April 18, 2014

Marilyn Tavenner
Administrator
Chief Operating Officer
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

ELECTRONIC DELIVERY

Re: CMS-9949-P (Exchange and Insurance Market Standards for 2015 and Beyond)

Dear Administrator Tavenner:

The Plasma Protein Therapeutics Association (PPTA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) March 21, 2014 proposed rule on Exchange and Insurance Market Standards for 2015 and Beyond (Proposed Standards or Proposed Rule).¹ PPTA represents human plasma collection centers and the manufacturers of lifesaving medicinal therapies derived from collected plasma, including albumin, alpha₁-proteinase inhibitor, antithrombin III, blood clotting factors, C1 esterase inhibitor, fibrin sealant, immune globulin, hyperimmune immune globulin, prothrombin complex concentrate and protein C concentrate.² Additionally, PPTA member companies innovate and manufacture recombinant blood clotting factors. Collectively, these therapies – both plasma-derived and recombinant – are known as “plasma protein therapies.” PPTA’s U.S. manufacturer membership includes Baxter BioScience, Biotest, CSL Behring, Grifols, and Kedrion. PPTA supports CMS’ goal to “promote access to care in qualified health plans in the [Federally-Facilitated Marketplaces] FFM[s].”³

As CMS considers policies to improve the patient experience in FFMs, the foremost objective of marketplace reform should be to ensure patients have timely and appropriate access to life-sustaining therapies and care, a priority previously (December

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² Human plasma is the clear liquid portion of blood that remains after the red cells, leukocytes, and platelets are removed. Due to its human origin, complexity, and richness in therapeutically useful proteins, human plasma is a unique biological material. See Thierry Burnol, Plasma Proteins: Unique Biopharmaceuticals – Unique Economics, in 7 PHARMACEUTICALS POLICY AND LAW, BLOOD, PLASMA AND PLASMA PROTEINS: A UNIQUE CONTRIBUTION TO MODERN HEALTHCARE 209 (2005, 2006).
17, 2013) established by CMS in regulations on qualified health plans. Accordingly, PPTA strongly supports CMS’ proposed update to the standards narrowing the opt-out provisions for self-funded, non-federal governmental group health plans that were previously available under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), in accordance with the amendments made by The Patient Protection and Affordable Care Act (42 u.s.c. § 18001 et seq.). Additionally, recognizing the limited resources of hemophilia treatment centers (HTCs) that provide important comprehensive care to many of the hemophilia patients who rely on plasma protein therapies for their lifesaving treatment, PPTA supports the agency’s intended revisions of the non-discrimination provisions 45 C.F.R. §155.120(c)(1) and (c)(2). PPTA also supports the National Hemophilia Foundation and Hemophilia Alliance’s proposal to protect patient access for hemophilia patients by treating HTCs as a distinct essential community provider (ECP) and establishing a separate category for HTCs under EC network requirements. To advance patient access and improve overall adherence and health outcomes, FPTA also recommends that CMS adopt several of the changes the Agency is considering related to the prescription drug benefit that is part of the “essential health benefits,” including:

- Amending the formulary exceptions standard in 45 C.F.R. §156.122(c) to (1) require insurers to issue decisions regarding formulary exceptions requests within 24 hours after receipt of requests that are based on exigent circumstances; and (2) cover non-formulary drugs during the course of coverage determination.
- Amending the formulary exceptions standard in 45 C.F.R. §156.122(c) to require issuers to provide meaningful assistance to patients who have been denied coverage through navigation of the exceptions and appeals processes.

Recognizing the rate at which the healthcare landscape is evolving and the substantial scale of reforms underway, PPTA appreciates the outreach CMS has undertaken and the agency’s transparency with regards to implementation.

**BACKGROUND**

Plasma protein therapies are unique, non-interchangeable biological therapies predominantly used to treat patients living with rare and chronic diseases. Given the unique nature of plasma protein therapies, to ensure patients have access to the therapy that interacts positively with their immune system and induces the best possible

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4 78 Fed. Reg. at 76,212.
5 79 Fed. Reg. at 15,945.
6 Where exigent circumstances are defined as when an enrollee is suffering from a serious health condition or is in a current course of treatment using a non-formulary drug and a delay in access to or changing from that drug to a different brand or formulation poses a risk of life threatening or irreversible damage to the enrollee’s health.
7 Where meaningful assistance is defined as providing clear instructions on the exceptions and appeals processes that are available, how to access those processes, and the timelines for resolution associated with each process. Meaningful assistance should also include the capacity for enrollees to track the progress of their appeal, readily ascertain interim decisions, reasons for delays or postponements, and a regularly updated estimated time to resolution.
outcome, patients must have unencumbered, timely, and appropriate access to a robust diversity of therapies within the class. Patients receiving plasma protein therapies generally receive regular infusions or injections for the duration of their lives. Any interruption in a patient’s administration schedule can result in severe or potentially life-threatening consequences. It is therefore of paramount importance that patients receiving plasma protein therapies have consistent access to the drugs needed for their particular treatment regimens.

Additionally, the majority of plasma protein therapies are approved for marketing in the U.S. by the Food and Drug Administration (FDA) for the treatment of one or more rare disease, disorder, or condition. In the U.S., a “rare disease or condition” is generally defined as a disease or condition that affects less than 200,000 people. Most of the rare conditions that require treatment with plasma protein therapies are genetic, chronic, and life-threatening. As representatives of a segment of the biopharmaceutical industry with considerable experience in treating rare diseases, PPTA recognizes that coverage of a wide range of therapies is necessary to ensure that patients receive the best possible treatment. Because of the rare, chronic, life-threatening nature of rare diseases like primary immunodeficiency disease, alpha-1 antitrypsin deficiency and hemophilia and other bleeding disorders, any impediment to treatment is particularly dangerous. Recognizing the especially vulnerable nature of the patients living with these diseases, PPTA urges CMS to take steps to ensure consistent and appropriate access to lifesaving therapies and care.

DISCUSSION

I. PPTA Urges CMS to Strengthen Coverage Exceptions Requirements to Protect Patient Access to Lifesaving Therapies

For patients living with primary immunodeficiencies (PIDs), alpha-1 antitrypsin deficiency, hemophilia, von willebrand diseases, chronic inflammatory demyelinating polyneuropathy (CIDP), hereditary angioedema (HAE), and the many other rare and chronic conditions and diseases treated with plasma protein therapies, expediency in access to the therapy for which they are best suited is necessary to avoid long-term, debilitating, and irreversible health consequences. Accordingly, in cases where a plan has issued a denial of coverage, if delay in care or therapeutic intervention has the potential to cause life-threatening or irreversible damage to an enrollee’s health as

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9 Diseases treated with plasma protein therapies include alpha-1 antitrypsin deficiency, chronic B-cell lymphocytic leukemia, chronic inflammatory demyelinating polyneuropathy (CIDP), hereditary angioedema, hereditary antithrombin III deficiency, protein C deficiency, primary immune deficiency diseases (PIDs), such as common variable immunodeficiency, X-linked agammaglobulinemia (Bruton’s disease), DiGeorge syndrome, Wiskott-Aldrich syndrome, Nezelof’s syndrome, severe combined immunodeficiency, graft-versus-host diseases, and bleeding disorders, such as hemophilia A, hemophilia B, congenital fibrinogen deficiency, von Willebrand disease, and factor XIII deficiency. Cytomegalovirus disease associated with transplant patients, hepatitis B reinfection in liver transplant patients, idiopathic thrombocytopenic purpura (ITP), infant botulism, and Kawasaki’s disease. Rabies, rhesus incompatible pregnancies, and tetanus are examples of acute rare conditions that are treated with plasma protein therapies.
determined by the enrollee’s attending physician, PPTA recommends that CMS require insurers:

- Issue decisions regarding formulary exceptions and appeals requests within 24 hours after receipt of requests that are based on exigent circumstances;
- Cover non-formulary drugs during the course of coverage determinations;
- Provide meaningful assistance to patients who have been denied coverage through navigation of the exceptions and appeals processes.

A. PPTA Urges CMS to Require Issuers to Issue Decisions on Formulary Exceptions and Appeals Requests within 24 Hours for Exigent Cases

Delays in treatment with plasma protein therapies significantly and adversely affect morbidity and mortality for patients living with the range of rare and chronic diseases traditionally treated by these lifesaving therapies. For example, due to changes in Medicare reimbursement, in 2006, plasma protein patients experienced problems with access to IVIG, resulting in an increase in hospitalizations, longer hospital stays, increased infections, and higher rates of adverse events due to patients having to switch from the brand best suited for their immune system to the brand that was available.\(^{10}\) Additionally, in patients living with hemophilia, delays in treatment with blood clotting factor have been shown to cause severe and irreversible side effects including debilitating joint degradation and fatal hemorrhages.\(^{11}\) Similarly, for patients living with alpha-1 antitrypsin deficiency, delays in treatment with plasma-derived alpha-1 proteinase inhibitor therapy has been shown to lead to irreversible lung damage, reducing patients’ forced expiratory volumes (FEVs), and inducing long-term negative effects on lung functionality.\(^{12}\)

The current formulary exceptions standard does not specify a time frame for insurers to make decisions on requests for coverage of non-formulary drugs and does not require coverage of those non-formulary drugs during the review process. Recognizing the life-threatening effects of delaying care for plasma protein patients, and the health risks posed by forcing plasma protein patients to switch between brands within the same therapeutic class, PPTA urges CMS to strengthen the current coverage exceptions requirements to ensure patients have guaranteed access to the therapies and care that best suit each patient’s individual health status. Based on the industry’s extensive and profound clinical understanding of plasma protein therapies, PPTA holds that requiring insurers to issue decisions regarding formulary exceptions and appeals requests within 24 hours after receipt of requests that are based on exigent

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circumstances will decrease the likelihood of adverse events and contribute to improved patient health outcomes.

**B. PPTA Urges CMS to Provide Uninterrupted Coverage Throughout the Exceptions and Appeals Process**

PPTA strongly recommends that CMS require issuers to provide uninterrupted coverage to the drug(s) that is (are) the subject of appeals throughout redetermination processes. Given the unique biological nature of plasma-derived therapies, requiring patients who have identified an effective plasma protein therapeutic brand and regimen to switch to another medication or discontinue treatment puts patients at risk of severe and debilitating adverse events. By ensuring patients have access to the best possible therapy, CMS will protect patient health and reduce unnecessary costs to the healthcare system arising from adverse events.

A 2008 study conducted by the Immune Deficiency Foundation (IDF) found that on average 14 percent of patients diagnosed and living with primary immune deficiency (PID) discontinue utilization of IVIG replacement therapy due to a lack of insurance coverage.\(^{13}\) The findings of the 2008 study also demonstrate that such discontinuance increases the risk for those patients of permanent impairment of lung function, mobility, digestive function, and vision and hearing. Once PID patients begin or resume treatment the functional impairments arising from non-treatment suppress the effectiveness of IVIG. Accordingly, not only do discontinuances and gaps in insurance coverage undermine the health of already immune-compromised patients, but they also serve to increase the overall costs of treatment and care to the healthcare system. An estimated 4,000 PID patients who are under the age of sixty-five receive Social Security Disability Insurance payments due to the functional impairments arising from their disease.

Accordingly, PPTA recommends that CMS prohibit plans from discontinuing coverage for patients who have filed an appeal to a denial of coverage decision. By prohibiting coverage discontinuance for plasma protein patients, CMS will protect patient health, prolong the lives of the most vulnerable patients, and reduce overall costs to the healthcare system.

**C. PPTA Urges CMS to Require Issuers to Provide Meaningful Exceptions and Appeals Assistance Concurrent to the Issuance of Coverage Denial**

Nearly 30 percent of enrollees in the ACA marketplaces are expected to be newly-insured, while the remaining enrollees will be purchasing insurance plans that are substantively different from the plans they previously owned.\(^{14}\) Recognizing the inherent

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\(^{13}\) Marcia Boyle, Christopher Scalchunes, Impact of intravenous immunoglobulin (IVIG) treatment among patients with Primary Immunodeficiency diseases, Pharmaceuticals Policy and Law 10 (2008) 133–146.

challenges associated with navigating the complexities of insurance exceptions and appeals processes, and that these complexities will present especially burdensome barriers to access for new entrants into the insurance marketplace, PPTA urges CMS to implement requirements that will improve the accessibility and utility of the exceptions and appeals processes for plans issued through the ACA marketplaces. In particular, PPTA recommends CMS require issuers to provide meaningful exceptions and appeals assistance concurrent to the issuance of coverage denials.

In September, 2013 MedPAC issued the agency’s findings that for Medicare beneficiaries participating in Part D, the appeals and exceptions process is overly complex and inaccessible.\textsuperscript{15} Notwithstanding the differences between Medicare Part D plans and the plans offered through marketplaces, the challenges faced by Part D beneficiaries to effectively engage in exceptions and appeals represents a precedent that CMS should proactively prevent for the marketplace population. Specifically, upon issuing a denial of coverage, issuers should be required to provide enrollees with clear instructions on how to access and engage the methods available for filing an appeal. To ensure greater transparency and allow for more efficient processing, claimants should also be able to readily track the progress of their appeal, and have the capacity to readily ascertain interim decisions, reasons for delays, and an estimated time to resolution.

Improving the transparency, accessibility and effectiveness of the exceptions and appeals process for the marketplace population will mitigate current barriers to access, and importantly, for patients who require uninterrupted access to care and therapies for their lifesaving treatment, taking these steps will protect patient health.

CONCLUSION

PPTA appreciates this opportunity to provide input in response to CMS’ proposed rule on Exchange and Insurance Market Standards for 2015 and Beyond. As the agency works to finalize its policy, we appreciate consideration of the recommendations provided above.

Please do not hesitate to contact Everett Crosland, Director, Federal Affairs, PPTA at (202) 302-8646 or by email (ECrosland@PPTAGlobal.org) if you have any questions or require any additional information.

Sincerely,

Everett Crosland
Director, Federal Affairs
