than ever to end cancer as we know it, for everyone.

More than 1.9 million Americans will be diagnosed with cancer this year and more than 18 million Americans living today have a history of cancer.[1] For these individuals finding the right doctor is one of the most important factors in their treatment and has a direct bearing on the overall affordability of their care. In general, we support many of the proposals contained in the 2024 NBPP proposed rule and offer comments on the following:

- *Navigator Program Standards*
- *Exchange Eligibility Standards*
- *Verification Process Related to Eligibility for Insurance Affordability Programs*
- *Annual Eligibility Redetermination*
- *Special Enrollment Periods*
- *Standardized Plan Options*
- *Plan Marketing Name Requirements*
- *Essential Community Providers*
- *Termination of Coverage or Enrollment for Qualified Individuals*

***Copay Accumulator Policy**:* Unfortunately, we are very concerned that HHS did not take this rulemaking opportunity to rescind the policy adopted in the 2021 NBPP rulemaking which allows issuers to no longer count manufacturer coupons towards an individual's limitation on cost-sharing. This copay accumulator policy hinders cancer patients' and survivors' access to medically appropriate therapies. We urge HHS to rescind the policy

[1] American Cancer Society. *Cancer Facts & Figures 2023.* Atlanta: American Cancer Society; 2023.

adopted in the 2021 NBPP rulemaking and reinstate the policy finalized in the 2020 NBPP rulemaking which would require issuers to include any amounts paid toward an enrollee's cost-sharing when calculating the enrollee's annual limitation on cost-sharing.

III. Provisions of Proposed HHS Notice of Benefit and Payment Parameters for 2024

B. Part 155—Exchange Establishment Standards and Other Related Standards

2. Navigator, Non-Navigator Assistance Personnel, and Certified Application Counselor Program Standards (§§ 155.210, 155.215, and 155.225)

HHS proposes to repeal the general prohibition on door-to-door and other direct, unsolicited outreach by Navigators and Assisters, believing such contact would be a positive step enabling Assisters to reach a broader consumer base in a timely fashion and would help reduce uninsured rates and health disparities by increasing access to health coverage.

ACS CAN recognizes that direct contact with certain individuals may be an important and necessary piece of an overall strategy to increase health insurance enrollment and target specific under-enrolled communities. Assistor organizations may find this tactic especially important in reaching individuals who are impacted by the end of the Medicaid continuous coverage provision.

However, we are also sensitive to the fact that many individuals do not want to receive solicitations at their doors and would respond negatively to someone seeming to "sell insurance" door-to-door. We also recognize that permitting individuals to conduct door-to-door outreach may compound efforts to combat fraudulent activities because it will be challenging for individuals to ascertain which solicitations are legitimate versus fraudulent. While we support Navigators and Assistors conducting outreach and education to consumers, we do not support repealing the prohibition on Navigators' and Assistors' ability to conduct door-to-door outreach to consumers.

4. Eligibility Standards (§ 155.305)

Currently Exchanges can determine an enrollee ineligible for advanced premium tax credits (APTCs) after having a "failure to file and reconcile" (FTR) status for one year. HHS proposes to increase this time allotment to two consecutive tax years. This gives Exchanges more time to conduct outreach to consumers whose data indicates a failure to file and reconcile, to prevent erroneous terminations of APTC and to provide access to APTC for an additional year even when APTC would have been correctly terminated under the original FTR process.

ACS CAN supports this policy as it will prevent some individuals from being dropped from coverage and give them continued access to care while they address their problems with tax filing. Many of the communities that are most served by the Marketplaces and who receive APTCs are communities that do not have experience with filing taxes and need the most help in correctly doing so. ACS CAN supports erring on the side of giving continued access to healthcare while such problems are resolved, especially when many of them do get resolved with the individual's eligibility for APTCs remaining intact.

5. Verification Process Related to Eligibility for Insurance Affordability Programs (§§ 155.315 and 155.320)

HHS proposes to require Exchanges to accept an applicant's or enrollee's attestation of projected annual household income when it cannot automatically verify the amount through IRS data, and to give enrollees with such data matching issues an additional 60 days to resolve them while still maintaining health insurance coverage through the Exchange.

ACS CAN supports these changes, as they promote continued access to care for individuals who are legitimately eligible for APTCs and enrollment through Exchanges but have difficulty obtaining the necessary paperwork or meeting other reporting requirements. HHS states in the proposal that the current time-period allotted to this process is often insufficient for many applicants to provide this documentation, since it can require multiple documents from various household members along with an explanation of seasonal employment or self-employment, including multiple jobs. As noted in the preamble, between 2018 and 2021, more than a third of consumers who resolved their income data matching issues on the Exchange did so in more than the current 90 days allotted. We support this time period being extended by 60 days to help prevent individuals from being wrongfully dropped from coverage and lacking access to healthcare.

6. Annual Eligibility Redetermination (§ 155.335)

For Marketplace enrollees who do not actively choose a new plan during open enrollment and are automatically re-enrolled, HHS proposes amending the re-enrollment hierarchy to 1) maximize the use of cost-sharing reduction subsidies (CSRs) where appropriate, and 2) include the similarity of networks as a factor in auto re-enrollment plan choice.

ACS CAN supports both of these changes. We note the policy to maximize the use of CSRs would involve moving an individual from a bronze to a silver-level plan – which would not only allow the individual to take advantage of a CSR plan structure but would give them a more generous plan. As long as the consumer continues to have the opportunity to change this selection if needed, we support this change.

We have in the past encouraged HHS to factor plan network into this auto re-enrollment hierarchy, and we congratulate the Department for incorporating this feedback in this proposal. Maintaining providers in-network during a coverage transition can be very important to cancer patients and survivors – particularly those in active treatment that cannot be disrupted, or for survivors of rare cancers for which there are a small number of qualified providers. While the best outcome for a cancer patient in active treatment would be for that patient to actively shop during open enrollment, we also know that cancer treatment is an all-consuming life event and administrative details like this sometimes do not get attended to on-time by the patient or their family. We support the auto-re-enrollment process protecting such patients from being dropped from coverage, and support provider networks being included as a factor in this process.

7. Special Enrollment Periods (§ 155.420)

HHS proposes, for consumers attesting to a future loss of minimum essential coverage (MEC), to permit Exchanges the option of offering earlier coverage start dates—that is, at the beginning of the month in which the loss of MEC will occur. HHS is soliciting input on whether the proposed change would help consumers, especially those impacted by Medicaid/CHIP unwinding, to seamlessly transition to Exchange coverage. HHS also proposes that, effective January 1, 2024, Exchanges will have the option to implement a new special rule that consumers eligible for a special enrollment period (SEP) due to loss of Medicaid or CHIP MEC will have up to 90 days after their loss of Medicaid or CHIP coverage to enroll in an Exchange qualified health plan (QHP), aligning with the timeline for an individual who was appealing their dis-enrollment from Medicaid or CHIP, but ultimately failed that appeal.

ACS CAN supports these changes and urges HHS to finalize these proposals. We also thank CMS for recently announcing a temporary Exceptional Circumstances SEP (from March 31, 2023 to July 31, 2024) for those loosing Medicaid or CHIP coverage due to the unwinding of the Medicaid continuous enrollment condition for Marketplaces using the federal platform. We support this policy and urge CMS to encourage state-based marketplace to provide a similar SEP.

For a patient in active cancer treatment, even a gap of a few weeks or months can be significantly disruptive to treatment, and even life-threatening. Gaps in insurance coverage have been shown to cause delays or inability to obtain prescription drugs[2] – which are an important part of most cancer treatment plans. 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. For example, research shows that delays in the initiation of chemotherapy for breast cancer patients result in adverse health outcomes.[3]

Mid-year provider changes: Additionally, HHS is considering a policy in future years that would provide consumers an SEP if they are affected by a "significant change in their plan's provider network". ACS CAN appreciates the sentiment behind this possible proposal, as the consumer has no control over the contract negotiations between providers and plans, but their access to care – particularly to physicians who are integral to their cancer care – can be significantly impacted by such negotiations and changes in networks.

ACS CAN has long supported policies that hold plans accountable to providing the coverage they committed to providing when the consumer selected the plan at the beginning of the plan year, and this policy would in some ways accomplish this goal. However, we note that if a consumer in this situation were to use the SEP to enroll in a new plan that allowed them to keep their provider, their deductible and maximum out-of-pocket amount would also re-set, meaning that any cost sharing the patient had expended up to that point would no longer count toward the patient's maximum out-of-pocket costs. In many cases, this change could cost the patient several thousands of dollars, and not be financially feasible or wise. Unless HHS can add a provision to the policy that prevents cost-sharing amounts from re-setting when the consumer changes plans through this SEP, we recommend that instead HHS expand the current regulations regarding provider transitions,[4] to include individuals who are impacted by significant mid-plan year changes to continue care from their providers at in-network cost-sharing rates. We also note that CMS has the authority to review the extent to which enrollees are utilizing out-of-network care. We urge CMS to review this data to determine the adequacy of a plan's network and whether the plan is meeting its obligations throughout the plan year.

C. Part 156—Health Insurance Issuer Standards, Standards Related to Exchanges

3. Standardized Plan Options (§ 156.201)

CMS proposes to largely retain the standardized plan option requirements. With respect to prescription drug coverage, CMS proposes to continue the use of four formulary tiers: generic drugs; preferred brand drugs; non-preferred brand drugs; and specialty drugs. CMS further clarifies that generic drugs can only be placed in the generic tier or in the specialty tier.

ACS CAN continues to support the continuation of standard plan offerings. We support CMS' proposal to prohibit issuers from placing generic drugs on a branded drug tier (other than the specialty drug tier). We believe this policy will help encourage utilization of generic drugs, which are less expensive than their branded counterparts. While CMS notes that generic drugs can be placed in the specialty drug tier provided there is a non-discriminatory basis for doing so, we strongly urge CMS to monitor the extent and frequency to which plans are putting generic drugs on the specialty tier to ensure that placement in that tier does not violate the anti-

[2] Yabroff KR, Kirby J, Zodet M. Association of Insurance Gains and Losses With Access to Prescription Drugs. JAMA Intern Med. 2017 Oct 1;177(10):1531-1532. doi: 10.1001/jamainternmed.2017.4011. PubMed PMID: 28892527; PubMed Central PMCID: PMC5820691.

[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.

[4] 42 C.F.R.§ 156.230(d)(2).

discrimination provisions.

4. Non-Standardized Plan Option Limits (§ 156.202)

HHS is proposing to limit the number of non-standardized plan options that QHPs can offer in Federally-facilitated Marketplaces (FFMs) and partnership exchanges to two per product type and metal level (excluding catastrophic plans) in any given service area. Alternatively, CMS proposes to apply a meaningful difference standard whereby an issuer could offer multiple offerings as long as the deductible differed by more than $1,000.

ACS CAN appreciates CMS' proposal which is designed to curtail the plethora of plan options and make it easier for consumers to choose a plan that best meets their needs. While having a choice of health plans is an important consumer protection, having too many options – particularly options offered by the same issuer in which there is minimal variation in benefit design – can be confusing for consumers. The American Cancer Society operates a specialized Health Insurance Assistance Service (HIAS) which provides cancer patients information about health insurance options that may be available to them in their area. HIAS representatives often hear from individuals with cancer about how overwhelming it can be to make insurance enrollment decisions while also dealing with cancer. It is crucial that individuals with cancer and survivors are able to choose a health insurance plan that provides coverage for their unique needs.

We urge CMS to consider adopting both approaches – limiting plan availability to no more than two options per product type and metal level AND imposing a meaningful difference standard. This will help to ensure that issuers have flexibility to offer different plan designs while at the same time ensuring that consumers are not overwhelmed by plan options.

6. Plan and Plan Variation Marketing Name Requirements for QHPs (§ 156.225)

HHS proposes to require QHP issuers to not include misleading information in plan names and plan marketing materials. HHS notes that it will review plan names as part of the QHP certification process.

ACS CAN supports this proposal. We have heard from consumers who have been confused by names of plans, which can make the enrollment process more difficult. We urge HHS to ensure that plan names are distinguishable and provide consumers with basic, accurate information such as name of issuer and metal level. We believe that limiting the number of plan options (as proposed above) and requiring issuers to accurately name their plans will help to reduce consumer confusion and improve the marketplace shopping experience.

7. Plans that Do Not Use a Provider Network: Network Adequacy (§ 156.230) and Essential Community Providers (ECP) (§ 156.235)

Current regulations provide that network adequacy standards apply only to plans that use a provider network. HHS proposes to review its network adequacy and ECP requirements to require all individual market QHPs (and stand-alone dental plans and all SHOP QHPs) to comply with the network adequacy and Essential Community Provider (ECP) requirements. HHS also proposes to require issuers to demonstrate compliance with wait time standards and notes that it will begin conducting reviews of issuer attestation for plan year 2024.

ACS CAN supports this policy. Under current regulations, QHPs are required to provide access to a network of providers that is sufficient in number and types of providers to ensure that all services will be accessible without unreasonable delay.[5] For a cancer patient – whether newly diagnosed or in active treatment – and cancer survivors, adequate access to needed providers is one of the most important components in fighting their disease. Even short gaps in coverage – or delayed access to services – can lead to significant disruptions in care for individuals with cancer and can result in negative health outcomes. That is why it is so critical that issuers offer robust networks of providers, including specialty physicians.

ACS CAN applauds HHS for reiterating that issuers will have to comply with wait time standards beginning in plan year 2024. We believe that quantitative standards like wait times are a key measure of determining the adequacy of a plan's network. HHS notes that it will review issuer attestations. We support these efforts and urge the Department to consider conducting random audits of plan attestations as well.

8. Essential Community Providers (§ 156.235)

HHS proposes to establish two additional stand-alone ECP categories: Mental Health Facilities and Substance Use Disorder (SUD) Treatment Centers. HHS also proposes to retain the requirement that a QHP network contract with at least 35 percent of the available ECP in of the plan's service areas, but also proposes to require that a QHP network have at least 35 percent of the available Federally Qualified Health Centers (FQHCs) and 35 percent of the available Family Planning Providers that qualify as an ECP in each plan's service area.

ACS CAN supports this proposal. Strong ECP in-network requirements are a critical step to improving access to care, especially given that ECPs serve as an entry point into the broader health care system and an ongoing source of care for millions of families. We support the requirement that QHPs must contract with 35 percent of available FQHCs and Family Planning Providers. These entities provide essential community-oriented primary care in areas that are underserved or lack other health care services and perform vital services including cancer screenings.

However, we urge HHS in future rulemaking to modify the ECP standards so that cancer patients have better access to specialized facilities. Currently cancer hospitals and children's hospitals (which are a primary provider of pediatric oncology services) are included within the broader ECP hospital category. As a result, these specialized facilities are often not in a QHP's network which impedes an enrollee's access.

9. Termination of Coverage or Enrollment for Qualified Individuals (§ 156.270)

HHS has long required issuers to send notices of non-payment of premiums, so that enrollees who become delinquent are aware and have a chance to avoid termination of coverage by settling their account. No timeliness requirements are currently set for issuers, which allows for the possibility of an enrollee being notified of delinquency too late – after their coverage has already been terminated. HHS proposes to explicitly require issuers to send the notice of payment delinquency promptly and without undue delay and requests comment on what a reasonable timeframe would be for sending delinquency notices.

ACS CAN supports this policy change and encourages HHS to establish the earliest timeframe that is reasonably possible – one that is the most protective of enrollees. We note that when an enrollee receives a delinquency notice, they not only have the opportunity pay their back-premiums and prevent termination, but if they are not able to do this, it also provides notice that they need to explore other coverage options. This is particularly important for enrollees who have, for example, stopped paying premiums because of a significant loss in income

[5] 42 C.F.R. § 156.230(a)(1)(i).

and lives in one of the 16 states that do not provide retroactive Medicaid coverage.[6] Even if that individual is now eligible for Medicaid, they could be responsible for medical costs while being uninsured and not even be aware of their uninsured status.

CONCLUSION

Thank you for the opportunity to comment on the Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for plan year 2024. 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.

Sincerely,

Lisa A. Lacasse, MBA
President
American Cancer Society Cancer Action Network

[6] As of December 2022, 16 states have approved waivers of Medicaid retroactive eligibility requirements, and 7 states have a pending request for such a waiver. Source: Kaiser Family Foundation. Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State. Published December 21, 2022. Accessed January 10, 2023. https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/#Table1.