January 8, 2024

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Comments on *HHS Notice of Benefit and Payment Parameters for 2025* Proposed Rule

Dear Administrator Brooks-LaSure;

The All Copays Count Coalition (ACCC) appreciates the clarification the Centers for Medicare and Medicaid (CMS) has issued in the 2025 Notice of Benefit and Payment Parameters (NBPP) proposed rule regarding prescription drugs as essential health benefits. The ACCC represents the interests of patients with chronic and serious health conditions who rely on specialty medications. For patients with serious, chronic health conditions, including life-threatening illnesses, ongoing and continuous access to these medications isn't optional – it is essential. However, these patients often face administrative barriers limiting or denying access to the therapies they need to treat their conditions and stay healthy.

The Affordable Care Act requires qualified health plans to cover essential health benefits including prescription drugs. Since 2013, HHS has required plans to provide EHB to cover the greater of one drug per U.S. Pharmacopeia's Medicare Model Guidelines (USP MMG) class and category, or the same number of prescription drugs in each category or class as the state's EHB benchmark plan. In other guidance, HHS has indicated that it considers this requirement to be the minimum required coverage, and that any additional prescription drugs covered by a plan must also be considered part of the EHB package. **We strongly support the proposal to add new paragraph (f) to §156.122, clarifying that all prescription drugs covered by a health plan are considered essential health benefits subject to the cost-sharing requirements at §156.130. We urge further clarification that this requirement applies to all non-grandfathered plans under the Affordable Care Act, including large group and self-insured plans.**

Over the past five years, ACCC members have noted an increase in the number of plans adopting benefit designs that either carve specialty drugs out of their benefit package altogether or cover specialty drugs but classify them "non-EHB". Because specialty medications are, by definition, medications used to treat serious health conditions, we argue that this practice amounts to an end run around the Affordable Care Act's (ACA's) protections against medical underwriting and a violation of the ACA's requirement to cover prescription drugs as part of the Essential Health Benefits package. Maximizers are now commonplace in employer-sponsored health insurance; one third of all health plans in the

employer market utilized a maximizer in 2022.[1] Although this practice began among large group and self-insured plans, in the last two years, we have noted that now even individual plans are adopting this practice. In a review of 2023 marketplace plan documents, The AIDS Institute discovered 7 plans' outline of pharmacy benefits excluded specialty drugs. The number of plans applying these discriminatory practices has more than doubled to 17 in the 2024 market.[2] Insurers and PBMs are exploiting patients and violating the terms of the ACA.

These harmful policies add to confusion for patients, increase their out-of-pocket costs, and impede access to care. For example, an enrollee may have different copay amounts for different medications classified by their plan as specialty medications, making plans more complicated at a time when CMS is working to make it easier for people to understand what is covered by their health plans and to standardize cost-sharing charges. Moreover, and perhaps even more insidiously, whether a plan classifies specialty drugs as "not covered" or "covered non-EHB", any payments made by or on behalf of an enrollee toward those drugs has not counted toward the enrollee's annual deductible or cost-sharing limit. When plans are allowed to discriminate against enrollees living with chronic illness by not covering the prescription drugs they need, or by covering them outside of the EHB package, patients are harmed.

Accordingly, again, the ACCC **strongly supports the proposal to codify its current policy to ensure that prescription drugs in excess of those covered by a state's EHB-benchmark plan are considered EHBs such that they are subject to EHB protections, including the annual limitation on cost sharing and the restriction on annual and lifetime dollar limits.** The ACCC also encourages CMS to use its enforcement authority when plans fail to comply with this regulation.

While we strongly support the proposal to require plans to count all prescription drugs as EHB for cost-sharing purposes, we note that CMS continues to oppose efforts to require PBMs and insurers to count copay assistance payments made by or on behalf of an enrollee toward that enrollees' annual deductible and out-of-pocket limit. Requiring insurers to cover specialty prescription drugs in accordance with the ACA marks an important step toward ensuring that people living with chronic illness can afford necessary medications, but in order to truly protect patients, CMS must also quickly issue guidance announcing its intention to enforce the copay assistance provision of the 2020 Notice of Benefit and Payment Parameters that is currently in effect, per the U.S. District Court decision in *HIV and Hepatitis Policy Institute et al. v. U.S. Department of Health and Human Services et al.*[3]

Thank you for your consideration.

Sincerely,

Arthritis Foundation
The AIDS Institute
National Multiple Sclerosis Society

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[1] Denise Myshko, IQVIA: Accumulator and Maximizer Programs are Growing, Formulary Watch, January 2023, https://www.formularywatch.com/view/iqvia-accumulator-and-maximizer-programs-are-growing.

[2] Anthem and Anthem BCBS: IN, MO, NV, WI; BCBS: NE, OH, RI; Cigna: FL, IN, MS, SC; Group Health Co-op WI: WI; Mountain Health Co-op: ID, MT, WY; Providence: OR; University Health Plan of Utah: UT.

[3] HIV & Hepatitis Policy Institute et al. v. U.S. Dep't of Health & Human Services et al., No. 1:22-cv-02604 (D.D.C. Sept. 29, 2023), https://law.justia.com/cases/federal/district-courts/district-of-columbia/dcdce/1:2022cv02604/246787/42/.

National Hemophilia Foundation
Alliance for Headache Disorders Advocacy
Ovarian Cancer Research Alliance
Foundation for Sarcoidosis Research (FSR)
Eastern PA Bleeding Disorders Foundation
Coalition of Skin Diseases
Immune Deficiency Foundation
HIV+Hepatitis Policy Institute
Derma Care Access Network
National Eczema Association
AiArthritis
The Headache and Migraine Policy Forum
Alliance for Women's Health and Prevention
Pulmonary Hypertension Association
Triage Cancer
Lupus and Allied Diseases Association, Inc.
Hemophilia Council of California
Looms For Lupus
Alliance for Women's Health and Prevention
The Coalition of State Rheumatology Organizations
Lupus Foundation of America
Patient Access Network (PAN) Foundation
Crohn's & Colitis Foundation
Nevada Chronic Care Collaborative
AIDS Foundation Chicago
Virginia Hemophilia Foundation
Hemophilia Federation of America
National Consumers League
ICAN, International Cancer Advocacy Network
National Psoriasis Foundation
American Academy of Ophthalmology
National Bleeding Disorders Foundation
Hemophilia Alliance
Cancer Support Community
Susan G. Komen
GO2 for Lung Cancer
National Pancreas Foundation
Society of Dermatology Physician Assistants (SDPA)
Western Pennsylvania Bleeding Disorders Foundation
LUNGevity Foundation
Alliance for Patient Access
Diabetes Patient Advocacy Coalition
Diabetes Leadership Council
Good Days

Association for Clinical Oncology
CLL Society
Pacific Northwest Bleeding Disorders
CancerCare
Infusion Providers Alliance
ALS Association
The Assistance Fund
Dravet Syndrome Foundation
Hereditary Angioedema Association
Bleeding Disorders Foundation of North Carolina
Epilepsy Foundation
Hope Charities
Rheumatology Nurses Society
Chronic Care Policy Alliance
CA Chronic Care Coalition