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Submitted Electronically at www.regulations.gov

January 30, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9899-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: CMS–9899–P; Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment
Parameters for 2024

Dear Administrator Brooks-LaSure,

I am pleased to submit these comments on behalf of the Association for Clinical Oncology (ASCO) in response to the Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2024 proposed rule, which was published in the Federal Register on December 21, 2022.

ASCO is a national organization representing nearly 45,000 physicians and other health care professionals specializing in cancer treatment, diagnosis, and prevention. We are also dedicated to conducting research that leads to improved patient outcomes and committed to ensuring that evidence-based practices for the prevention, diagnosis, and treatment of cancer are available to all Americans.

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Access to Coverage

The Centers for Medicare & Medicaid Services (CMS) proposes to allow Marketplaces to adopt a special enrollment period (SEP) for individuals losing Medicaid or Children's Health Insurance Program (CHIP) coverage that is also considered minimum essential coverage (MEC). Enrollees may currently report a loss of MEC to Exchanges up to 60 days before and 60 days after their loss of MEC. However, when these individuals are disenrolled from Medicaid or CHIP based on modified adjusted gross income (MAGI) following an eligibility redetermination, the State Medicaid agency has a 90-day reconsideration window. If the consumer exhausts their attempt to regain coverage through

Medicaid or CHIP, which they must do within those 90 days, they may have missed their window to enroll in the 60-day Exchange SEP. If finalized and the plan chooses to adopt the extended SEP window, consumers would have 60 days before and 90 days after their loss of Medicaid or CHIP coverage to select a plan for Marketplace coverage.

ASCO supports CMS' proposal to permit Marketplaces to adopt SEPs for individuals losing Medicaid or CHIP coverage that is considered MEC and to extend the timeline to 90 days following the loss of coverage. ASCO urges CMS to make these SEPs mandatory.

CMS is also proposing to minimize or eliminate gaps in coverage for consumers attesting to a future loss of MEC. Under the current rule consumers reporting a future loss of MEC may have to wait weeks for their coverage to start, even if they were proactive and attested to a coverage loss as soon as they became aware, affecting mostly beneficiaries whose states allow mid-month termination of Medicaid. For example, if this proposal is finalized as proposed, when a consumer attests between May 16 and June 30 that they will lose other MEC on July 15 and selects a plan on or before June 30, coverage would be effective on July 1. If that consumer selects a plan after June 30, coverage would be effective as of August 1. These changes would ensure qualifying individuals are able to transition from other forms of coverage to Exchange coverage as quickly as possible with minimal coverage gaps.

ASCO supports CMS' proposal to allow Marketplaces to adopt SEPs for individuals attesting to a future loss of MEC to eliminate and/or reduce any gaps in coverage. ASCO urges CMS to make these SEPs mandatory.

ASCO supports the other access to coverage provisions included in the proposed rule:

- **Grant SEPs to qualified consumers who are affected by a material plan display error related to plan benefits, service area, or premium that influenced their decision to purchase a qualified health plan (QHP) through the Marketplace.**
- **Prohibit issuers participating in Exchanges on the Federal platform from terminating coverage for a dependent child prior to the end of the plan year because the dependent child has reached the applicable maximum age.**

ASCO is committed to supporting policies that allow individuals to access affordable insurance without interruption[1], and we agree with CMS that the proposals discussed in this section would likely increase access to continuous health coverage.

ASCO believes that all eligible individuals should be able to apply, enroll in, and receive Medicare coverage benefits in a timely and streamlined manner that promotes equitable coverage, especially for individuals with a cancer diagnosis, or who are at increased cancer risk. Efforts to preserve access to

[1] https://www.asco.org/sites/new-www.asco.org/files/content-files/2017-ASCO-Principles-Healthcare-Reform.pdf

health insurance, given the integral link to health care access, can improve cancer health outcomes.[2] Enrollment delays or restrictions result in disruptions in care, unanticipated treatment delays, and delays in screening and care, all of which are linked to worse cancer care outcomes. When patients are no longer able to access screening or other preventative care services, they may (knowingly or not) delay seeking treatment until their disease is at an advanced stage.[3]

Further, in the coming months we expect to see a higher than usual volume of individuals transitioning from Medicaid and CHIP coverage to the Exchange due to the uncoupling of Medicaid enrollment from the COVID-19 Public Health Emergency (PHE). Specifically, the Medicaid continuous enrollment provision was decoupled via the Consolidated Appropriations Act, 2023 and the provision will be terminated on March 31, 2023. Consistent coverage without disenrollment or a gap in benefits is essential for Medicaid beneficiaries with a cancer diagnosis or for those who have recently finished treatment. Even one day without coverage can halt cancer treatment or stop treatment altogether. Likewise, beneficiaries transitioning between coverage programs may face many challenges including changes in the list of covered drugs, cost-sharing requirements, and the network of providers. For those that have recently finished treatment, follow-up visits with their provider for on-going monitoring must remain covered. ASCO appreciates that CMS is providing guidance for states to transition those who will no longer be eligible for Medicaid and CHIP to Marketplace coverage. We encourage CMS to work with states to ensure maintenance of coverage benefits for cancer patients to avoid disrupting treatment protocols currently in place.

Plan Marketing Names

CMS proposes to require that QHP marketing names include correct information, without omission of material fact, and do not include content that is misleading. If finalized, CMS would review marketing names during the annual QHP certification process. ASCO supports this proposal.

ASCO agrees with CMS that this proposal could help consumers applying for coverage to better understand references to benefit information in plan, and to use this information to make an informed plan selection. We support the agency's proposal to require all information included in plan marketing names match the information included in the Plans & Benefits Template, the Summary of Benefits, or other information submitted during the certification process. Furthermore, QHPs must not implement marketing practices that discourage enrollment by individuals with significant health needs.

Copay Accumulator Programs

We continue to be extremely disappointed that the agency has not reversed the copay accumulator policy that was finalized in the 2021 Notice of Benefit and Payment Parameters (NBPP) final rule. The

[2] Yabroff KR, Reeder-Hayes K, Zhao J, et al: Health insurance coverage disruptions and cancer care and outcomes: Systematic review of published research. J Natl Cancer Inst 112:671-687, 2020
[3] Amini A, Jones BL, Yeh N, et al: Disparities in disease presentation in the four screenable cancers according to health insurance status. Public Health, 138, 50-56, 2016

finalized policy allows issuers to disregard all manufacturer copay assistance when determining whether an enrollee has met their annual deductible and/or out-of-pocket limit, which disproportionately impacts patients with cancer and other chronic illnesses. ASCO addressed this issue in our comments on the 2023 NBPP proposed rule highlighting the devastating effects copay accumulator programs have on patient access to needed care and life-saving prescription drugs. We continue to urge CMS to reverse course and prohibit copay accumulator programs to align with the improved access to coverage updates in this rule.

Copay assistance is generally available for high-cost brands and specialty medications without a medically equivalent generic alternative and is used by people with serious and complex chronic illnesses.[4] People with low incomes and people of color are more likely to be living with a chronic illness.[5] Such utilization management tactics negate the intended benefit of patient assistance programs—and remove a safety net for patients who need specialty medications but cannot afford them. ASCO strongly opposes the use of copay accumulator and copay maximizer programs for patients with cancer. We strongly urge CMS to reverse the current policy and eliminate copay accumulator programs. To learn more, please read our position statement.

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We appreciate the opportunity to comment on this Notice of Benefit and Payment Parameters for 2024. Please contact Gina Hoxie (gina.hoxie@asco.org) or Karen Hagerty (karen.hagerty@asco.org) with any questions or for further information.

Sincerely,

Lori Pierce, MD, FASTRO, FASCO
Chair of the Board
Association for Clinical Oncology

[4] K. Van Nuys, G. Joyce, R. Ribero, D.P. Goldman, *A Perspective on Prescription Drug Copayment Coupons. Leonard D Schaeffer Center for Health Policy & Economics*. (February 2018), https://healthpolicy.usc.edu/research/prescription-drug-copayment-coupon-landscape/
[5] The Center for American Progress, Fact Sheet: *Health Disparities by Race and Ethnicity*. (May 7, 2020), https://www.americanprogress.org/article/health-disparities-race-ethnicity/