

CANCER LEADERSHIP COUNCIL

A PATIENT-CENTERED FORUM OF NATIONAL ADVOCACY ORGANIZATIONS
ADDRESSING PUBLIC POLICY ISSUES IN CANCER

February 25, 2014

The Honorable Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Ms. Tavenner:

The Cancer Leadership Council, representing cancer patients, health care professionals, and researchers, appreciates the opportunity to comment on the 2015 Letter to Issuers in the Federally-facilitated Marketplace (FFM). We are pleased that some of the standards for certification of health plans as qualified health plans (QHP) have been modified from 2014 in a manner that is responsive to the needs of individuals with cancer and other serious and life-threatening illnesses.

We have comments on several of the standards for plan certification, some of which could be strengthened to ensure that qualified health plans provide adequate coverage for all, including cancer patients.

As requested in the Letter to Issuers, we have organized our comments according to the chapter and section of the letter.

Chapter 2, Section 3. Network Adequacy

We commend the decision of the Centers for Medicare & Medicaid Services (CMS) to establish a process for determining network adequacy that does not rely on plan accreditation and state review. We support the decision of CMS to undertake a "reasonable access" review of the lists of network providers and facilities submitted by issuers. The special focus on oncology providers, mental health providers, hospital systems, and primary care providers is also appropriate, but the network adequacy review cannot stop with these providers. Cancer patients are obviously most concerned about the adequacy of oncology provider networks, but they are also mindful of the need for adequate networks in the other areas of focus identified by CMS and beyond. Such provider networks are of critical importance to assure access to high quality, multi-disciplinary care that addresses not only cancer treatment but also symptom management across the continuum of the cancer experience.

Children with cancer and adults who are diagnosed with rare cancers may find that their only appropriate care options are in children's hospitals or cancer centers. As part of the network adequacy and essential community provider review, we urge CMS to consider network adequacy standards that would protect these vulnerable patients, essential community provider designations for children's hospitals and cancer centers, and out-of-network provider access that is timely and accompanied by cost-sharing protections.

We also note that CMS "intends to use information learned during the network adequacy review process to assist in its articulation of time and distance or other standards for FFM QHP networks that CMS intends to reflect in future rulemaking." We strongly support this process of review and refinement of network standards, which over time should achieve the appropriate balance between network access and cost. The creation of a search engine function for consumer searches for particular providers and provider types is especially important to cancer patients, including those with rare cancers who may need access to out-of-network providers.

We note that the Office of Personnel Management (OPM), in its Multi-State Plan Program Issuer Letter of February 4, 2014, has stated that multi-state plan (MSP) issuers:

"...must have in place a process to provide timely exceptions to ensure that consumers who need care from out-of-network providers (because of rare or complex medical conditions or lack of in-network providers in a geographic area) can receive it with reasonable cost-sharing, applying enrollee costs to the in-network out-of-pocket maximum, and protection from balance billing."

It is likely that cancer patients with rare or difficult-to-treat cancers will find themselves in the position that OPM describes in its Issuer Letter. We urge CMS to consider a requirement for QHP issuers that is comparable to the requirement OPM proposes for MSP issuers. The cost-sharing protections proposed by OPM will be essential to making care out-of-network a realistic possibility for cancer survivors, an important protection when out-of-network care may represent the best, or even the only, treatment option for certain cancer patients.

Chapter 3, Section 1. Discriminatory Benefit Design: 2015 Approach

The proposed CMS outlier analysis, which will compare benefit packages with comparable cost-sharing structures to identify cost-sharing outliers, will strengthen the agency's analysis of plans and provide more information about possible discriminatory benefit designs that should be corrected. We agree with the recommendation of CMS that the outlier analysis should begin with (but not be limited to) inpatient hospital stays, inpatient mental/behavioral health stays, specialist visits, emergency room visits, and prescription drugs.

The decision to review plans for outliers based on "an unusually large number of drugs subject to prior authorization and/or step therapy requirements in a particular category and class" and to require revisions of possibly discriminatory practices is a positive

development for cancer patients for whom quality treatment may require access to a wide range of prescription drugs, including combination therapies and a number of different drugs in a single class over the course of cancer treatment.

Although the standards for reviewing plans are stronger than in 2014, we note that CMS has not clearly defined discriminatory benefit design. Such a definition is critical to making plan reviews rigorous.

Chapter 3, Section 2. Prescription Drugs

CMS proposes that issuers be permitted to indicate whether a drug is a “medical drug” covered under a plan’s medical benefit or a drug covered under the prescription drug benefit. The agency indicates that this will provide clarity regarding how drugs are covered and will also permit issuers to include medical benefit drugs in meeting the requirement for coverage of one drug in every United States Pharmacopeial Convention (USP) category or class or the same number of prescription drugs in each USP category and class as the state’s essential health benefit-benchmark plan. We are very concerned that this proposal would permit issuers to consider medical benefit drugs and prescription benefit drugs in meeting formulary adequacy standards. Allowing issuers to meet formulary standards in this way could limit access to cancer therapies that are provided incident to a physician’s service and also hinder access to the most appropriate therapy for cancer patients. If this policy is implemented, we urge that the reviews that are undertaken to protect against discriminatory benefit design take into account this new means of listing drugs for the purpose of determining formulary adequacy.

Because CMS will permit but will not require issuers to identify prescription benefit drugs, consumers will not necessarily be able to compare medical benefit drug coverage across plans.

We are pleased that CMS will require issuers to provide a URL link that will direct consumers to an up-to-date formulary where they can view covered drugs, tiering, and cost-sharing for a given QHP. For those consumers who are already diagnosed with cancer, the availability of up-to-date formulary information will permit them to make informed plan choices. Those who are diagnosed with cancer AFTER making a plan choice will obviously not benefit from formulary information in the same way. The situation of those diagnosed after choosing a plan serves as a reminder of the need for protections to ensure that formularies are adequate to meet the needs of those with serious and life-threatening illnesses who need timely access to pharmaceuticals. In addition, the formulary comparisons will be hindered if some issuers identify medical benefit drugs and others do not.

CMS has stated that it will propose by rulemaking that issuers provide transitions in drug coverage as well as coverage transitions for other types of care, including continuity of access to specialists for individuals in the midst of a course of cancer treatment. In the letter to issuers, CMS suggests a standard for coverage of a “transitional fill” of non-formulary drugs to new enrollees in a health plan. We will comment on the proposed

rule that addresses transitions in care, providing more detail about the length and nature of transitions that are necessary to ensure continuity of care for cancer patients. We note that the proposal from CMS for transitional fills and access to specialists will not address issues of care continuity unless patients are notified that the care they are receiving is transitional and that they must initiate an exceptions process immediately to prevent disruptions in care after the transitional period.

Continued access to cancer specialists and to cancer medications, which are not readily interchangeable and are often prescribed according to an individual's tumor and molecular profile, may help patients complete their course of treatment and achieve better outcomes. Preventing interruptions in care is of critical importance to cancer patients, and steps must be taken to ensure that the CMS proposal does not simply delay disruptions in care.

Chapter 3, Section 7. Coverage of Primary Care: 2015 Approach

We encourage CMS to move forward with rulemaking that would require plans, or at least one plan at each metal level per issuer, to cover three primary care office visits prior to meeting any deductible. We believe that this coverage standard would contribute to improvements in survivorship care for cancer patients, including but not limited to young adult cancer survivors. Regular monitoring of the late and long-term effects of cancer treatment and interventions to address those effects are critically important, yet some survivors delay this care. Ready access to primary care may positively influence utilization of such survivorship services.

Chapter 6, Section 1. Provider Directory

We support the requirement that qualified health plans make their provider directories available to consumers. We urge that the directories provide up-to-date information, so that consumers can make decisions about providers with assurance that they are relying on accurate data about network status of those providers. These decisions have important financial implications, and there should be no delays in updating the information in the directories.

Chapter 6, Section 2. Complaints Tracking and Resolution

The letter to issuers clearly establishes expectations for QHP performance related to the investigation and resolution of consumer complaints. The letter establishes that complaints received directly from consumers, complaints forwarded by the state, and complaints forwarded by CMS through the Health Insurance Casework System must be promptly resolved. In addition to articulating complaint resolution standards, CMS has

stated that it will track complaints and use aggregated data about complaints to enhance oversight of federally-facilitated marketplaces. We applaud this effort, which will contribute to improvement of QHPs over time.

We appreciate the opportunity to comment on the letter to plan issuers for 2015.

Sincerely,

Cancer Leadership Council

American Society for Radiation Oncology
American Society of Clinical Oncology
Bladder Cancer Advocacy Network
CancerCare
Cancer Support Community
The Children's Cause for Cancer Advocacy
Coalition of Cancer Cooperative Groups
Free to Breathe
International Myeloma Foundation
Leukemia & Lymphoma Society
LIVESTRONG Foundation
Lymphoma Research Foundation
National Coalition for Cancer Survivorship
Ovarian Cancer National Alliance
Pancreatic Cancer Action Network
Prevent Cancer Foundation
Sarcoma Foundation of America
Us Too International Prostate Cancer Education and Support Network