January 31, 2023

The Hon. Xavier Becerra
Secretary
Department of Health and Human Services
200 Independence Avenue S.W.
Washington, D.C., 20201

Re: Advancing Health Equity Through Essential Health Benefits

Dear Secretary Becerra:

The National Health Council (NHC) is pleased to provide the following comments in response to the Request for Information: Request for Information; Essential Health Benefits (EHB). The protections that having EHB in place for plans in the marketplace and the ripple effect that it has created to increase the quality of coverage for all Americans is significant. We applaud CMS for this RFI to revisit EHB to make sure that the program is up-to-date and as comprehensive as possible.

Created by and for patient organizations more than 100 years ago, the NHC brings diverse organizations together to forge consensus and drive patient-centered health policy. We promote increased access to affordable, high-value, sustainable health care. Made up of more than 150 national health-related organizations and businesses, the NHC's core membership includes the nation's leading patient organizations. Other members include health-related associations and nonprofit organizations including the provider, research, and family caregiver communities; and businesses representing biopharmaceutical, device, diagnostic, generic drug, and payer organizations.

The state benchmarking process has resulted in variation of coverage depending on what state a patient lives in, rather than on their medical needs. A growing body of evidence shows that under current requirements, health plans often fail to meet the needs of underserved populations, including persons with disabilities and chronic illness, as well as Black, Indigenous, and other people of color (BIPOC). Thus, we appreciate CMS' willingness to review the current landscape to inform potential modifications to the EHB process.

It is important that CMS undertake efforts to carefully monitor and enforce EHB standards to assure people in all states have access to critical services. The NHC would support developing federal EHB definitions that are inclusive and comprehensive to create a "floor" of what EHBs mean. That definition should be revisited and revised frequently and should be done with ongoing input from the patient community and other stakeholders. We also encourage EHB benchmarks, no matter how they are developed, to be communicated clearly with patients and advocates in language that is understandable and consistent.

There are some specific areas that need review to assure that EHB are inclusive and comprehensive. The NHC encourages CMS to consider reviewing and revising EHB standards for the following areas of coverage.

Habilitative and rehabilitative services and devices.

Because habilitative and rehabilitative services were not routinely covered by a “typical employer plan” during passage of the ACA, these services have often been among the most difficult considerations of EHB since the creation of the EHB package. Plans subject to EHB cannot impose a single, combined limit on habilitative and rehabilitative services and devices and, if limits are used, those that apply to habilitative services and devices cannot be less favorable than those that apply to rehabilitation. These are important protections, yet there is insufficient data on service use to determine compliance with this important provision. In addition, benefit limits, which are often applicable to a specified period (e.g., the calendar year), should be revisited. We suggest that such limits, if used at all, should be tied to a particular condition or episode of care, to ensure that patients with multiple conditions can access care sufficient to address their various needs.

Too often, people with chronic conditions and disabilities have difficulty accessing durable medical equipment (DME) such as mobility aids, oxygen supplies, and hearing aid devices and fitting services. For individuals with chronic diseases and disabilities this equipment can be key to their health and independence and can be cost prohibitive if not covered or have high cost-sharing requirements. HHS should clarify coverage of rehabilitative and habilitative services and require a minimum level of coverage of DME. In addition, HHS should encourage states and plans to exempt coverage of all DME from cost-sharing, including deductibles, copayments, and coinsurance.

Pediatric Services and Maternal Care

The benchmark process uses plans that are designed primarily for the health needs of adults, and there has been significant variation across state EHB benchmarks in the coverage of benefits and services for children specifically. In the coming year, upon the Medicaid redeterminations beginning April 1, we expect many families will lose Medicaid, and its robust Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) pediatric benefit, and enroll in marketplace coverage. This enhances the need to assure that the EHB pediatric services benefit standard is reassessed and, if necessary, revised.

To ensure that numbers of pre- and post-natal visits are in line with standards of care and given the significant health disparities in maternal care and mortality, it is critical that we address this to help assure better health outcomes for mothers and babies.

Mental Health and Substance Abuse Disorder Benchmarks

Before the ACA, most health insurance plans were not required to include coverage for mental health (MH) and substance use disorder (SUD) services, despite the outstanding need for them. The benchmarking process has increased access to services, but there are still significant gaps in coverage. One way to close these gaps is to increase enforcement of and guidance about federal parity requirements. In 2020, researchers published a comprehensive study of EHB benefits provided under the category for mental health and substance use disorder services, including behavioral health treatment, reviewing 112 EHB documents from all states between 2012 to 2017. They concluded that "[o]ur research finds notable divergence between accepted medical practice standards and the reviewed essential benefit benchmark plans standards. Coverage that does not reflect minimum standards of care threatens to harm individuals and populations and may constrain providers' ability to provide appropriate quality care."[1]

We firmly believe plans must provide coverage for all services deemed medically necessary for treating any MH/SUD condition. Some examples of services that should be specified for EHB plans include crisis intervention services, intensive care coordination, and intensive community-based services. Including these services in the EHB definitions would prevent the need for interventions such as inpatient or residential services later that are both costly, and in most cases, not in line with providing services in the community as required by the Olmstead decision.

Mental health and SUD services are considerably underutilized by marginalized populations. We support updating EHB requirements to improve access to important MH/SUD services to address health disparities and HHS should use EHB as a vehicle to achieve behavioral health equity.

Prescription Drugs

The NHC appreciates that CMS is seeking input of prescription drug coverage. It is important that we expand coverage as much as possible so that patients have access to needed treatments. Plans currently satisfy EHB standards for prescription drugs if, among other things, they cover the greater of one drug per U.S. Pharmacopeia (USP) class and category or the number of such drugs included in the state's benchmark plan. This standard has not been updated since the EHB rules came into effect in 2014. Since then, the USP developed a second drug classification system, the USP Drug Classification (DC). CMS is seeking public comment on the risks and benefits of replacing the current USP Guidelines with a different drug classification system, such as the USP DC or others, in the future. As CMS explores the type of coverage for prescription drugs, the NHC supports a classification system that is more representative

[1] Charley E. Wilson, Phillip M. Singer, & Kyle L. Grazier, Double-edged Sword of Federalism: Variation in Essential Health Benefits for Mental Health and Substance Use Disorder Coverage in States, 16 HEALTH ECON., POL'Y & L. 170 (2021), https://pubmed.ncbi.nlm.nih.gov/31902388/.

of the marketplace population versus the Medicare population. We also support a system that is updated regularly with significant input from a diverse set of patient advocates to assure that any changes to the model result in comprehensive and affordable coverage of treatments that all patients need.

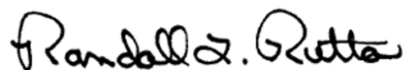
Patient Engagement

The ACA authorizes HHS to update and expand EHB administratively, addressing coverage gaps without the need for congressional action. The ACA also requires HHS to periodically review EHB and report to Congress on EHB effectiveness and impacts. HHS should establish a framework for reviewing and updating EHB. The process for review of EHB must be transparent, with mechanisms in place to allow for regular and meaningful patient engagement on their experience with coverage. In addition, quality data about patient experience with denials, complaints and appeals should be available and transparent. An independent advisory council to assist in reviewing and updating EHB should be created. Patient and consumer representatives should be adequately represented on the advisory council. There should be flexibility available to HHS and the advisory council to make recommendations as to how benefits can be modified to address identified gaps in access.

Conclusion

Please do not hesitate to contact Eric Gascho, Senior Vice President of Policy and Government Affairs, if you or your staff would like to discuss these issues in greater detail. He is reachable via e-mail at egascho@nhcouncil.org.

Sincerely,



Randall L. Rutta
Chief Executive Officer