July 19, 2023

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

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Secretary Becerra and Administrator Brooks-LaSure:

The 54 undersigned organizations thank the Department of Health and Human Services (HHS) for reviewing its regulatory approach to the Essential Health Benefits (EHB) under the Affordable Care Act (ACA) through the December 2022 EHB request for information. As HHS continues to review those comments, we strongly urge the Department to initiate rulemaking to address the gaps and inconsistencies highlighted by commenters. As states continue to unwind Medicaid continuous eligibility policies over the next year, millions of people are likely to transition to marketplace coverage and other private insurance plans that must adhere to EHB requirements. As such, HHS has an immediate opportunity to strengthen and align coverage standards across private and public insurance programs and address inequitable barriers to essential health care services. In addition, we urge HHS to establish a permanent and transparent process to review and update EHBs on a regular basis. Such a process should align with the Biden-Harris administration's equity agenda by integrating a data-driven evaluation with feedback from a community or enrollee advisory council comprised of individuals facing barriers to care and gaps in EHB coverage. For too long, our policies have not included the input and perspectives of the people who are impacted by them.

Since 2014, there have been considerable changes to the implementation of the ACA and plan offerings on the health insurance marketplaces. Increased competition and enhanced premium subsidies reduced costs for people across income levels and drove record enrollment. However, the ACA's underlying approach to defining EHBs remains largely unchanged, relying on the initial state benchmark plan approach to defining the ACA's ten categories of Essential Health Benefits.

As a result of the benchmark plan approach, there is considerable variation in EHB coverage across states and, historically, many states defaulted to less generous small group benchmark plans. We are concerned about the inequitable access to critical services caused by such

variation, including access to prescription drugs, mental health and substance use disorder (SUD) treatment, maternal and reproductive health services, gender-affirming health care, and pediatric services. In addition, the benchmark approach has left significant gaps in coverage for other necessary preventive, ambulatory and chronic disease services such as oral health care. As a result, the EHB framework has not kept up with clinical evidence or the needs of the enrollee population. The undersigned organizations continue to hear that these gaps and inconsistencies in coverage are of particular concern for the health and economic well-being of low-income and marginalized populations who struggle to access and afford the care they need.

The ACA authorizes HHS to update EHBs through administrative action to address gaps in access or changes in scientific evidence, pursuant to its periodic review of EHB.[1] However, to our knowledge, HHS has not conducted such a review and submitted a subsequent report to Congress to date. HHS must establish a framework for reviewing and updating EHBs that incorporates community input to appropriately address health disparities.[2] This is critical in order for individuals with EHB coverage to have access to affordable and comprehensive health care.

Examples of Gaps and Inconsistencies in EHB Coverage

Oral health care

Oral health is essential to every person's overall health and economic well-being, but oral health services for adults are currently absent from the EHB framework. **We strongly encourage HHS to incorporate adult dental services into the EHBs.** Access to dental care improves health outcomes for costly chronic conditions, reduces risk for adverse birth outcomes and improves people's job prospects. The ACA's inclusion of dental coverage for children into the EHBs has helped to address racial and income-based disparities in oral health outcomes. And, research shows that expanding adult dental coverage can further reduce racial disparities.

Access to dental care for adults also presents long-term benefits for oral and overall health. Receiving preventive dental care during pregnancy and the postpartum period reduces the long-term risk of tooth decay in children and adolescents. And, the deep connection between

[1] 42 U.S.C. § 18022(b)(4)(H).

[2] We note that the Institute of Medicine, in its 2011 *report* *Essential Health Benefits: Balancing Coverage and Cost*, discusses possible features of an EHB review process. While many of the report's assumptions and priorities are outdated, some IOM recommendations remain relevant and are reflected herein.

oral health and other chronic diseases means that investment in dental benefits goes a long way. Access to dental care to treat oral health problems can improve diabetes outcomes, address the link between oral health and cardiovascular disease, and improve SUD outcomes.

Despite the robust health and economic benefits of access to dental care, current EHB standards do not include dental coverage for adults, leaving millions of people to pay high out-of-pocket costs, seek care in emergency departments where they incur debt, or live in pain because they can't afford the care they need. People of color and low-income communities are the most likely to experience lack of access to care and associated poor oral health outcomes. **We urge HHS to close this glaring gap now by embedding adult dental services into the ambulatory and preventive services EHB categories.**

Mental health and substance use disorder services

The EHBs generally require coverage of mental health and substance use disorder (MH/SUD) services, including behavioral health treatment. However, EHB standards for MH/SUD treatment services are so broad that patients' access to life-saving SUD treatment medications like methadone, buprenorphine and naltrexone varies widely and depends on where they live and which health plan they choose. Similarly, some states' benchmark plans, which were adopted prior to the finalization of the Mental Health Parity and Addiction Equity Act (MHPAEA), contain blatant parity violations such as lack of coverage for residential MH/SUD services while covering physical health skilled nursing facilities. Additionally, while all state benchmark plans cover emergency services, including EMS and ambulance transport, some benchmarks do not require coverage of MH/SUD mobile crisis response and stabilization services.

EHB coverage standards should clearly and consistently cover the full continuum of MH/SUD treatment and services for both children and adults, including: medically necessary services; crisis and emergency services (including mobile crisis response and crisis receiving/stabilization services); harm reduction services; all medications for addiction treatment and opioid reversal; recovery support services including those delivered by peers; coordinated specialty care; the Collaborative Care Model (CoCM); and the full continuum of care as described by the American Society for Addiction Medicine, the American Academy of Child and Adolescent Psychiatry, and the American Association of Community Psychiatrists. State should also be required to demonstrate that their EHB benchmark plans are fully compliant with MHPAEA.

Prescription drugs

The price of prescription drugs is more than 2.5 times higher in the U.S. than in other countries and those costs continue to outpace inflation. This leaves millions of people unable to pay for the medications they need. Coverage of prescription drugs varies in EHB plans from state to state and insurance plan documents aren't always clear on what's covered. **At a minimum, the Biden administration should align EHB prescription drug coverage requirements with Medicare Part D, ensure coverage of all protected classes of drugs as well as medications for opioid disorder treatment and reversal.**

Maternity care

Our country's maternal mortality crisis is only getting worse and disparities in maternal health outcomes for Black and Indigenous birthing people are widening. Lack of clarity around EHB coverage for maternal health care at the federal level means that many patients encounter limits on prenatal and delivery services covered, inconsistent coverage of breastfeeding and lactation services, and unnecessary restrictions on midwives and doula services. This only compounds the racial inequities in access to high quality care for pregnant and postpartum people. EHB coverage of maternity care should be consistent with the recommendations of medical experts and should not impose limits that restrict access to critical life-saving services, regardless of pregnancy outcomes, including miscarriage, stillbirth, live birth and abortion.

At a minimum, EHBs should adhere to the clinical guidelines developed by the American Academy of Pediatrics Committee on Fetus and Newborn as well as the American College of Obstetricians and Gynecologist Committee on Obstetric Practice. Our state partners have also highlighted the importance of several maternity services that should be included in order to improve the quality of care provided through EHB plans:

- Postpartum and family home visits. The majority of maternal mortalities occur in the postpartum period. Postpartum people need follow-up visits, lactation support, and maternal mental health services, among other services that can and should be delivered in the home. Attending multiple postpartum or newborn appointments in the first 30 days outside of the home is exhausting and burdensome for the postpartum parent. Further, several states' EHB benchmark plans cover home health visits, including in Colorado and Connecticut. Family home visiting, which can begin prenatally and last through a child's fifth birthday, also produces positive benefits in infant, early childhood, and maternal health as well as improvements in physical health, school readiness, and decreased child maltreatment. 28 states currently cover these longer-term, intensive home visiting services through their Medicaid programs.

- Childbirth and parenting education classes. Pregnant and parenting people need access to critical educational resources to supplement their medical care. These services can be delivered by midwifes or doulas, or offered in classroom settings. The Better Beginnings program, offered under Vermont's benchmark plan, covers educational classes on breastfeeding, sibling relationships, parenting, and CPR, in addition to childbirth.
- Coverage for home-birth and birthing centers. Birthing people should have access to the full range of safe maternity care through EHBs, to include home-birth and birthing centers. These are models that have been proven safe and effective and provide improved quality and value, especially for families of color. Currently, birth centers are covered explicitly in more than one third of states' benchmark plans and some states cover home-birth explicitly as well.

Gender affirming care

Despite federal civil rights protections against nondiscrimination in health care, transgender and nonbinary (TNB) individuals face significant marginalization in health care settings, including high rates of uninsurance, cost-related barriers to accessing needed care, and direct harassment and discrimination. While the Biden administration has taken steps to clarify protections against discrimination in health care based on gender identity, access to gender-affirming care remains under direct attack at both the state and federal levels. Even among states taking action to improve access to these services, covered benefits vary considerably between states and health insurance plans. **HHS must strengthen EHB standards to reflect the full range of services under existing standards of care for transgender and nonbinary children and adults, ensuring equitable access regardless of where a person lives.** Without greater clarity in federal EHB standards, access to this cost-effective and life-saving set of services remains at risk.

Pediatric services

Medicaid requires comprehensive and child-specific services in every state through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits, which are considered to be the gold standard. But private coverage differs because the current EHB framework does not currently define pediatric services beyond oral and vision care, with the exception of no-cost preventive services endorsed by the Health Resources and Services Administration. This means that coverage for many children is largely based on insurance plans that were designed for adults. As many children are likely to transition to private coverage during the Medicaid

unwinding, the Biden administration should make sure their access to care remains unchanged. At a minimum, EHB standards should align with the American Academy of Pediatrics' most recent policy on pediatric coverage. However, **we also urge HHS to align pediatric EHB coverage standards with those found in Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) as part of its continued efforts to ensure equitable and seamless access to care across Medicaid, Medicare and Marketplace coverage.** This is critical to ensuring that children and adolescents, particularly children with disabilities or other special health care needs like speech or behavioral therapy, receive care that is age-appropriate and individually tailored.

Establishing a regular review and update process

As advocacy organizations working closely with state and community partners, we offer the following recommendations to support HHS in establishing a regular and permanent review process. At minimum, we recommend a standard review process take place every other year.

Meaningful community participation

HHS should create a community or enrollee advisory council to assist in reviewing and updating EHBs through recommendations made to the secretary. Both HHS and the advisory council should have the flexibility to make recommendations as to how benefits could be expanded to address identified gaps in access. Additionally, the advisory council, alongside any appointed clinical and policy experts, should have the authority and resources to monitor changes and developments in medical evidence to make such recommendations to benefits packages in a timely manner. The advisory council should be comprised primarily of individuals with EHB coverage and who do not have a vested interest in a health system or insurance company; membership could include additional community-facing stakeholders such as health care providers or community health workers.

We strongly urge that HHS apply the principles of co-design and transparency in establishing the advisory council and any other bodies that will play a role in reviewing and updating the EHBs. This should include: appropriate compensation for participation; relevant member trainings about pertinent health policy topics; multiple methods for participation such as in-person, by phone and through video conferencing platforms; offering meetings during and outside of traditional work hours; simultaneous interpretation across languages; and the availability of dedicated staff or consultants to answer questions from members or provide necessary research.

During recruitment of advisory council members, HHS should make concerted efforts to reach underserved and disenfranchised populations including, but not limited to: Black, Hispanic, and other people of color; members of Asian American, Native Hawaiian, and Pacific Islander (AANHPI) communities; people with disabilities; people with mental health diagnoses or substance use disorders; members of Tribal communities; LGBTQ+ people; people with limited English proficiency; and immigrants. All outreach materials should use plain language, follow digital accessibility standards where applicable, and be translated into multiple languages. Partnering with community leaders and other trusted messengers can help HHS reach people directly where they live, work and congregate.

To promote transparency, the advisory council should follow best practices including holding public meetings, soliciting public comment, establishing staggered terms to ensure continuity, for-cause removal, and rigorous disclosure and conflict of interest protocols. In addition, there should be a public notice and comment process to address updates and full transparency on advisory council proceedings and materials. HHS should consider modeling the advisory group after other permanent structures like the CMS Core Set Working Group, the Advisory Committee on Minority Health, or the HRSA Advisory Committee on Training in Primary Care Medicine and Dentistry.

Data Evaluation of Gaps in Coverage and Barriers to Access

In addition to consulting with an advisory council, HHS should regularly review benefits packages to ensure that certain populations or specific diseases or conditions are not adversely affected by the services or level of coverage offered and that covered benefits reflect standards of care and current clinical approaches.

The process for review of the EHB packages must be transparent, with mechanisms in place to allow for regular and meaningful public review and comment. HHS should establish ongoing mechanisms available to track access to health services and potential obstacles in accessing services due to coverage limitations or cost. EHB data collection should include:

1. Periodic review, analysis and comparison of state base benchmark plans in EHB benefit categories;[3]
2. Review issuer claim denials, utilization management and consumer complaints; HHS should have a system in place for monitoring these reports as well as the outcomes

[3] See, *e.g.*, 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/.

(appeals/overrides) to provide early warnings of what types of problems individuals are encountering;[4]

3. Population-based health data tracking health trends, outcomes and unmet health needs.[5]

The HHS EHB review can rely, in part, on existing data sources and analyses. In addition, agencies within HHS should coordinate their efforts to review and update EHB.[6]

HHS should also consider a system of regular, standardized surveys and listening sessions with both quantitative rating and qualitative experience reporting to assist in determining whether individuals are facing difficulty in accessing coverage due to cost, unlawful practices, or other barriers.[7] All information collected and reported should be made publicly available, with opportunities to provide comment, and no charge should be required to access this information.

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[4] A recent study of ACA Marketplace plans by the Kaiser Family Foundation found that issuers denied 1 in 5 claims. Some plans denied up to 80% of claims. Yet only .1% of denials are ever appealed to the first level; and only 2,100 of denied claims were appealed to external review. See Karen Pollitz , Matthew Rae, & Salem Mengistu, KFF, Claims Denials and Appeals in ACA Marketplace Plans in 2020 (Jul. 5, 2022), https://www.kff.org/private-insurance/issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans/?utm_campaign=KFF-2022-Private-Insurance&utm_medium=email&_hsmi=218624983&_hsenc=p2ANqtz-8uT0YrfvPbX_L6xr90SSjNAxPwvB6_j3FaeL-PS1URqC2rmoaGizrH7kllZpQOUtzXGrgapwq6Qp0NICigJNkXdc9W5A&utm_content=218624983&utm.

[5] *E.g.*, U.S. Ctrs. for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, https://www.cdc.gov/brfss/index.html; U.S. Ctrs. for Disease Control and Prevention, Youth Risk Behavior Surveillance System, https://www.cdc.gov/healthyyouth/data/yrbs/index.htm; U.S. Ctrs. for Disease Control and Prevention, National Health Interview Survey, https://www.cdc.gov/nchs/nhis/index.htm.

[6] For example, the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) issued a report, Facilitating Consumer Choice: Standardized Plans in Health Insurance Marketplaces (Dec. 28, 2021), https://aspe.hhs.gov/reports/standardized-plans-health-insurance-marketplaces#:~:text=Standardized%20plans%20are%20a%20policy,and%20cost%2Dsharing%20across%20plans, which bolstered a rulemaking from the HHS Center for Consumer Information and Insurance Oversight (CCIIO) establishing requirements for standardized plans in ACA Marketplaces. See HHS, Dept. of Treasury, Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond, 86 Feb. Reg. 53412 – 53506 (Sept. 21, 2021), https://www.govinfo.gov/content/pkg/FR-2021-09-27/pdf/2021-20509.pdf.

[7] For example, the Federal Employee Health Benefits program can be an instructive model in this context. This program conducts an annual survey of a random sample of plan members to assess satisfaction with plans. The indicators include: overall plan satisfaction, getting needed care, speed of getting care, provider communication, customer service, claims processing, and plan information on costs. This information is publicly available to members so they can compare results across plans (generally surveys are only available for those plans with more than 500 subscribers). See Office of Personnel Management, *2019 Federal Employee Benefits Survey Report* (April 2020), https://www.opm.gov/policy-data-oversight/data-analysis-documentation/employee-surveys/2019-federal-employee-benefits-survey-report.pdf.

We thank the Department for considering these recommendations for updating the EHBs and establishing a regular EHB review and updating process.

Sincerely,

Academy of Dentistry for Persons with Disabilities
Achieva-Disability Healthcare Initiative
Allegany Franciscan Ministries
American Academy of Pediatrics
Arcora Foundation
Asian & Pacific Islander American Health Forum
Association of Asian Pacific Community Health Organizations (AAPCHO)
Association of Maternal & Child Health Programs
California Pan-Ethnic Health Network
Center for Law and Social Policy (CLASP)
Center for American Progress
Colorado Center on Law and Policy
Colorado Children's Campaign
Colorado Consumer Health Initiative
Community Catalyst
Community Servings
Contact Center
Families USA
First Focus
Florida Voices for Health
Futures Without Violence
Georgians for a Healthy Future
Health Care For All
Health Care for America Now (HCAN)
Health Care Voices
Justice in Aging
Kansas Breastfeeding Coalition
Kentucky Voices for Health
La Union del Pueblo Entero-LUPE
Maternal and Child Health Access
Mental Health America
MomsRising
NAADAC, the Association for Addiction Professionals
National Center for Advocacy and Recovery, Inc.
National Health Law Program
NC Justice Center
New Jersey Oral Health Coalition
Northwest Health Law Advocates
PA Coalition for Oral Health
Partnership to End Addiction
Policy Center for Maternal Mental Health
Protect Our Care
Protect Our Healthcare Coalition RI
Small Business Majority
Tennessee Health Care Campaign
The Healthy Living and Learning Center
The Kennedy Forum
The Leadership Conference on Civil and Human Rights
United States of Care
Utah Health Policy Project
Virginia Coalition of Latino Organizations
Virginia Health Catalyst
Westside Family Healthcare, Inc.
Young Invincibles