August 17, 2012

Ms. Danielle Holahan
New York State Health Benefit Exchange
New York State Department of Health

[Submitted electronically to exchange@health.state.ny.us]

RE: Benchmark Options for Essential Health Benefits

Dear Ms. Holahan:

The American Cancer Society appreciates the opportunity to comment on New York's selection of an Essential Health Benefits (EHB) benchmark plan for use in the individual and small group insurance markets. This decision is a fundamental step in implementing the Affordable Care Act in New York State.

The mission of the American Cancer Society is to eliminate cancer as a major health problem through improved prevention, early detection, and better treatment and support services for people with cancer. In 2012, an estimated 109,440 New Yorkers will be dignosed with cancer, and 34,140 will die of the disease, making it the second leading cause of death in New York. An estimated 850,000 New Yorkers alive today have had a diagnosis of cancer.

The EHB decision is critically important for all New Yorkers at risk of cancer – that is to say, everyone. The package that New York decides upon must meet the needs of all diverse segments of the state's population. The threat of cancer has been significantly reduced in recent years as science has deployed new, more effective methods of prevention, early detection and treatment. Cancer treatment has become more effective by becoming more individualized and more complex. Increasingly, cancer is a chronic disease requiring medical care for many years.

Because lack of insurance and under-insurance prevents many New Yorkers from receiving optimal health care, the American Cancer Society has been a strong supporter of insurance reform, including the provisions of the Affordable Care Act that improve access to cancer prevention and treatment, and we are strongly committed to ensuring that New Yorkers receive maximum protection from cancer as the ACA is implemented.

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For cancer patients, lack of insurance can be deadly. Research suggests that approximately 10 percent of cancer patients are uninsured at the time of diagnosis.[1] More troubling, about one-third of cancer survivors report a loss of health insurance at some point in time since their diagnosis.[2]

Uninsured patients are less likely to get recommended cancer screenings and are more likely to be diagnosed with cancer at later stages.[3] For example, uninsured women diagnosed with breast cancer are 2.5 times more likely to have a late stage diagnosis than women enrolled in private health insurance.[4]

According to an analysis by Milliman, in a given year, 22 percent of cancer patients will receive chemotherapy costing, on average, $20,000 (exclusive of chemotherapy-related inpatient admissions or emergency room visits).[5] A 2011 review conducted by the American Cancer Society found wide variation in the specific anti-neoplastic drugs included in insurers' formularies, leading to concern that a cancer patient with the "wrong" insurer could be denied coverage for the most appropriate medication.

Issue: "Off-label" prescription drug use.
A large percentage of cancer patients are treated using drugs that the FDA has only approved for other type(s) of cancer (so-called "off-label" use), and it is important that physicians have the authority to prescribe such drugs without seeking prior approval. Clearly, a robust, flexible prescription drug benefit is important to any one facing the prospect of cancer treatment.

Because a large percentage of cancer patients are treated using drugs "off-label", there is obviously some concern over this benefit in the three Federal Health Benefit Plans. Is this benefit covered for cancer treatment and if so, is there some kind of prior authorization required before coverage is determined?

The CDPHP and Independent Health state employee plans also show coverage for off-label use of drugs, but they require prior approval. It raises the question of what this

[1] Thorpe KE, Howard D. "Health Insurance and Spending Among Cancer Patients" *Health Affairs 2003. W3; 189-198.*
[2] American Cancer Society Cancer Action Network. "Facing Cancer in the Healthcare System: A National Poll." May 21 – June 10, 2010. http://www.acscan.org/healthcare/cancerpoll.
[3] Halpern MT, Bian J, Ward EM, Schrag NM, Chen AY. "Insurance status and stage of cancer at diagnosis among women with breast cancer." *Cancer,* 2007; 110: 403-11.
[4] Kaiser Commission on Medicaid and the Uninsured. "The Uninsured: A Primer. Key Facts About Americans Without Health Insurance," January 2006.
[5] Fitch, K, Pyenson, B, "Cancer Patients Receiving Chemotherapy: Opportunities for Better Management," Milliman, 2010.

approval process is and does the Department believe that this requirement would apply to all other plans offered in the exchange if either is selected as the benchmark plan.

Issue: Tobacco cessation.
Tobacco causes 25 percent of cancer incidence and at least 30 percent of cancer deaths. Each year three to five percent of smokers will actually stop smoking. Clearly, increasing the number of successful attempts will have an important effect on health and health care costs. Nicotine addiction is classified as, and should be treated as, a chronic disease.

Tobacco users vary in what tobacco products they use, how much, how often, and in what coexisting medical conditions they may have. When quitting, they need access to a range of treatments, both medication and counseling, to find the most effective tools that work for them. The covered benefit should include all over the counter and prescription medications approved by FDA (including combination use) and multiple face-to-face counseling sessions conducted by a qualified health professional. Several attempts are usually necessary to successfully quit, and the frequency and duration of treatments should not be limited. Limiting the benefit with cost-sharing or preauthorization requirements deters people from using preventive services.

Regarding this benefit, our review of the available plans has identified important issues:

- State Employee Plans
  - The CDPHP plan only covers over-the-counter drugs prescribed by a physician for 2 twelve week cycles per year. Does this also apply to prescription drugs? If so, this is not an adequate benefit as smokers trying to quit usually require more than two cycles of quit attempts in a year's time.
  - The Independent Health plan only allows 1 six month course of treatment per year. If the patient relapses prior to that 6 month period ending, will they be given another period of benefits during that year for a 2nd quit attempt? In other words, if they fall off treatment after 3 months, will they be eligible for another 3 months of cessation benefits during that same year?

- Small Group Plans
  - A cessation benefit is not specifically covered under any of these plans. It would be worth noting that plans that DO NOT have a cessation benefit are of major concern to the cancer community and that we would certainly advocate for selecting a benchmark plan that does provide adequate coverage for this service.

Recommendation: Adopt the New York State Employees' Empire Plan as the benchmark for New York.

We urge adoption of the New York State Employee Plans' Empire Plan as the best benchmark option for EHB in New York. The Empire Plan is the most comprehensive of the ten benchmark plan options. For example, it is the only benchmark option that covers almost all of New York's individual and small group benefit mandates, which include many mandates supported by the cancer community including off-label prescription drug use for cancer care and robust tobacco cessation treatment.[6]

New York should not reject the Empire plan as the EHB benchmark merely because of the slightly higher predicted effect on premium cost. While affordability of coverage is important to our members, we expect that the Exchange will bring down premium costs, particularly for those who attempt to purchase individual coverage. And our members need the security that a comprehensive benefit package provides.

Thank you for considering our comments.

Sincerely,

Russ Sciandra
State Advocacy Director

[6] Newell, P, "Defining Essential Health Benefits: Federal Guidance and New York Options," United Hospital Fund, 2012, page 22.