

Hardee, Amy

From: Paul.Hull@Cancer.Org
Sent: Monday, July 30, 2012 8:21 PM
To: Robleto, Michelle
Cc: Jennifer.Sharp@CANCER.ORG
Subject: Public Comment from American Cancer Society
Attachments: Public Comment ACS - Essential Health Benefits

Michelle,

It's my understanding that public comment is being accepted through today on essential health benefits-related issues. Please find attached, for the record, comment from the American Cancer Society.

Thank you...

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July 30, 2012

Kevin McCarty, Commissioner
Office of Insurance Regulation
200 East Gaines Street
Tallahassee, Florida 32399-0308



Re: Public Comment on Essential Health Benefits and Benchmark Plan Decision

Dear Commissioner McCarty:

Thank you for your office's response to my correspondence of May 25th, in which I requested information regarding benchmark plan options in Florida and a number of health plan benefits that many health consumer groups consider to be critical.

Due to dynamics in our state, I can appreciate the uncertainty as to what, if any, process will transpire in our state on implementation of the Patient Protection and Affordable Care Act. That ambiguity notwithstanding, on behalf of the nearly 118,000 Floridians who will be diagnosed with cancer this calendar year and the more than 42,000 who will succumb to the disease, as well as a myriad of cancer survivors and family members keenly interested in health care that is accessible, affordable, adequate, and administratively simple, we wanted to submit comments on the matter.

Earlier this year, you and your NAIC colleagues were provided by consumer representatives with input on the important role insurance commissioners should play in states' essential benefits decisions. The respectfully suggested steps still are as crucial here in your home state as anywhere, and I will state them here for the record:

Identify benchmark plan options: Insurance regulators should quickly identify the three largest plans in the state's small group market as well as the largest HMO. The department should also work with the appropriate state agency in identifying the three largest state employee plans. This information should be posted prominently on the department's web site and other public forums.

Provide plan documents: For consumers and policy-makers to make an informed assessment of the benchmark plan options, it is critical that insurance regulators publicly disclose the summary of plan description, the certificate of coverage, or the insurance contract for each benchmark plan option. (The summary of benefits typically provided to consumers, while informative, does not provide sufficient information on which to make such an important decision.)

Establish standards for benchmark selection: In concert with other relevant state agencies, insurance regulators can help establish the substantive criteria the state will use to select the benchmark plan, such as comprehensiveness of the benefits, cost considerations, balance among the benefit categories, and interactions with existing markets.

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Facilitate public understanding of the benefits: Insurance regulators should develop and make publicly available a crosswalk between the potential benchmark plans and the state's mandated benefits, as the Maine Bureau of Insurance did earlier in the year. This type of comparative analysis can help the public understand what's really covered under various policies and aid an informed selection process.
(See: http://www.maine.gov/pfr/insurance/legislative/BOI_presentation_Jan17.html).

Engage the public on benchmark selection: Help lead a state effort to engage the public on the selection of an appropriate benchmark plan, including the conducting of stakeholder meetings and allowing for public input on both the substantive standards for selecting a benchmark and the selection itself. The process should be open, transparent, and allow time for public review and comment.

Advocate for a true benefits standard that does not permit significant insurer deviation. Under the HHS bulletin issued several months ago, insurers may be allowed to vary the benefits they cover from a state's selected benchmark as long as the alternative benefits are actuarially equivalent to the state's benchmark. Particularly because insurers will have a large degree of flexibility apart from the essential health benefits (in terms of cost-sharing charges, provider networks, etc.), this raises significant concerns about how complicated it will be for consumers to understand their coverage and for insurance regulators to monitor compliance and enforce the new standards, particularly at a time when so many changes are occurring in the marketplace. Allowing insurers to deviate from the state's benchmark benefits also would provide an avenue for some insurers to cover benefits in ways that lead to adverse selection or harm vulnerable patient populations. Commissioners should strongly discourage insurer variation on benefits, starting by urging HHS to allow states to adopt more protective standards that prohibit such variation. Commissioners should encourage their states to require insurers to meet the benchmark plan standards without deviation. Particularly in the initial years of implementation, this would provide greater market stability, enhance consumer confidence in the changes, simplify monitoring and enforcement for regulators, and mitigate the potential for market segmentation by insurers that might result if they are able to adjust benchmark plan benefits. If insurer flexibility on benefits is permitted, regulators should be vigilant that any changes that insurers make are based on evidence and actuarial standards. "Flexibility" cannot become a euphemism for discrimination or adverse risk selection.

Monitor impact on patients, particularly vulnerable populations: To control costs and improve health outcomes, state insurance regulators and other relevant state agencies should monitor closely the actual impact of the benchmark plan decision. We are particularly concerned about the trend toward using "inside benefit limits" — e.g., arbitrary numerical limits on such benefits as doctor visits or lab tests that may impair the proper treatment of serious medical conditions like cancer. Monitoring should focus especially on people who have chronic diseases, the disabled, and other vulnerable

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populations. These groups often have unmet needs for specific health services as well as high out-of-pocket costs that can cause financial problems. State mandated benefits that protect these populations should be conserved. These are the areas that offer the most promise for improving health outcomes and containing costs, but improvements can only be achieved if we better understand the utilization of services and the outcomes associated with them.

While the core essential health benefits and benchmark plans decisions are at the forefront of discussions, please know that we are acutely interested in access to medications for cancer patients in any new health care delivery paradigm, as well. For instance, there is growing concern about the lack of parity between oral anti-cancer medications and their intravenous equivalents, with cancer patients unfairly incurring more out-of-pocket costs for drugs ingested orally. Moreover, the evolving trend of incorporating specialty tiers for certain medications, with exorbitant co-insurance, can make potentially life-saving treatment for some patients simply unattainable. It is our sincere hope that the ongoing discourse on health care will lead to remedies for these issues.

Thank you for the opportunity to submit comments. We stand prepared to provide perspective on behalf of patients, through the cancer lens, and we look forward to continued dialogue as the State of Florida contemplates these matters.

Sincerely,

A handwritten signature in cursive script that reads "Paul Hull".

Paul Hull, Vice President
Advocacy and Public Policy