November 27, 2017

Seema Verma
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9930-P
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: CMS-9930-P; Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019

Dear Administrator Verma:

The American Society of Hematology is pleased to offer comments on the proposed rule for the Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019.

ASH represents over 17,000 clinicians and scientists worldwide who are committed to the study and treatment of blood and blood-related diseases. These disorders encompass malignant hematologic disorders, such as leukemia, lymphoma, and multiple myeloma, as well as non-malignant conditions, such as sickle cell anemia, thalassemia, bone marrow failure, venous thromboembolism, and hemophilia. In addition, hematologists were pioneers in demonstrating the potential of treating various hematologic diseases through bone marrow transplantation, and we continue to be innovators in the fields of regenerative medicine, transfusion medicine, and gene therapy. ASH membership is comprised of basic, translational, and clinical scientists, as well as physicians who are providing care to patients in diverse settings including teaching and community hospitals, as well as private practices.

ASH is concerned with how this proposed rule could adversely impact access to care for patients with hematologic diseases and disorders and in particular, is providing comments on the proposed change to the definition of a "typical employer."

The Affordable Care Act (ACA) required non-grandfathered health plans in the individual and small group markets to cover ten essential health benefits (EHBs), including hospitalization, prescription drugs, and preventive and wellness services and chronic disease management. To help address variation of coverage, the ACA also established guidance for the states to determine to what level these benefits would be covered. Current law allows states to select a benchmark plan that reflects the benefits and limitations of a “typical employer” plan. Federal guidance narrowed this down to ten existing plans in a particular state. These plans include the three largest small-group plans, based on enrollment; the three largest state employee health plans, based on enrollment; the three largest federal employee health plans, based on enrollment; and the state’s largest commercial HMO plan.
The proposed rule, however, includes an updated definition of a typical employer, dropping the threshold of a typical employer to any plan with 5,000 enrollees. This may include self-insured plans, which tend to provide less generous benefits than those offered by large groups. If this proposed rule becomes final, states would have the option of choosing from the benchmarks set by these less generous plans when setting benchmarks for the EHBs, whereas previously they were limited to choosing from plans which were much more robust. For example, a less generous employer plan may restrict coverage to generic medications only or strictly limit the number of hospital days per year. In hematology, a provision for generic medications only could be quite problematic; in many instances, there are no generic alternatives to the therapies used to treat certain hematologic diseases and disorders. People with cancer or bleeding disorders who cannot afford the out-of-pocket cost of the brand name drug may delay or go without treatment, resulting in a disability or other complication that can lead to increased long-term health care costs.

The proposed rule leaves the decision to make changes regarding EHBs to the states. It is unclear how many states would choose to set their benchmarks based on these more limited plans. However, in a supporting statement for the proposed rule, the Centers for Medicare and Medicaid Services (CMS) estimate that 10 states will choose to change their EHB-benchmarks in any given year, totaling 30 states over the three-year authorization of the information request. This estimate is based on state activity under the previous benchmark plan selection policy. Additionally, CMS acknowledged that it is more likely that states would modify EHBs to reduce benefits, thereby reducing premiums, rather than use the opportunity to expand them. ASH is very concerned that this change will move the individual market closer to how it operated before the passage of the ACA, making it more difficult for consumers to compare their coverage options and more difficult for those with complex health needs to get the comprehensive coverage they require. Other actions, such as the decision to end the cost-sharing reduction (CSR) payments, have led to the increase of premiums. If, as a result, insurers are looking for ways to reduce premiums, they may now use this opportunity to provide less comprehensive EHBs. Ultimately, this may lead to increased out-of-pocket costs and reduce access to critical services, particularly for the patients treated by ASH members.

Additionally, important patient protections only apply to services defined as EHBs, including the elimination of annual and lifetime limits. Consequently, if a plan chose to set their new EHB benchmarks by a less generous plan and thereby limit coverage to generic drugs, the prohibition against the annual and lifetime limit would not apply to brand name drugs. Patients with hematologic diseases and disorders cannot afford to lose protections such as the elimination of lifetime and annual caps.

Lastly, the Society is concerned about what changes to the EHBs will mean for an individual’s ability to compare their plan options. The actuarial value of a plan and its "metal" designation (i.e. bronze, silver, gold, platinum) is calculated on the provision of EHBs to a standard population. If a patient’s health care needs are not reflected by that population, they may end up with insufficient coverage for their condition.

EHBs are critical to patients with hematologic diseases and disorders, many of which are rare and extremely expensive to treat. These EHBs are just that – essential – and have allowed patients to finally have access to the comprehensive coverage that they need. For the reasons stated in this letter, ASH opposes the proposed changes to the definition of a "typical employer" because of the impact it could have on coverage provided by EHBs and consequently, on access to care for patients with hematologic diseases and disorders.
Thank you for the opportunity to provide feedback. We welcome the chance to discuss these comments and others being considered with you and your team. If you have any questions or require further clarification, please contact Suzanne Leous, ASH Director of Government Relations and Practice at sleous@hematology.org or 202-292-0258, or Leslie Brady, ASH Policy and Practice Manager at lbrady@hematology.org or 202-292-0264.

Sincerely,

Kenneth C. Anderson, MD
President