

# CANCER LEADERSHIP COUNCIL

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

November 27, 2017

The Honorable Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
200 Independence Avenue, SW

Re: Comments on Notice of Benefit and Payment Parameters for 2019 Proposed Rule, CMS 9930-P

Dear Administrator Verma:

The undersigned organizations represent cancer patients and health care professionals. We share the goal of a cancer care system that provides high-quality and affordable care to all. Our individual organizations fund cancer research, provide a wide range of educational and patient services to those living with cancer, engage in cancer care quality improvement efforts, and represent stakeholders in the cancer community in advocating for access to quality cancer care.

People who are diagnosed with cancer often need complex, multi-disciplinary care. Treatment for cancer may include surgery, radiation therapy, and drug therapy. People with cancer often experience a wide range of treatment side effects that must be addressed. In addition, cancer patients increasingly confront “financial toxicity” caused by the heavy financial burden they shoulder for their care.

New cancer treatment options, including but not limited to immunotherapies, are providing significant benefits to cancer patients. In addition, many exciting new therapies are in the research and development pipeline. However, these treatments will only make a difference for those with cancer if patients have timely access to them through high-quality and affordable insurance.

We appreciate the opportunity to comment on the proposed Notice of Benefit and Payment Parameters for 2019, an important step in defining what qualified health plan options patients will have access to in that year. We focus our comments on the

portions of the proposal related to essential health benefits, network adequacy, and navigators.

### ***Options for States to Develop “Essential Health Benefits”***

The proposed rule suggests that states need more flexibility in how they meet the Affordable Care Act (ACA) requirement that health insurers in the individual and small group markets cover at least ten essential health benefits (EHB) to the extent that they would be covered under a typical employer plan.

The proposal changes the definition of a typical employer plan to 1) a small or large employer plan solid in one or more states with enrollment of at least 5,000 enrollees, or 2) a self-insured group health plan sold in one or more states with enrollment of at least 5,000 enrollees. But the more significant proposal is the process for states to select an EHB benchmark plan. The states have these options:

- States could maintain their current 2017 EHB-benchmark plan.
- States could select any of the 50 EHB-benchmark plans used by other states in 2017.
- States could replace one or more EHB categories from another state’s 2017 EHB-benchmark plan. A state could replace any of the ten required EHB categories in its 2017 EHB-benchmark plan with the same category or categories from another state’s 2017 EHB-benchmark. For example, the state could choose a prescription drug benefit from one state’s benchmark, maternity care benefits from another state’s benchmark, and the hospitalization benefits from a third state’s benchmark.
- States could select a new EHB-benchmark plan so long as the plan is equal in scope to a typical employer plan and is no more generous than the most generous comparison plan. The comparison plans are the state’s 2017 EHB-benchmark plan and the state’s largest small group health plans by enrollment.

We are concerned that the flexibility that would be granted to the states in selection of the EHB benchmark plan will result in plans that are inadequate to meet the needs of many, including those with cancer. If it is the aim of the state to define a narrow benchmark, we believe it could easily construct such a plan by carefully choosing different benefit categories from different states to achieve a benchmark with limited benefits.

We are concerned that much less generous benchmarks could be the result in 2019, and that means that cancer patients may see plan choices in that year that are inadequate for their complex health care needs. The costs that consumers would bear for care not covered by the plan would not, with one exception, be counted toward their out-of-pocket limits. We are pleased that the proposed rule provides that all drugs will be

considered essential health benefits, which means that the costs associated with them will count toward the annual limits on cost-sharing. This would apply in those situations where a plan's drug coverage exceeds that of the benchmark. This is an important protection but not an adequate protection from crippling cost-sharing for people with cancer.

The drafters of the proposed rule concede that patients with significant health care needs may not have coverage for certain services, depending on the choices of states regarding their benchmark plans. We think cancer patients will be among those who will suffer from more limited benchmark plans in 2019. We strongly urge the Centers for Medicare and Medicaid Services (CMS) to retain the current standards for benchmark choices, which give states ten choices of plans for benchmarks, including seven that are state-specific and three others that are the largest three national Federal Employees Health Benefits Program plan options by enrollment. The current system gives states considerable flexibility. The proposed rule would significantly increase state flexibility, but at the potential expense of patients relying on comprehensive coverage for their care.

### ***Federal Default Definition of EHB***

The proposed rule identifies a "federal definition of EHB" as a matter for future consideration. A federal EHB definition is not discussed at length in the proposed rule. We look forward to the opportunity to provide input on a federal EHB definition, keeping in mind the needs of cancer patients with significant health care needs. We recommend, as we have above, that the current standards for benchmark plan choice remain in effect while other approaches, including a federal definition of EHB, are considered. We are certainly not endorsing a federal EHB definition in the absence of details about such definition, but we look forward to further discussion about this concept.

The limited information in the proposed rule about a federal EHB definition includes mention of a national benchmark plan standard for prescription drugs. We are concerned that this could be implemented as a national formulary accompanied by strict utilization controls.

We have concerns about a limited formulary that would create obstacles to cancer patient access to drugs, including targeted therapies. At a time when cancer treatments are increasingly targeted or even personalized, a limited formulary poses substantial challenges for prompt patient access to those drugs.

We appreciate that the concept of a national benchmark plan standard for prescription drugs is identified for future consideration and discussion. We will, at the appropriate time, provide additional insights about the potential impact of formulary limits on cancer patients.

### ***Network Adequacy***

The proposed rule would continue the certification approach for network adequacy and essential community providers that CMS adopted in the Market Stabilization rule. According to this approach, states would have responsibility for review of network adequacy if they have authority to enforce standards that are at least equal to the “reasonable access standard” defined in federal regulations. In states unable to conduct network adequacy reviews, CMS would permit insurers to rely on accreditation.

We are concerned that the approach that permits state deference without any federal oversight will result in restrictive networks that will be inadequate for people with serious health care needs that require multi-disciplinary specialty care.

We recommend instead that quantitative standards of time and distance be combined with qualitative standards for assessing access to specialty care. In addition, there should be a rapid and neutral dispute resolution process for addressing patient requests for out-of-network care. Finally, out-of-pocket costs for out-of-network care should be counted toward out-of-pocket maximums. These standards could be utilized in a system that defers generally to the states but retains a layer of federal oversight.

Cancer patients often receive care in cancer care settings near home, but there are also often occasions when patients, including those with rare or difficult-to-treat cancers, need care at cancer centers or providers that are not in-network. We urge that network adequacy be reviewed according to qualitative and quantitative standards and that strong patient protections be available for those patients whose best treatment option is out-of-network.

### ***Out-of-Pocket Maximums***

The proposed rule would increase the out-of-pocket maximums to \$7,900 for individual coverage and \$15,800 for family coverage, the largest single-year increase since the maximums were implemented in 2014. These maximums will pose a serious burden on cancer patients, and their impact is exacerbated by the fact that certain out-of-pocket spending, including for out-of-network care, is not counted toward the maximums.

## ***Navigators***

The proposed rule makes two significant changes in the standards for navigators. First, the proposal eliminates the requirement that at least one navigator be a community and consumer-focused nonprofit group. Second, the proposed rule would eliminate the requirement that a navigator maintain a physical presence in the exchange service area to provide in-person support.

We do not support these changes. Although we understand that most services can be provided via phone and online, we strongly believe that there should be a requirement for in-person services when consumers need that special assistance. We also believe that the combination of a consumer-based organization and other navigator entities (a chamber of commerce, professional organizations, and trade associations) is preferable to a system that eliminates any consumer-focused organizations.

Thank you for the opportunity to comment on the proposed rule.

Sincerely,

### **Cancer Leadership Council**

*CancerCare*  
Cancer Support Community  
The Children's Cause for Cancer Advocacy  
Fight Colorectal Cancer  
International Myeloma Foundation  
**LIVESTRONG**  
Lymphoma Research Foundation  
National Coalition for Cancer Survivorship  
Prevent Cancer Foundation  
Sarcoma Foundation of America  
Susan G. Komen