



March 7, 2017

The Honorable Dr. Thomas Price  
Secretary  
U.S. Department of Health & Human Services  
Room 445-G, Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, DC 20201

**Re: Patient Protection and Affordable Care Act; Market Stabilization**

Dear Secretary Price:

The Leukemia & Lymphoma Society (LLS) believes that stabilizing the exchange market is an important step toward providing more comprehensive, accessible care for patients. LLS serves the needs of blood cancer patients by working to find cures for leukemia, lymphoma, Hodgkin's disease, and multiple myeloma, and by ensuring that blood cancer patients have sustainable access to quality, affordable, coordinated healthcare. We share the Centers for Medicare & Medicaid Services' (CMS') goal of improving the stability of the exchange. We also appreciate CMS' interest in receiving stakeholder perspectives about the impact of policies included in this proposed rule, and we appreciate the opportunity to offer the following comments.

While we commend CMS on its efforts to stabilize the market and promote active participation among issuers, we are disappointed that this proposed rule does not go far enough to address the instability in the exchange market, and we are concerned that, if finalized without substantial changes, the rule could further destabilize the market that it is intended to bolster. In particular, we believe that for the exchanges to be viable in the long-term, the individual mandate should be retained and enforced. In addition, we recommend that steps be taken to ensure that risk is accurately calculated and that plans are appropriately compensated for providing care to the sickest patients, such as those with blood cancers. Unfortunately, the proposed rule does not include meaningful steps to ensure that the structure of the market creates incentives for plans to offer reasonably priced, comprehensive care, and we recommend that CMS take action to improve both the reinsurance program and its approach to risk corridor payments.

We are also concerned that the result of CMS' proposed course of action will not be the higher quality, more affordable care that the Administration has promised patients. The ongoing debate over the future of the Affordable Care Act (ACA), and the possibility that it will be repealed without a replacement plan in place has left many patients afraid that they will lose the access to the coverage and the consumer protections upon which they depend. While we recognize the agency's efforts to mitigate some issuer concerns, LLS believes that this is an opportunity for CMS to use this rule as a vehicle to increase the value of coverage in the exchanges. If

consumers can count on plans that are both affordable and high-quality in the exchanges, more of them overall will be more likely to seek coverage in the individual market.

To get the care they need, cancer patients must have access to meaningful health insurance coverage. Their lives quite literally depend on it. For many cancer patients, even a short interruption in their coverage can have dire consequences for their treatment and their outcomes. We hope for a clear and unambiguous statement from the Trump Administration that the President will veto any legislation that repeals the ACA without replacing it with a plan that will guarantee access, ensure quality, promote affordability, and provide stability. Such a statement would reassure both consumers interested in purchasing individual market coverage, as well as insurers offering or considering offering coverage to exchange customers—increasing stability and viability of exchange markets.

### **Network Adequacy (§ 156.230) and Essential Community Providers (§ 156.235)**

LLS recommends that CMS reconsider its plan to take a reduced role in regulating network adequacy. Access to robust provider networks that provide meaningful choice across the full range of providers and facilities is essential for patient access. In particular, blood cancer patients have limited treatment options and often need at least occasional access to specialty providers and facilities offering expertise in blood cancer diagnosis and treatment, such as National Cancer Institute (NCI) Designated Cancer Centers or transplant centers.

We are concerned that CMS' proposal to rely on state network adequacy reviews, combined with the proposed reduction in essential community provider requirements, will lead to narrower networks, further loss of choice for all consumers and, for blood cancer patients, further erode access to in-network cancer specialists, thereby increasing out-of-pocket costs and limiting treatment options. Access to appropriate specialty care ensures that blood cancer patients have the best possible chance of being diagnosed correctly and immediately put on a suitable treatment plan, which not only gives patients the best chance of successfully fighting cancer but also reduces the likelihood that they will waste valuable time and resources on treatments that are either unlikely to or will not succeed.

In addition, while some states have pursued innovative policies to promote network adequacy, LLS believes that the federal government's reliance on state reviews will result in vast discrepancies in access across the country; yet, patients' access to robust networks should not be contingent upon the state in which they live. LLS continues to believe that the federal government should define and implement guardrails to ensure adequate networks, establish and manage a coherent exemptions process, and ensure that consumers have the information that they need to make the best choices about their care.

If states will be expected to take the lead in setting network adequacy policy and enforcing compliance with those rules, LLS believes that CMS ought to provide the resources and tools that the states will need to monitor network adequacy. Further, LLS believes that CMS ought to ensure the availability of tools and resources that will enable consumers across the country to access clear and comprehensive information about network adequacy so that they can make the best choices about their care. Greater network adequacy transparency is in the interest of patients and can promote competition within the marketplace.

## **Levels of Coverage (Actuarial Value) (\$156.140)**

We have several concerns about the proposed changes to Actuarial Value (AV) standards. Most importantly, we are concerned that CMS' proposal will increase consumers' out-of-pocket exposure, potentially without commensurate reductions in premiums. The Trump Administration has identified lowering deductibles and reducing cost sharing as critical to consumers. Patients are already experiencing high out-of-pocket costs: recent analysis of 2017 QHPs shows that the average combined deductible for silver plans is \$3,703, a 20 percent increase from 2016, and that half of silver plans charge more than 30 percent coinsurance for specialty drugs.<sup>1</sup> We are concerned that allowing greater flexibility could lead to a "race to the bottom" as insurers shift even more costs to consumers and/or provide lower quality care.

In addition, we believe that the proposal will make it very difficult for consumers to compare and select plans that best fit their needs. Under CMS' proposal, plans in a given metal level could vary by as much as six percentage points – almost the amount of variation between metal levels established in the ACA. For example, a consumer shopping for silver level coverage could be presented with plans with 66 percent AV alongside plans with 71 percent AV. However, all of these plans would be displayed as "comparable" to the consumer. Choosing insurance is a complex and highly personal process, and we encourage CMS not to introduce additional complexity by presenting as "similar" plans that have material differences in benefit design generosity.

With respect to silver plans specifically, CMS' proposal may also reduce the amount and purchasing power of premium tax credits. Because tax credits are indexed to the second-lowest cost silver plan available to each enrollee or family, their value is particularly vulnerable to the "race to the bottom effect." The lowest and second-lowest cost plans available to an individual or family are likely to be plans that took full advantage of the -4 percentage points offered under this proposal – meaning, are likely to be less generous options. This dynamic reduces the dollar value of premium tax credits in a region: recent analysis of CMS' proposal estimated that the premium tax credit for a family of four with \$65,000 a year in income would decrease by \$327.<sup>2</sup> It also reduces the purchasing power of those credits across other plans that do not similarly reduce coverage and benefit design generosity.

## **Initial and Annual Open Enrollment Periods (\$155.410)**

LLS believes CMS' proposal to shorten the open enrollment period should only be implemented if it is paired with outreach funding sufficient to inform existing and potential consumers of this change, in order to avoid locking younger, healthier enrollees out of the exchange market due to confusion about the duration of the enrollment period.

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<sup>1</sup> Avalere Health. "Consumer Cost Continue to Increase in 2017 Exchanges." January 18, 2017. Online at <http://avalere.com/expertise/life-sciences/insights/consumer-costs-continue-to-increase-in-2017-exchanges>

<sup>2</sup> Aron-Dine, Aviva and Edwin Park. "Trump Administration's New Health Rule Would Reduce Tax Credits, Raise Costs, For Millions of Moderate-Income Families." February 15, 2017. Online at [http://www.cbpp.org/research/health/trump-administrations-new-health-rule-would-reduce-tax-credits-raise-costs-for#\\_ftnref8](http://www.cbpp.org/research/health/trump-administrations-new-health-rule-would-reduce-tax-credits-raise-costs-for#_ftnref8)

In addition, shortening the enrollment period to six weeks will likely increase the volume of consumers visiting HealthCare.gov and seeking customer support during that time. Without sufficient resources, many consumers are unlikely to receive the necessary assistance or will experience long waits. In particular, it will be critical to support the potentially large number of consumers who will need to select and purchase coverage at the close of the open enrollment period to ensure that all those who wish to purchase coverage are able to do so. Shortening the enrollment period without substantially increasing resources dedicated to consumer education and enrollment facilitation capacity is a recipe for greater instability in the exchange market.

### **Special Enrollment Periods (§155.420)**

LLS recognizes the need for a more stable risk pool and agrees that CMS should take action to ensure that only eligible individuals are able to enroll in a plan through a Special Enrollment Period. We believe that CMS should monitor the patient impact of this new approach, however, to ensure that patients in need of care are not unduly impacted or prevented from acquiring coverage. In particular, LLS is concerned that, if sufficient resources are not devoted to the verification system, there could be delays in the verification process that, in the interim, could lead patients to forgo necessary care for fear of incurring costs directly in the case of rejection.

In addition, if the verification process is burdensome, it is likely that healthy eligible consumers will be discouraged from taking the steps necessary to purchase coverage and that only sicker consumers, who know they will need coverage, will persist through the process. As a result, it is possible that these SEP changes could further skew the exchange risk pool toward unhealthier individuals—increasing the instability that CMS is attempting to reduce.

We encourage the administration to deploy appropriate technical, personnel, and support resources to the verification process to ensure that the process is straightforward, efficient, and predictable for consumers.

### **Guaranteed Availability of Coverage (§147.104)**

While LLS appreciates the need to sufficiently incentivize patients to pay their bills in a timely fashion, we are concerned that CMS's proposal to allow insurers to condition coverage on full repayment of past due premiums would have negative impact on families who, due to financial hardship, cannot repay their past debts quickly and would therefore be "locked out" of receiving coverage for an extended period of time while debts continue to accrue and the open enrollment window closes.

Before considering this proposed policy, CMS should gather and publish data related to the problem it seeks to solve, namely the prevalence of consumers in the exchange market repeatedly neglecting to pay monthly premiums at the end of a plan year and enrolling in exchange coverage the following plan year. If the data demonstrate that this problem warrants a solution that significantly increases premium costs for some consumers, CMS may consider permitting insurers to condition coverage to such consumers on the consumer agreeing to a fair repayment plan with a reasonable timeline, particularly in cases of financial hardship or if the prior non-payment was a consumer's "first offense." Finally, if CMS does move forward with its

proposed policy in any form, it is imperative that carriers be required to give consumers advance notice of their policies in this area.

More broadly, LLS opposes CMS actions that would seek to erode the guaranteed availability principle that was established under the ACA. LLS is always willing to work with CMS and other policymakers to consider innovative approaches that promote consumers maintaining continuous coverage. At the same time, cancer patients often face complex financial struggles due to loss of income and the high costs associated with their treatment. As a result, policies that penalize cancer patients or other consumers at the point at which they are finally able to regain coverage would further imperil these vulnerable families and delay the date at which they are able to contribute to the stability of the healthcare market.

### **About LLS**

LLS is the world's largest voluntary health agency dedicated to the needs of blood cancer patients. Each year, over 150,000 Americans are newly diagnosed with blood cancers, accounting for nearly 10 percent of all newly diagnosed cancers in the United States. The mission of LLS is to find cures for leukemia, lymphoma, Hodgkin's disease, and multiple myeloma and to ensure that blood cancer patients have sustainable access to quality, affordable, coordinated healthcare. LLS funds lifesaving blood cancer research, provides free information and support services, and advocates for public policies that address the needs of patients with blood cancer. Since our founding more than 65 years ago, LLS has invested more than \$1 billion into research for cures and LLS-funded research has been part of nearly all of the FDA-approved therapies for blood cancer.

LLS appreciates the opportunity to offer its comments on the proposed rule. Should you have any questions about our comments or our organization, please do not hesitate to contact Bernadette O'Donoghue ([bernadette.odonoghue@lls.org](mailto:bernadette.odonoghue@lls.org)) or Brian Connell ([brian.connell@lls.org](mailto:brian.connell@lls.org)).

Sincerely,

A handwritten signature in black ink that reads "Bernadette O'Donoghue". The signature is written in a cursive style with a large, stylized initial "B".

Bernadette O'Donoghue  
Vice President, Public Policy