



National
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March 7, 2017

The Honorable Tom Price
Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: CMS-9929-P, Patient Protection and Affordable Care Act; Market Stabilization

Dear Secretary Price:

The National Comprehensive Cancer Network® (NCCN®) is pleased to comment on the CMS proposed rule for stabilizing the individual and small group health insurance marketplaces under the Affordable Care Act, as it relates to NCCN’s mission of improving the quality, effectiveness and efficiency of cancer care so that patients can live better lives.

As an alliance of 27 leading academic cancer centers in the United States that treat hundreds of thousands of cancer patients annually, NCCN is a developer of authoritative information regarding cancer prevention, screening, diagnosis, treatment, and supportive care that is widely used by clinical professionals. NCCN Clinical Practice Guidelines in Oncology® (NCCN Guidelines®) represent the standard of care for clinicians and policy makers. The NCCN Guidelines® and their derivatives help ensure access to appropriate care, clinical decision-making, and assessment of quality improvement initiatives. NCCN Guidelines are the recognized standard for clinical policy in cancer care and are the most thorough and frequently updated clinical practice guidelines available in any area of medicine.

The CMS proposed rule seeks to amend standards relating to special enrollment periods, guaranteed availability, open enrollment timing in the individual market for the 2018 plan year, standards related to network adequacy and essential community providers for qualified health plans (QHPs), as well as actuarial value requirements. NCCN is pleased that CMS is taking steps to remedy the health and competitiveness of the Exchanges in a balanced way through both: 1) attracting healthy consumers to enroll in insurance to improve the risk pool, thereby enhancing access and controlling costs for those who are low income or sick and in need of care and 2) amending certain issuer requirements to entice them to stay in the Exchanges, thereby maintaining more options for patients in a competitive marketplace.

Consistent with our mission, NCCN believes that part of ensuring access to high quality cancer care is ensuring such care is affordable both at the monthly premium level as well as at the out of pocket level. If care is too high cost or there are minimal options available (e.g. due to issuers exiting the exchanges, etc.), then high quality cancer care is truly not accessible. Maintaining a balanced risk pool is critical to ensuring continuous affordability of health care coverage, services, and therapies.

Fred & Pamela Buffett
Cancer Center

Case Comprehensive Cancer
Center/University Hospitals
Seidman Cancer Center and
Cleveland Clinic Taussig
Cancer Institute

City of Hope Comprehensive
Cancer Center

Dana-Farber/Brigham and
Women’s Cancer Center
Massachusetts General Hospital
Cancer Center

Duke Cancer Institute

Fox Chase Cancer Center

Huntsman Cancer Institute
at the University of Utah

Fred Hutchinson Cancer
Research Center/
Seattle Cancer Care Alliance

The Sidney Kimmel
Comprehensive Cancer
Center at Johns Hopkins

Robert H. Lurie Comprehensive
Cancer Center of Northwestern
University

Mayo Clinic Cancer Center

Memorial Sloan Kettering
Cancer Center

Moffitt Cancer Center

The Ohio State University
Comprehensive Cancer Center -
James Cancer Hospital and
Solove Research Institute

Roswell Park Cancer Institute

Siteman Cancer Center
at Barnes-Jewish Hospital
and Washington University
School of Medicine

St. Jude Children’s
Research Hospital/
The University of Tennessee
Health Science Center

Stanford Cancer Institute

University of Alabama at
Birmingham Comprehensive
Cancer Center

UC San Diego
Moore’s Cancer Center

UCSF Helen Diller Family
Comprehensive Cancer Center

University of Colorado
Cancer Center

University of Michigan
Comprehensive Cancer Center

The University of Texas
MD Anderson Cancer Center

University of Wisconsin
Carbone Cancer Center

Vanderbilt-Ingram
Cancer Center

Yale Cancer Center/
Smilow Cancer Hospital

Initial and Annual Open Enrollment Periods

CMS proposes to change the annual open enrollment period, for all benefit years beginning on January 1, 2018 and beyond, from November 1 through January 31 to November 1 through December 15 of the calendar year preceding the benefit year. **NCCN believes a shorter enrollment period could positively impact accessibility and affordability of coverage by better ensuring consumers have a full year of coverage and by reducing adverse selection associated with those who learn they will need services in late December or January. NCCN believes this timeframe still offers enough time for people to enroll, provided there is sufficient education and outreach about the open enrollment timeframe and assistance to help people enroll in coverage.**

Special Enrollment Periods

Special enrollment periods exist to ensure that people who lose health insurance coverage during the year or experience other qualifying events have the opportunity to enroll in coverage or make coverage changes outside of the annual enrollment period. As CMS noted in the proposed rule, a recent Government Accountability Office report noted that relying on self-attestation without verifying documents submitted to support a special enrollment period triggering event could contribute to adverse selection by allowing applicants to obtain coverage for which they would not otherwise qualify. In effect, as CMS noted, self-attestation undermines the incentive for individuals to enroll in a full year of coverage through the annual open enrollment period and increases the risk of adverse selection from individuals who wait to enroll until they are sick.

NCCN supports special enrollment changes that reduce adverse selection and ensure high quality care is affordable and accessible to all. Better safeguards are required to ensure that consumers are not taking advantage of special enrollment periods, using them as an excuse to sign up only after realizing that they need coverage or to switch plans when they realize they may need more coverage, as this contributes to high and unsustainable costs for those who are enrolled. **Thus, we support the CMS proposal to require consumers to submit documentation for pre-enrollment verification for special enrollment periods.**

However, we acknowledge and agree with CMS that requiring additional documentation has the potential to create more barriers to enrollment, potentially dissuading more people from seeking coverage. The alternative though, of allowing some consumers to continue to use the special enrollment loophole in order to sign up for coverage after becoming sick, would be more detrimental to the entire system. We believe the most efficient approach to ensuring access to care is via policies that promote continuous and affordable coverage. **That said, NCCN supports the proposed document verification process as long as it is operationally feasible to manage and does not dissuade or disrupt legitimate enrollments.**

Continuous Coverage

CMS seeks comment on policies that would promote continuous coverage and enrollment and dissuade consumers from waiting until illness occurs to enroll in coverage. **As mentioned previously, NCCN believes a well-balanced risk pool is essential to the health insurance**

marketplace's success in providing access to high quality, affordable care. Furthermore, we think a more rigorous individual mandate with a stronger penalty to those who do not enroll and maintain coverage would be the most effective way to ensure continuous coverage of individuals, maintain a balanced risk pool, control costs for consumers and issuers, and in turn allow for better access to high quality, high value care. Additionally, we recommend a gradual escalation of penalties in order for consumers to become more familiar with the intent and use of health insurance. CMS may wish to consider a health insurance literacy strategy accordingly.

Actuarial Value

In this proposed rule with comment period, CMS states that further flexibility is needed for the Actuarial Value (AV) de minimis range for health plan metal levels to help issuers design new plans for future plan years in order to promote market competition and keep cost sharing stable year to year. **NCCN supports any proposed changes that could allow for more flexibility in the AV ranges, so long as patient access to high quality and affordable care remains paramount.** We acknowledge that this proposal has the potential to allow issuers to create more competitive, better-priced plans, which in turn may motivate them to re-join the health insurance exchanges.

However, NCCN does not support a significantly large adjustment in actuarial value that results in substantially higher out-of-pocket (OOP) costs. If a plan's coverage levels are exponentially increased, we believe consumers are likely to drop out of the marketplace or not sign up for coverage if eligible for initial enrollment, because even with a lower premium the OOP costs would not be affordable. Moreover, we express concern that issuers may abuse their discretion and make the plans so variable that people with pre-existing conditions, such as patients with cancer, would pay significantly more than those without pre-existing conditions. We also worry if lower AV plans would result in smaller federal premium subsidies for low-income members, thus discouraging their participation, since such subsidies are currently based on the cost of coverage. **For this reason, we only support changes in AV as long as they are accompanied with changes that would also: balance the risk pool, incent healthy consumers and those of all levels of socioeconomic status to enroll and maintain coverage, and guarantee access to high quality, high value care.**

Priority should be given to ensuring that any plan benefit design used to meet the designated AV de minimis range should at a minimum, provide for the basic prevention, diagnosis and treatment of cancer per the NCCN Guidelines®. Thus, the AV range or variation should not cause significant negative disruption in continuity or coordination of cancer care (e.g. large rate increases, substantive benefit changes, disruption in provider access, etc.)

Lastly, when evaluating AV changes, we ask CMS to consider that AV accounts for only a portion of total healthcare costs. Beyond health insurance premiums, total OOP patient costs may include copays, deductibles, and coinsurance for health services and treatments as well as indirect costs, such as travel. For this reason, it is important that the AV is not raised by such a

high amount that these other patient OOP costs are also raised significantly, thereby making care unaffordable or causing non-adherence to prescribed, evidence-based quality treatment.

Network Adequacy

§ 156.230(a)(2) requires a QHP issuer to maintain a network that is sufficient in number and types of providers. In this proposed rule, CMS proposes to rely on state reviews for network adequacy in States in which the Federally-Facilitated Exchange (FFE) is operating. For states without the authority or means to conduct sufficient network adequacy reviews, CMS proposes relying on an issuer's QHP accreditation from the National Committee for Quality Assurance (NCQA), URAC or the Accreditation Association for Ambulatory Care (AAAHC).

NCCN supports standards to regulate network adequacy standards in a way that allows health insurance companies to negotiate appropriate rates with all high quality, high value providers, including academic cancer centers, which frequently see higher severity cases and offer best in class and innovative therapies as well as access to clinical trials. Academic cancer centers remain the backbone of oncology care, providing essential resources that patients with cancer may not be able to access in other settings of care; in turn, it is imperative that access to academic centers is available—at affordable rates—via the provider networks in both the federal and state health insurance marketplaces. NCCN encourages CMS to incorporate into the network adequacy requirements additional guidance specific to cancer-related care, which tends to be multi-disciplinary and often multi-site, requiring close care coordination and adherence to established guidelines to optimize outcomes in the highest quality and most cost-effective way.

Additionally, NCCN respectfully requests that QHP accreditation detail be made publicly available. Upon review of this proposed rule, the NCQA, URAC, and AAAHC detailed QHP network criteria appear to only be available on a paid basis.

Essential Community Providers

Essential community providers (ECPs) include providers that serve predominantly low-income and medically underserved individuals. Under the current guidance, issuers may only identify providers as ECPs based on those providers who have petitioned they are ECPs and are therefore on a Department of Health and Human Services (HHS) "HHS ECP list." However, to maintain the required number of ECPs, CMS proposes a "write-in process," in which issuers may identify additional ECPs as well. **NCCN supports an ECP write-in process not only to make the ECP list more inclusive of the providers patients access but also to help issuers remain in the Exchanges who otherwise do not have enough petitioned ECPs on the HHS ECP list.**

NCCN again appreciates the opportunity to comment on CMS' proposals to promote health insurance marketplace stabilization. If you have any questions, we would welcome the chance to discuss our comments further on how we may work together to ensure access to high quality, high value care for patients with cancer.

Sincerely,

A handwritten signature in black ink, appearing to read "Robert W. Carlson".

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