January 27, 2022

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS-9911-P – Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023 Proposed Rule
87 Fed. Reg. 584 (January 5, 2022)

Dear Secretary Becerra and Administrator Brooks-LaSure:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on the 2023 Notice of Benefit and Payment Parameters (NBPP) proposed rule. 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 critical to the fight for a world without cancer.

Having comprehensive and affordable health insurance coverage is a key determinant for surviving cancer. Research from the American Cancer Society shows 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.[1] This not only impacts the more than 1.9 million Americans who will be diagnosed with cancer this year, but also the 16.9 million Americans living today who have a history of cancer.[2]

In general, we support many of the proposals contained in the 2023 NBPP proposed rule, including the proposals related to standardized benefit options, network adequacy, and clarity around discriminatory benefit designs. 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 policy hinders cancer patients' and survivors' access to medically appropriate therapies. We urge HHS to rescind the policy 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.

[1] 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.

[2] American Cancer Society. *Cancer Facts & Figures 2022.* Atlanta: American Cancer Society; 2022.

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III. Provisions of the Proposed HHS Notice of Benefit and Payment Parameters for 2023

B. Part 155 – Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act

1. Guaranteed Availability of Coverage (§ 147.104)

a. Past-due premiums

ACS CAN supports the proposal to eliminate the policy that allows insurers to refuse to enroll an applicant in a new plan if the consumer fails to pay outstanding premium debt from the prior year. This would return the agency to a policy that allows insurers to pursue collection for past-due premiums, but they cannot condition new coverage on payment of the amount due.

We share HHS' concerns that the previous policy harmed low- and moderate-income individuals who experience a sudden or unexpected financial burden associated with a serious disease like cancer. An individual in active treatment for cancer usually incurs significant out-of-pocket costs for required deductibles, copayments and coinsurance, as well as costs for services not covered by insurance. For instance, some standard insurance plans have deductibles of $2,500 or more. These additional costs may make it even more difficult for a cancer patient to pay their insurance premiums. Nearly half of all American adults report being unable to cover an emergency expense costing $400 without having to borrow or sell something to do so.[3] Individuals often need additional time in order to try to obtain funds to cover these unexpected medical costs. We congratulate HHS on recognizing that life circumstances for individuals with serious illness could negatively impact patients' ability to pay their monthly premium and protecting these enrollees' access to coverage when they need it the most.

b. Nondiscrimination based on sexual orientation and gender identity

HHS proposes restoring prior rules that prohibit discrimination in benefit design (and the implementation of benefit design) to ensure that LGBTQ people are explicitly protected from discrimination by qualified health plans, exchanges, states, insurers, agents and brokers. These nondiscrimination provisions are consistent with, but independent of, Section 1557 protections.

ACS CAN supports the removal of these discriminatory measures to restore pre-2020 nondiscrimination protections and agrees that prohibiting discrimination based on sexual orientation or gender identity can lead to improved health outcomes for this community and improve health equity. People who identify as part of the LGBTQ community disproportionately face health disparities and are at higher risk for many conditions including cancer. Research confirms that because this population has distinctive risk

[3] Report on the Economic Well-Being of U.S. Households in 2019, Featuring Supplemental Data from April 2020. Accessed April 9, 2021. https://www.federalreserve.gov/publications/files/2019-report-economic-well-being-us-households-202005.pdf.

factors and face additional barriers to accessing health care, LGBTQI+ people experience both greater cancer incidence and more late-stage diagnoses.[4,5,6]

D. Part 155 – Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act.

4. Ability of States to Permit Agents and Brokers and Web-Brokers to Assist Qualified Individuals, Qualified Employers, or Qualified Employees Enrolling in QHPs (§ 155.220)

a. Required QHP comparative information on web-broker websites and related disclaimer

ACS CAN supports the proposal to require web-broker websites to display the same qualified health plan (QHP) comparative information as healthcare.gov, including premiums, cost-sharing information, summary of benefits and coverage, the plan's provider directory, and other information. Web-brokers who are unable to satisfy this requirement must post a standardized disclaimer.

Many consumers rely on web-brokers to assist them in making plan selections. Requiring web-brokers to display the same information as is available on healthcare.gov would reduce the ability of web-brokers to steer enrollees to a particular product.

b. Prohibition of QHP advertising on web-broker websites

ACS CAN supports the proposal to prohibit web-broker non-Exchange websites from displaying QHP advertisements or otherwise provide preferential display of QHPs based on the compensation agent, brokers, or web-brokers receive from QHP issuers. Consumers should be provided information in a transparent manner. We do not believe that fee-based preferential display or advertising is in the best interests of consumers.

9. Annual Eligibility Redetermination (§ 155.335)

Currently, enrollees that remain eligible for a QHP from one plan year to the next are automatically re-enrolled in the same plan unless they make an active choice otherwise (either by choosing a different plan or by dis-enrolling from their plan). If that plan is not available, HHS uses a hierarchy to enroll the individual in a similar plan based on metal level, issuer, and product. HHS seeks comment on adding premiums, out-of-pocket costs, and plan generosity to the automatic reenrollment hierarchy.

ACS CAN recognizes the important goal re-enrollment hierarchies serve – keeping consumers – particularly those with serious conditions like cancer – insured and making it easy for them to re-enroll. We appreciate HHS' interest in adding additional factors to the reenrollment hierarchy given that enrollees have different needs with respect to their plan selection. For individuals with a history of cancer, the provider network and covered benefits are an important consideration. Switching providers or facilities could cause major disruption to their treatment. In addition, levels of cost-sharing,

[4] Quinn GP, Sanchez JA, Sutton SK, et al., Cancer and lesbian, gay, bisexual, transgender/transsexual, and queer/questioning (LGBTQ) populations. *CA: A Cancer Journal for Clinicians.* 2015;65(5):384-400.
[5] Ceres M, Quinn GP, Loscalzo M, Rice D. Cancer screening considerations and cancer screening uptake for lesbian, gay, bisexual, and transgender persons. *Seminars in Oncology Nursing.* 2018;34(1):37-51.
[6] US Department of Health and Human Services. Smoking Cessation: A Report of the Surgeon General. 2020. Access at http://www.hhs.gov/sites/default/files/2020-cessation-sgr-full-report.pdf on January 21, 2021.

particularly for drugs can be a critical component of a cancer patient's treatment. A change in plan that resulted in significantly increased out-of-pocket costs for oncology care would be incredibly disruptive and challenging for the patient in active treatment. Therefore, we support HHS' proposal to add out-of-pocket cost and plans generosity to the re-enrollment hierarchy. Additionally, we recommend that if an individual is automatically reenrolled in a plan that is materially different from their current plan, the individual should have 60 days from the start of the plan year in which to choose a different plan that better suits their needs.

10. Special Enrollment Periods – Special Enrollment Period Verification (§ 155.420)

Currently, many individuals enrolling in coverage through a special enrollment period (SEP) are required to verify their eligibility for that SEP by submitting documents pre-enrollment. HHS notes that younger individuals are less likely to successfully submit these documents and enroll – resulting in an older risk pool for these plans. Additionally, Black and African American consumers are less likely to complete this process (and therefore get coverage) than white consumers – making this a policy that further contributes to health inequities. HHS proposes that for exchanges using the federal platform, the agency would only conduct pre-enrollment verification of SEP eligibility for the loss of minimum essential coverage, which has electronic data sources that can be used for auto-verification. For state-based exchanges (SBEs), HHS proposes giving them the option to conduct pre-enrollment SEP verification processes, and to provide an exception to this requirement for special circumstances (such as natural disasters or public health emergencies).

ACS CAN strongly supports this change. For several years our organization has been concerned that pre-enrollment verification requirements caused gaps in insurance coverage because some individuals are unable to satisfy verification requirements, or do not understand the process – and therefore knowingly or unknowingly go without coverage. This is particularly concerning for persons with cancer. ACS CAN supports HHS' proposal to rely as much as possible on verification from automatically available data, as it will likely lead to fewer individuals having accidental gaps in coverage.

E. Part 156 – Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges

4. Provision of EHB (§ 156.115)

In the 2019 Payment Notice, HHS allowed states to permit issuers to substitute benefits between EHB categories. Citing stakeholder concern and the fact that to date no state has taken advantage of this flexibility, HHS proposes to eliminate the state option for between-category substitution.

ACS CAN applauds HHS for eliminating the option of states to substitute benefits between EHB categories. We were concerned that the 2019 policy would have allowed a state to set a plan that has never been offered within the state as an EHB-benchmark plan could cause significant consumer confusion, particularly to the extent that the chosen EHB-benchmark plan is less generous than that offered by the state. By eliminating this unnecessarily state flexibility, HHS is reaffirming the original intent of the state EHB benchmark standard. In announcing the policy in 2011 CMS stated that a "major advantage of the benchmark approach is that it recognizes that issuers make a holistic decision in constructing a package of benefits and adopt packages they believe balance consumers' needs for

comprehensiveness and affordability."[7] Eliminating this flexibility also addresses a concern that we raised in our comments in response to the 2019 proposal, namely that such flexibility would allow the state to adopt a less generous EHB benchmark, thus potentially exposing consumers to additional out-of-pocket costs.

5. Prohibition on Discrimination (§ 156.125)

HHS proposes to refine its existing nondiscrimination policies with "a clear regulatory framework" for nondiscrimination. HHS would require EHB benefit design—including plan limits and coverage requirements—to be based on clinical evidence. This means that plan design, coverage decisions, and exclusions by insurers that are required to provide EHB (i.e., those that offer coverage in the individual and small group markets) must incorporate evidence-based guidelines (e.g., peer-reviewed medical journals, practice guidelines, or other expert bodies).

ACS CAN supports ensuring more uniform coverage of benefits so that enrollees have more equal access to medically necessary care across different plans and insurers. We believe that federal guidance with clear examples of discrimination would be vital and beneficial. ACS CAN also supports the plan that Federal officials will monitor how EHB are delivered and whether insurers are incentivizing certain methods of delivery (e.g., telehealth) to ensure that the service delivery model does not inadvertently result in discrimination.

6. Access to prescription drugs for chronic health conditions: adverse tiering

HHS identified several specific types of plan designs that are presumptively discriminatory, including adverse tiering of prescription drugs. While HHS notes that cost is an important factor in determining tier placement of a particular drug, HHS also clarifies that "relying on cost alone is an insufficient basis to defend an otherwise discriminatory benefit design."[8] HHS notes that an issuer's EHB prescription drug benefit design must be clinically based.

ACS CAN thanks HHS for noting that more than half of U.S. adults have chronic conditions, including many with cancer, that require prescription medication. We also appreciate HHS' recognition that "placing all drugs for a high-cost chronic condition on the highest formulary tier is a presumed discriminatory benefit design, even when those drugs are costly."[9]

We urge HHS to engage in robust enforcement and oversight of prescription drug formularies to ensure they are in compliance with this standard. In reviewing plan formularies, we caution that HHS will need to engage in rigorous review, beyond conducting an outlier analysis, which would not reveal discriminatory practices if most or all plans were imposing significant cost-sharing on products to treat the same disease (like cancer).

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[7] Center for Consumer Information and Insurance Oversight, "Essential Health Benefits Bulletin" (Dec. 16, 2011).
[8] 87 Fed Reg. at 667.
[9] Id.

10. Standardized Options (§ 156.201)

Standardized Plans: HHS proposes to require QHP insurers in the federally-facilitated exchanges (FFEs) and state based exchanges using the federal platform (SBE-FP) to offer standardized plans beginning in 2023. HHS states that standard options are warranted given increases in the number of plans available to most consumers and the need to help simplify the plan selection process. Issuers would have to offer a standardized plan at every product network type and metal level, and throughout every service area where they also offer non-standardized options.

ACS CAN applauds HHS for proposing policies that seek to address the challenges of individuals who may be overwhelmed with plan options when shopping for health insurance coverage in the exchanges. 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. ASC CAN agrees with HHS that standardized plans will help accomplish this goal in the marketplaces, as this policy could allow individuals shopping for coverage to focus on certain important aspects of their health insurance plan such as plan provider networks, covered benefits, quality, and premiums. We support the proposal to require issuers offer a standardized plan when offering non-standardized plans, as this will result in more plan options being standardized and available to enrollees. We encourage the agency to move forward with this proposal, while also considering the comments below on certain details of the standardized plans.

Standardized Plan Design: HHS proposes standardized plan designs based on the most popular QHPs in the FFEs and SBE-FPs in the 2021 plan year, accommodating state cost sharing laws. In general, standardized plans would have: 1) Standard deductibles (ranging from $0 for the platinum plan and 94 percent silver CSR plan to $9,100 for the bronze plan); 2) Standard annual out-of-pocket maximums (ranging from $1,700 for the 94 percent silver CSR plan to $9,100 for the bronze plan); 3) Four-tier drug formularies; and 4) Deductible-free services (including urgent care, primary care visits, specialist visits, and some drugs).

ACS CAN supports the inclusion in these standardized plan designs of many plan benefits that are crucial to cancer patients, including primary care doctor visits, specialty care doctor visits, emergency and urgent care, inpatient hospital services, imaging and laboratory services, and prescription drugs. We have the following comments about specific elements of the plan designs:

Use of copays: We applaud HHS' emphasis on using copays instead of coinsurance in these plan designs. Copayments are more transparent to the consumer and make it easier to predict out-of-pocket costs. The ability to predict and compare costs is very important for individuals with cancer and those with chronic conditions, particularly patients who are low-income and very price sensitive.

We also support HHS' proposal to include only copayments in the standardized prescription drug formularies – using transparent copayments is particularly important for prescription drug benefits, because a patient is almost always required to pay up-front for a drug when picking it up at a pharmacy (as opposed to being billed later for services already rendered in a hospital or physician's office) and because many patients with chronic conditions rely on prescription medication on a monthly basis. We

support the use of copayments in other benefit categories frequently used by cancer patients, including primary care, urgent care, and specialist visits.

We note that other benefit categories frequently used by cancer patients – including emergency room services, hospital inpatient services, imaging services and laboratory services – are assigned coinsurance amounts in the standardized plan designs. Many of these services can be very expensive, and being required to pay a percentage of these costs – an amount that is often hard to determine for the patient – can be very unaffordable for many patients. We urge HHS, in future rulemaking, to consider requiring that all enrollee cost-sharing – regardless of the service – be required to be provided as a copayment rather than a coinsurance.

Standard formulary tiers: HHS includes four formulary tiers in every standardized plan design for coverage of prescription drugs. ACS CAN notes that some plans currently cover certain drugs with a $0 copayment as part of coverage of preventive services and/or value-based insurance designs that encourage use of drugs that prevent certain conditions from becoming worse (like covering blood pressure medications at $0 to prevent heart attacks and strokes). We are concerned that a plan that might otherwise provide some medications at $0 would be forced to charge copayments under this plan design. We encourage HHS to include an exception to these rules for $0 drugs and ensure these plan designs allow plans to comply with ACA requirements for providing preventive services at no cost-sharing.

Tier provider networks: It is unclear from HHS' proposal whether standardized plan designs may include tiered provider networks. We urge HHS to provide clarification on what constitutes a provider tier and the extent to which standardized plans are limited in the categories of provider tiers.

Number of Plans Offered: HHS asking whether, beginning in the 2024 plan year it should limit the number of non-standardized QHPs that an insurer can offer. The purpose of standardized plan designs is to limit the amount of choices enrollees must make when enrolling in a plan. ACS CAN encourage HHS to monitor the plan selection process and subsequent results in 2023 to further inform future rulemaking. We also encourage HHS to engage in extensive consumer testing – with an emphasis on populations with low health literacy – to determine if limiting the number of non-standardized QHPs would assist consumers in making the right plan selection choices for them.

11. Network Adequacy (§ 156.230)

The ACA requires all QHPs to ensure enrollees have a sufficient choice of practitioners and provide information on the availability of in-network and out-of-network providers. HHS proposes to evaluate the adequacy of an issuer's provider network offered through FFEs. But HHS would not conduct a network adequacy review in states that perform their own plan management functions, using standards at least as stringent as the federal standards. HHS proposes to use time and distance standards, calculated at the county level. Maintaining an adequate plan network helps to ensure that cancer patients are able to access to providers needed to treat their condition.

QHP certification process: ACS CAN supports HHS' proposal to independently assess the adequacy of a plan's network and applaud HHS for adding this requirement as part of the QHP certification, which means that HHS' oversight will occur before a plan is approved to market to consumers. Such prior approval – using previously established quantitative standards – will help to ensure that access problems are addressed in advance of the product being sold and utilized by consumers.

Quantitative standards: We support HHS' intent to apply quantitative standards – including time and distance standards – to ensuring the adequacy of a plan's network. We also appreciate that HHS intents to adopt appointment wait time standards as another way to assess the adequacy of a plan's network. While the specific wait time standards will be conducted through future guidance, we urge HHS to adopt an appointment wait time standard for Specialty Care (Non-Urgent), such as oncology care, in addition to the proposed provider specialty list for appointment wait time standards.[10] In addition to the QHP certification review, we urge the Department to conduct ongoing review of plan network adequacy – including the monitoring of the use of a plan's appeals process – to ensure that plans are meeting their network adequacy requirements throughout the plan year.

Tiered networks: We applaud HHS for requiring that for plans using tiered networks, only those providers who are included in the lowest cost-sharing tier will be counted for purposes of a plan's network adequacy. This policy allows a plan to offer a robust provider network, but also ensures that individuals have access to an adequate plan network without having to incur higher cost-sharing depending on the type of provider they need.

Telehealth: HHS proposes to require that all QHP issuers to FFEs submit information about whether network providers offer telehealth services. This information is intended to be used for informational purposes. We support the use of telehealth services as an alternative means of provider-patient communication, when appropriate. At the same time, we appreciate HHS' clarification that telehealth services should not be counted in place of in-person services for purposes of network adequacy standards.

12. Essential Community Providers (§ 156.235)

HHS is proposing to amend it Essential Community Providers (ECP) standard to ensure that plan networks contract with more ECPs . Specifically, HHS is proposing that the required ECP provider participation standard be raised from the current 20 percent to 35 percent of available ECPs.

ACS CAN applauds HHS for increasing the required number of ECPs with whom a plan must contract. As HHS is aware, ECPs such as community health centers largely serve underserved and vulnerable communities and increasing the ECP standard will ensure that more community health centers will be included in QHP's networks. We are particularly pleased HHS has clarified that for plans that use tiered networks, the issuer must include only those ECPs included in the lowest cost-sharing tier. This clarification improves enrollees' access to ECPs. Without this important clarification, enrollees who wished to have access to a broad range of ECPs could face higher cost-sharing, depending upon the provider tier in which the ECP was placed.

19. Solicitation of Comments – Choice Architecture and Preventing Plan Choice Overload

HHS notes its concern about plan choice overload in which consumers have too many plan options on an Exchange. An overwhelming number of choices can create confusion for consumers and can lead to poor enrollment decisions. HHS solicits comments on whether it should limit the number of non-standardized plans each issuer can offer.

[10] See Table 20. 87 Fed. Reg. at 683.

While consumers benefit from having a choice of plan offerings, too many options can hinder an individual's ability to make an informed choice. At the same time, imposing an arbitrary limit on the number of plan offerings an issuer is permitted to offer in some cases could be detrimental to consumers. We support restoring the "meaningful difference" standard that would allow consumers to better differentiate between plan offerings.

CONCLUSION

Thank you for the opportunity to comment on the 2023 Notice of Benefit and Payment Parameters proposed rule. 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