The Honorable Chiquita Brooks-LaSure
Administrator, Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

RE: CMS-9898-NC

Dear Administrator Brooks-LaSure,

I am writing on behalf of the National Association of Benefits and Insurance Professionals (NABIP), a professional association formerly known as the National Association of Health Underwriters (NAHU), representing over 100,000 licensed health insurance agents, brokers, general agents, consultants, and employee benefit specialists. We are pleased to respond to your "Request for Information (RFI): Essential Health Benefits" published in the *Federal Register* on December 2, 2022.

The members of NABIP help millions of people purchase, administer, and utilize health insurance coverage, including individuals purchasing private individual-market coverage and employers of all sizes who are designing and purchasing group coverage for their employees and their dependents. As such, we are please to be able to provide comments on the questions you posed about essential health benefits (EHBs).

To develop our response to this RFI, NABIP assembled a representative group of members who routinely help group health plan sponsors with their compliance needs. Their thoughts on the specific RFI questions that were relevant to the expertise of health insurance benefit professionals are presented below, broken down by sections listed in the RFI.

Typical Employer Plans

The RFI notes, "In the 2019 Payment Notice, we finalized options at § 156.111 to provide states with greater flexibility to select new EHB-benchmark plans beginning with the 2020 plan year if they so choose. A state's EHB-benchmark plan must still provide a scope of benefits equal to the scope of benefits provided under a typical employer plan. We seek comment on changes in the scope of benefits offered by employer plans since plan year 2014. In particular, we are interested in comments that discuss the relative generosity of the current typical employer plans described at § 156.100(a)(1) through (4) and § 156.111(b)(2)(i)(B), and whether they are reflective of the scope of benefits provided under employer plans offered in more recent plan years, or whether employer plans offered since plan year 2014 are more or less generous."

NABIP members believe that the scope of benefits provided under employer plans is typically more generous than they were in 2014. Some of these benefit-design changes are the result of legal action, such as the *Bostock v. Clayton County* decision, which resulted in plan-design changes addressing gender equity and coverage of gender dysphoria. Others are the result of legislative efforts, such as the Consolidated Appropriations Act of 2021 and its related regulations, which expand access to emergency-care services and caused plans to review and revise coverage and plan-design requirements related to mental health conditions and substance-use disorders. The COVID-19 pandemic, and its related impact on the economy and workforce, also affected benefit design. Telehealth benefits are now mainstream, and employers are looking to enhance the scope of their group health and welfare plans as a means of attracting and retaining quality employees.

Employer-sponsored health insurance coverage options are always evolving based on employee demand, economic conditions, the cost of medical care, and legal and policy actions. To keep the EHB standards current, NABIP members suggest that CMS consider implementing a routine review process, perhaps on a biennial basis.

Barriers of Accessing Services Due to Coverage or Cost
Are there significant barriers for consumers to access mental health and substance use disorder services, including behavioral health services that are EHBs?

Based on market observation, NABIP members believe that the most significant consumer barrier to accessing mental health and substance use disorder treatment services is the lack of adequate network coverage of mental health and substance use disorder providers. The general lack of bedspace in mental health and substance use disorder treatment facilities, particularly in those that contract with plan networks is also paramount.

While plan-reimbursement rates and network-adequacy standards are an issue (particularly since nationally accepted network-adequacy standards call for fewer mental health and substance use disorder providers in a geographic area than other types of care), plan non-quantitative treatment limitations are not the only issue. Outpatient mental health providers are often solo practitioners who prefer not to work with health plan networks, no matter what the reimbursement rate. Furthermore, particularly in more affluent geographic areas, American healthcare consumers have become accustomed to paying out of pocket for mental health and substance use disorder care, particularly at the office-visit level. Finally, overall provider and facility availability shortages are a critical concern.

To what extent has the utilization of telehealth impacted access to the behavioral health services that are EHB, particularly during the COVID-19 pandemic? How could telehealth utilization better address potential gaps in consumer access to EHB for behavioral health services or other

healthcare services? What other strategies have plans implemented to broaden access to telehealth services?

NABIP members find that there are two different types of telehealth benefits offered to group health plan participants. The use of both types increased among plan participants during the pandemic, for both behavioral health services and medical services. While often lumped together and billed as "telemedicine," the two types of benefits are distinct in the kinds of providers they attract, their funding mechanisms, and the likelihood of widespread continuance as we move past the most serious of pandemic travel restrictions.

The first type of telehealth services individuals gained access to during the height of the COVID-19 pandemic was the increase of traditional brick-and-mortar medical providers converting office-visit appointments to telehealth visits, including group health plan network providers. Due to federal and state-level flexibilities granted during the pandemic, most network health providers (and other traditional health providers that do not accept group coverage reimbursement) initiated telehealth capabilities to serve patients in lieu of in-person office visits. This type of telehealth service lends itself very well to many behavioral health therapies, so it was in widespread use during the pandemic. However, now that many COVID-19 flexibilities are being lifted at the state level, and likely will be soon at the federal level, it is unclear how prevalent these types of visits will be in the future, including for behavioral health services. Issues that will need to be resolved to perpetuate providers offering these types of visits include: (1) state-level licensing restrictions; (2) data-security issues; (3) ensuring appropriate provider-level reimbursement that is on par with a traditional office visit; and (4) the preference and desire of individual providers and greater medical practices to continue to offer telemedicine appointment in lieu of, or as an alternative to, traditional office visits.

The second type of telehealth benefit is standalone telemedicine coverage that pairs with comprehensive group medical coverage. This coverage was an option for employer groups prior to the start of the pandemic. It can include only medical coverage, only mental health and substance use disorder coverage, or both. As an add-on to traditional group coverage, standalone telemedicine benefits are not a typical employer-sponsored benefit offering, but they have certainly increased in prevalence. Unlike traditional network providers that needed to obtain compliant technology, address potential reimbursement challenges and the switch to online or telephonic patient care, and tackle licensing issues, the providers that contract with standalone telemedicine providers have chosen to practice and see patients in this manner and have related resources at their disposal.

NABIP members have noticed an increase in employer group plan sponsors adding standalone telemedicine benefits for both traditional medical and behavioral healthcare over recent years, and this trend has only increased with the pandemic. Employers that offer self-funded coverage may save on claims costs through telemedicine, which is generally paid for on a

monthly per-employee basis, and it is an attractive benefit to employees. Furthermore, some employers have embraced its use as a way of expanding coverage of behavioral healthcare services if traditional health plan network providers are lacking. To incent its use, employers frequently offer standalone telemedicine benefits on a first-dollar basis or with minimal cost-sharing so that cost is not a barrier to entry. Ensuring that federal protections allow for individuals with coverage through a qualified high-deductible health plan (HDHP) to access telehealth services on a first-dollar basis and still be allowed to contribute to a Health Savings Account is a way federal policy makers can incentivize the use of telehealth services through EHB plans and for other HDHP plan consumers.

What efforts have plans found effective in controlling costs of EHB? To what extent do plans that provide EHB see increased utilization and higher costs if those efforts are not implemented? What strategies have consumers and providers seen plans implement to reduce utilization and costs, such as use of prior authorization, step therapy, etc.? Are these strategies to reduce utilization and costs applied broadly or are they targeted to a specific area? What, if any, geographic differences have been found in the strategies plans use to reduce utilization and costs within a state? How are these tools effective or ineffective? To what extent do these tools curb or complicate access to medically necessary care?

Group health plan sponsors and health insurance issuers use a variety of utilization-management techniques to control health-plan costs and ensure that plan participants are receiving medically necessary care, including prior authorization, concurrent and retrospective review, emergency-admission authorizations, treatment-plan reviews, and ongoing case management. The use of step therapy as a utilization-management technique is common regarding pharmaceutical coverage, but much less so for coverage of medical, surgical, mental health, and/or substance use disorder inpatient and outpatient care. The broadest and most common type of utilization management is prior authorization, which generally applies to most or all planned inpatient care, as well as to select outpatient services and pharmaceuticals. Review of inpatient care, either concurrently or retrospectively, is also commonly used to protect against inpatient visits that are longer than medically necessary. Treatment-plan reviews and ongoing case management are less common and can even be voluntary, but some plans require their use to monitor participant progress. A limited number of plans are engaging in value-based utilization-management practices, but this practice currently is only utilized by a very small portion of group plans, and it almost never extends to the fully insured group marketplace.

Group health plans engage with utilization-management vendors that almost exclusively use industry standard criteria for making medical necessity and utilization-management decisions, such as MCG and InterQual guidelines. The routine use of standardized and evidence-based guidelines that are regularly updated allows for generalized consistency in utilization-management practices among plans. NABIP members can attest that effective utilization

management can help reduce costs for plan sponsors and participants. Services like disease management are often voluntary and can be a strong source of support for plan participants struggling with complex and/or chronic medical or behavioral health conditions. The impact utilization has on access to care may warrant more study, but plan analyses of non-quantitative treatment limitations required by the Mental Health and Addiction Equity Act are helping alert plan sponsors to inequities, even beyond those inequities related to parity issues.

Changes in Medical Evidence and Scientific Advancement
We seek comment on whether and to what extent the EHB need to be modified or updated to account for changes in medical evidence and scientific advancement. How can the EHB better track with changes in medical evidence and scientific advancement? What steps should be taken to address EHB that are not supported by current medical evidence?

NABIP members believe a more regular review of EHBs would be warranted but suggest keeping mindful of the need to keep the EHB list as "evergreen" as possible. Our association points to the model employed by the Department of Health and Human Services in determining the annual list of preventive care benefits, and wonders if something similar could be used to ensure the appropriateness of plan benefits offered through EHB plans.

How might the EHB adapt to more quickly address pressing public health issues such as public health emergencies (including the opioid and overdose epidemic) and maternal mortality rates (particularly among underserved populations)? For example, what are the barriers for third parties such as family members or caregivers to obtain naloxone?
During a public health emergency, NABIP members believe the executive branch might need to consider modifying the EHB benchmarks for limited timeframes and due to extraordinary need. Our association points to the conditional-use authorizations and emergency changes to preventive-care guidelines utilized during the height of the pandemic to ensure the release and coverage of vaccines and COVID-19 home tests as an example that might be extended to EHBs should extraordinary need arise.

In what ways could EHB better address health conditions that disproportionately affect underserved populations or large parts of the American population? For example, how could EHB address nutrition-related health conditions for the American population? How has the medical evidence regarding nutrition-related health conditions changed since 2014? How can EHB better improve nutrition-related health outcomes for the populations that are most likely to benefit from coverage of nutrition-related care, such as people with diabetes?
NABIP members suggest that increased coordination with the preventive-care requirements, including additional screening for nutrition-based disorders, as well as a EHB focus on social determinants of health, could be effective means of reaching these populations.

Addressing Gaps in Coverage

Are there examples of benefits that are essential to maintaining health, including behavioral health, that are insufficiently covered as EHB but that are routinely covered by other specific health plans or programs, such as employer-sponsored plans, Medicare, and Medicaid? To what extent does the EHB cover screening, consultative and treatment modalities that supports the integration of both mental health and substance use disorder services into primary care?

NABIP members believe the EHBs, when combined with federal preventive-care requirements, do a comprehensive job of covering screening, consultative and treatment modalities that support the integration of both mental health and substance use disorder services into primary care. One area that might warrant federal improvement is the amount of mental health and substance use disorder screenings and services that fall under the preventive-care guideline, as currently that is limited.

Many state based-benchmark plan documents do not include specific coverage for habilitative services. To comply with section 1302(b)(1)(G) of the ACA, these states supplement the base-benchmark plans with habilitative services pursuant to § 156.110(f) by determining which services in that category will be covered as EHB. In our experience, state supplementation of habilitative services is inconsistent. We are interested in comments on which habilitative services are currently covered as EHB, and whether further definition is needed in general to clarify the covered benefits. We also seek comment on whether EHB-benchmark plans' current coverage and limits regarding habilitative services, which were primarily based on coverage for rehabilitative purposes, are sufficient and in line with current clinical guidelines for treatment of developmental disabilities.

Coverage of habilitative services is certainly variable among state EHB standards and typical employer-sponsored plans. One of the greatest places of variation seen by our membership in plan design is the coverage of habilitative services for mental health and substance use disorders, including the coverage of ABA therapy and other therapies for the treatment of autism spectrum disorders. Another common limitation is keeping the scope of coverage of speech and other habilitative and rehabilitative therapies to medical conditions only. Put another way, habilitative therapies may not be covered for the treatment of mental health conditions even though there are mental health conditions that could benefits from such therapeutical treatment. It is our observation that variations in long-standing, state-mandated benefit laws for the coverage of rehabilitative and habilitative services has spilled over to benefit design for plans of all funding structures.

To what extent could EHB better address any gaps in coverage for those with chronic and lifelong conditions?

Coordinating appropriate participation in ongoing care and disease-management and wellness programs targeted at specific conditions would be one way to help support these plan

participants. Providing additional support, such as social-worker support, patient-advocacy services, and nursing-care assistance, including via telemedicine, would be another beneficial means of addressing coverage gaps and facilitating health improvements.

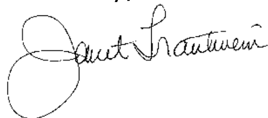
Prescription Drug Classification

The RFI notes, "as finalized in the EHB Rule, plans subject to EHB requirements must comply with § 156.122(a)(1) to cover at least the same number of prescription drugs in every United States Pharmacopeia (USP) category and class as covered by the state's EHB-benchmark plan, or one drug in every category and class, whichever is greater. We also stated that plans could exceed the minimum number of drugs required to be covered and that additional drugs would still be considered EHB. In that final rule, we chose to use the USP Model Guidelines Version 5.0 (USP Guidelines) to classify the drugs required to be covered as EHB under § 156.122(a)(1). We seek comment on whether CMS should consider using an alternative prescription drug-classification standard for defining the EHB prescription drug category, such as the USP DC or others, in the future."

NABIP members believe that prescription drug coverage is always an issue in plan design due to both cost and effective coverage concerns. Our membership notes that switching drug classifications would add an additional complication and administrative burden to plan design, and that the potential cost effects of such a switch would not be worth any potential benefit that might come from switching away from the USP Guidelines at this time.

NABIP members appreciate the opportunity provided by CMS to respond to this RFI. If you have any questions about our comments, or if you need additional information or assistance, please do not hesitate to contact me at either jtrautwein@nabip.org or (202) 595-0639.

Sincerely,



Janet Stokes Trautwein
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