CANCER SUPPORT COMMUNITY
COMMUNITY IS STRONGER THAN CANCER

January 27, 2022

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

The Honorable Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-9911-P, P.O. Box 8016
Baltimore, MD 21244-8016

Dr. Ellen Montz
Deputy Administrator and Director
Center for Consumer Information and Insurance Oversight
Department of Health and Human Services

Re: Patient Protection and Affordable Care Act; *HHS Notice of Benefit and Payment Parameters for 2023 Proposed Rule*; CMS-9911-P, RIN 0938-AU65

Dear Secretary Becerra, Administrator Brooks-LaSure, and Director Montz,

The Cancer Support Community (CSC), an international nonprofit organization that provides support, education, and hope to cancer patients, survivors, and their loved ones, appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule, Patient Protection and Affordable Care Act (ACA); Health and Human Services (HHS) Notice of Benefit and Payment Parameters for 2023 (hereinafter NBPP 2023 Proposed Rule). As the largest provider of social and emotional support services for people impacted by cancer, CSC has a unique understanding of the cancer patient experience. In addition to our direct services, our Research and Training Institute and Cancer Policy Institute are industry leaders in advancing the evidence base and promoting patient-centered public policies.

Equitable and Timely Access to Care

CSC supports and advocates for policies that improve equitable, timely, and affordable access to comprehensive, high-quality health care and coverage. It is imperative that all people impacted by cancer and other health conditions have an opportunity to achieve their best health outcomes, no matter who they are or where they live. Despite cancer innovations in diagnostics and therapeutics and decades of federal initiatives challenging health disparities, cancer care disparities persist in every aspect of care. For instance, Black women have a 7% lower risk of cancer diagnosis but a 13% risk of cancer death, and Black men have higher incidence and death rates than white men for all cancers combined (DeSantis et al., 2019). On the issue of timeliness, cancer screenings and continuity of cancer care is critical to ensuring patients' health and well-being. Any delays or disruptions to care threatens outcomes for patients. The NBPP 2023 Proposed Rule contains several provisions addressing patients' access to equitable and timely care, and we provide comments on several of them below.

Guaranteed availability of coverage (§ 147.104).
The NBPP 2023 Proposed Rule reinterpret the provision on guaranteed availability of coverage to prohibit insurers from denying coverage to individuals and employers with past-due premiums. Guaranteed coverage will help promote continuous, timely care for people impacted by cancer and, as HHS acknowledges in the NBPP 2023 Proposed Rule, this reinterpretation will help reduce barriers to coverage that disproportionately impact people with lower incomes. By promoting continuity of coverage, patients will be able to achieve better health outcomes at lower costs to themselves and the health care system (Brill, 2020).

Nondiscrimination on the basis of sexual orientation and gender identity (Part 147) (§§ 147.104(e), 155.120(c), 155.220(j), 156.125(b), 156.200(e), and 156.1230(b)).
People in the LGBTQ community confront discrimination in both accessing health coverage and in receipt of care (Quinn, et al., 2015; Mirza & Rooney, 2018). The discrimination and its consequences are so far reaching and detrimental to the health of LGBTQ people, especially those with chronic conditions, that in 2020 CSC and other patient advocacy organizations joined an amici curiae brief to raise awareness of the need to keep in place the protections Congress adopted in Section 1557. The NBPP 2023 Proposed Rule's prohibition of exchanges, insurers, agents, and brokers discriminating based on sexual orientation and gender identity aligns with Congress' intent under the ACA to prohibit regulations that create unreasonable barriers for people to access appropriate, timely, and well-informed care (Patient Protection and Affordable Care Act of 2010).

Nondiscrimination policy for health plan designs (§ 156.125). One goal of the ACA was to end insurance companies discriminating on the basis of health status (Pollitz, 2020). While the ACA has sought to redress discrimination against people with pre-existing conditions, insurers have continued to use benefit design and burdensome utilization management tools to prevent people with health conditions such as cancer from accessing appropriate care (Guo E., et al., 2017). We appreciate confirmation that an insurer does not provide essential health benefits (EHBs) if its benefit design or the implementation of its benefit design discriminates based on an individual's age, expected length of life, presented or predicted disability, degree of medical dependency, quality of life, or other health conditions. The provision establishing that a nondiscriminatory benefit design providing EHBs is clinically-based, incorporates evidence-based guidelines into coverage and programmatic decisions and relies on current relevant peer-reviewed medical journals, practice guidelines, recommendations from reputable governing bodies, or similar sources will help curb back-door discrimination against people with health conditions. By recognizing that benefit design can be used as a means to discriminate and designating adverse tiering as an example of a presumptively discriminatory benefit design, HHS has established an important starting point for patients who have experienced discriminatory tiering. We note that the NBPP 2023 Proposed Rule includes adverse tiering as one example of discrimination in benefit design, or implementation of benefit design. Later in our comments on insurers' use of copay accumulator adjust programs we will revisit the provision on discriminatory benefit design and urge the application of this provision to prohibit copay accumulator adjustment programs as discriminatory against people with chronic health conditions. To help guard against the perpetuation of inequities in the health care system, we urge HHS to ensure the evidence-based guidelines, practice guidelines, etc. used to determine nondiscriminatory benefit design incorporate data, including patient experience data, that is derived from a diverse and representative patient population.

Network Adequacy (§ 156.230). Evaluating networks of Qualified Health Plans (QHPs) and potential QHPs within Federally Facilitated Exchanges (FFEs) pre- and post-certification with regard to time and distance standards, appointment wait times standards, and tiered network standards will help improve equitable and timely access to high quality health care. HHS should require states to use the same standards in their evaluation and review of State Based Exchanges (SBEs). For both FFEs and SBEs, while not requiring as a standard, it would be beneficial for networks of QHPs to include if they are

accessible by public transportation, the type of public transportation, and its proximity to the provider or facility. Also, because a cancer diagnosis is often accompanied by a diagnosis of anxiety or depression (Mausbach, B.T. et al., 2018; Niedzwiedz, C.L. et al., 2019), we support including behavioral health providers that address the psychosocial well-being of cancer patients and their caregivers in the specialty list of providers. Expanded coverage of telehealth and tele-mental health services during the COVID-19 public health emergency has enabled cancer patients to see providers from the safety of their homes and ensure continuity of care when in-person care was either not available or presented heightened risk for people vulnerable to a poor outcome from exposure to the virus. Beyond the public health emergency, telehealth and tele-mental health will continue to provide an important means of receiving care, especially for cancer patients and others with serious illness for whom travel to a provider's office or facility may be too burdensome or present potential health hazards. We support HHS's proposal to require all insurers seeking certification of plans to be offered as QHPs through the FFE to submit information about whether their network providers offer telehealth services. We urge this requirement be expanded to explicitly include tele-mental health and for providers to specify if they provide *audio only* telehealth and tele-mental health which is important to address issues of health equity, including rural health, and non-discrimination against people with disabilities. To guard against unnecessary delays in providing patients access to telehealth and tele-mental health services, we encourage a timely deadline for the submission and consideration of the information.

Quality standards: quality improvement strategy (§ 156.1130)
Affirmative and meaningful steps must be taken to identify, address, and redress the long-standing inequities that are entrenched in our health care system. We support the NBPP 2023 Proposed Rule requiring all QHPs with at least two consecutive years in a market to include in their quality improvement strategies (QIS) at least one payment structure that provides financial incentives for activities aimed at reducing health and health care disparities. Members of the communities that have experienced disparities should be engaged from the outset in identifying the causes of disparities, developing the activities proposed to reduce them, and establishing the measures against which success is determined.

Affordable Access to Care
While the importance of equity and timeliness cannot be overstated, absent affordability, access to care can neither be equitable nor timely. CSC and numerous other patient advocacy organizations looked to the NBPP 2023 Proposed Rule to ban copay accumulator adjustment programs (CAAPS) which make medications necessary to treat serious health conditions unaffordable and inaccessible for many patients. **We are extremely disappointed that the current NBPP 2023 Proposed Rule fails to ban CAAPS and we urge CMS to include a provision in the final rule that requires insurers and Pharmacy Benefit Managers (PBMs) to count all copayments made by or on behalf of an enrollee toward the enrollee's annual deductible and out-of-pocket limit.**

Standardized Benefit Plans

CSC strongly support the proposal to reinstate standardized benefit plans with flat dollar copayments instead of cost-sharing for specialty prescription drugs. We urge HHS to make these copayments pre deductible for all (as compared to many) of the metal levels.

Standardized benefit plans will help simplify the process of selecting a plan and help improve affordability and predictability for many enrollees. However, for cancer patients and others with serious health conditions who require specialty medications to treat their condition, the proposed copay amounts in the standardized plan provision – beginning at $150 and rising to $350 per fill – are still too high. Since many people with cancer also have co-morbidities (Pirschel, 2017), the cost to fill their cancer medication may well not be the only drug copayment they must incur on an ongoing basis.

While certainly less expensive than needing to first pay a deductible potentially in the thousands of dollars before being able to access a needed prescription medication, less expensive is not synonymous with affordable. Research shows that when the cost to fill a prescription reaches $250, 70% of patients will not fill it. Even when the cost of a prescription drug drops to $125, 55% of patients will still choose to leave it unfilled (IQVIA, 2019). With the maximum annual out-of-pocket limit on cost-sharing (charged post-deductible by most plans) for 2023 proposed to be $9,100, people with chronic conditions will continue to incur high out-of-pocket expenses to adhere to their treatment regimen. To help ensure cancer patients and others with serious chronic health conditions are also able to benefit from standardized health plans, copay assistance must count toward the deductible and out-of-pocket limit *and* all copayments for specialty drugs must be pre-deductible to facilitate timely access to medications.

The Role of Copay Assistance

In addition to the reasons explained above for why copay assistance and its application to a patient's deductible and out-of-pocket limit is necessary to ensure people with serious chronic health conditions can afford medications even with standardized health plans in place, the proposed standardized health plans are not applicable to all health plans. With patients bearing more of the costs of health care coverage and care than ever before through higher premiums, deductibles, cost-sharing, and expenses incurred from utilization management techniques (the maximum out-of-pocket for 2023 is $9,100), cancer patients and others requiring medication on an ongoing basis to treat their health condition cannot afford the high cost of their prescription drugs and rely on copay assistance to treat their condition. Patients' inability to adhere to a treatment regimen costs the health care system between $100 - $289 billion a year (Boylan, 2017).

Insurer Double Dipping

Copay assistance neither lowers the cost of the prescription medication nor lessens the amount received by the insurer. When a copay accumulator adjustment program is in place, the insurer accepts the assistance paid on the patient's behalf treating it as a windfall in lieu of applying it toward the plan's deductible or maximum out-of-pocket limit. This scenario subverts the patient protections of the ACA by allowing insurers and PBMs to collect in excess of the established annual out-of-pocket limits for covered health care services.

Discriminatory Benefit Design

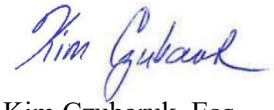
Earlier in these comments we noted that we would revisit the issue of discriminatory benefit design or implementation of benefit design in connection with copay accumulator adjustment programs. A plan's deductible and maximum out-of-pocket limit is an integral part of its benefit design and the health care services it provides to its enrollees. Insurers who implement a copay accumulator adjustment program do so with the explicit intent to facilitate receipt of funds paid for by another on behalf of the plan's enrollee to avoid having to apply those funds to the deductible or maximum out of pocket under the plan's benefit design despite the requisite amount of money required under the plan design having been received by the

insurer in return for the enrollee receiving the medication. Since copay assistance is generally only provided to people with certain serious, complex health conditions, implementation of a copay accumulator adjustment program to alter the mutual reciprocity under the benefit design only for enrollees relying on copay assistance constitutes discriminatory implementation of the benefit design against people living with chronic health conditions.

Conclusion

The Cancer Support Community appreciates the opportunity to share these comments and we look forward to working with the HHS, CMS, and CCIIO to promote policies that improve equitable, timely, and affordable access to comprehensive, high-quality health care and coverage. Should you have any questions or would like to discuss these comments in more detail, please reach out to Kim Czubaruk at kczubaruk@cancersupportcommunity.org.

Sincerely,



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