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Coalition of State Rheumatology Organizations

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December 21, 2023

Ms. Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9895-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted electronically via regulations.gov

Re: 2025 Notice of Benefit and Payment Parameters

Dear Administrator Brooks-LaSure,

The Coalition of State Rheumatology Organizations (CSRO) is comprised of over 40 state and regional professional rheumatology societies whose mission is to advocate for excellence in the field of rheumatology, ensuring access to the highest quality of care for the management of rheumatologic and musculoskeletal disease. Our coalition serves the practicing rheumatologist. Today, we write to share feedback on policies described in the aforementioned proposed rule.

Non-Standardized Plan Option Limits (§ 156.202)

CSRO urges the Agency to closely monitor non-standardized plan options should it finalize its proposal to permit issuers to offer additional options in 2025 and subsequent years. Allowing Exchange plan issuers to offer additional non-standardized plan options centered around chronic and high-cost conditions with lower out-of-pocket cost sharing for consumers is laudable. The Agency specifically mentions rheumatoid arthritis (RA), which we agree is suitable for this purpose.

Nevertheless, we are concerned that issuers may use this opportunity to establish even narrower "preferred" provider networks and more restrictive condition-specific drug formularies, directing consumers away from their current physician(s) and/or therapies. Plans are notorious for hindering access to specialty care – usually by excluding specialists from their provider networks and forcing "non-medical" medication changes on certain patient populations. These plan behaviors run counter to the goal of the proposal, which is to combat health disparities and advance health equity. ***The Agency must provide enhanced oversight of non-standardized plan options to ensure access to care and treatment is not hindered for consumers that may decide to enroll.***

Prescription Drug Benefits (§ 156.122)

CSRO supports referencing USP Drug Classification (USP DC) as a means of classifying the drugs required to be covered as Essential Health Benefits (EHB) under § 156.122(a)(1), in lieu of the current USP Medicare Model Guidance (MMG), which is ill-suited for purposes of Marketplace plans.
Consumers in the Exchanges and Medicare beneficiaries face varying health challenges, and the rules on which their plan options rely are separate and distinct. As such, the standards on which plans must rely for prescription drug benefits should be appropriate for each. Now that a prescription drug standard is available for purposes of Marketplace plans, it stands to reason that the implementing regulations should be revised to account for this. ***We urge the Agency to issue rulemaking to codify this change.***

CMS also asks about the prevalence of "alternative funding programs." CSRO recently joined a coalition of patient and provider groups in support of litigation brought by a pharmaceutical company, alleging that the alternative funding program used in that case was fraudulent and exploitative of the company's charitable assistance program. (For more information, see here.) To be eligible for charitable assistance, patients must generally be un- or under-insured. Excluding specialty drugs from coverage is an attempt to create eligibility for charitable assistance, even though the patient does have insurance, including for other medications. In fact, if the drug company finds the patient ineligible, the "excluded" medication at issue reverts back to regular coverage. This not only creates delays for patients who are ultimately found ineligible for charitable assistance, but it also diverts that limited assistance away from patients who are truly uncovered for the medication, i.e., have no coverage to revert back to. For those reasons, it is our hope that CMS's proposal to close the essential health benefits loophole will help stop this practice, and we urge the agency to finalize it.

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Thank you for considering our comments on the development of RA-focused episode-based cost measure. Please do not hesitate to contact us at info@csro.info should you require additional information.

Sincerely,

Gary R. Feldman, MD, FACR
President

Madelaine A. Feldman, MD, FACR
Vice President, Advocacy & Government Affairs