UNITED STATES of CARE

January 31, 2023

Chiquita Brooks-LaSure
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9898-NC
P.O. Box 801
Baltimore, MD 21244-8016

Submitted via regulations.gov.

RE: *United States of Care Response to CMS Request for Information Regarding Essential Health Benefits*

Dear Administrator Brooks-LaSure,

United States of Care (USofCare) is pleased to submit the following response to the request for information by the Centers for Medicare & Medicaid Services (CMS) and Department of Health and Human Services (HHS) seeking input from stakeholders on what the federal government can do to improve coverage of benefits in health plans subject to the Essential Health Benefits (EHB) requirements of the Affordable Care Act (ACA).

USofCare is a nonpartisan nonprofit working to ensure everyone has access to quality, affordable health care regardless of health status, social need, or income. We drive change at the state and federal level in partnership with everyday people, business leaders, health care innovators, fellow advocates, and policymakers. Together, we advocate for new solutions to tackle our shared health care challenges — solutions that people of every demographic tell us will bring them peace of mind and make a positive impact on their lives.

After listening to people tell us about their needs for their health care, USofCare released a set of twelve concrete and achievable aims, known as our United Solutions for Care, to help us build a better and more equitable health system. These twelve solutions are derived from four goals for the health care system that continuously rose to the top when talking to people around the country about what works and what is lacking in their health care. People want health care they can depend on, understandable and easy to navigate, affordable, and accessible when and how they need it. **Strengthening the Essential Health Benefits (EHB) framework is critical in order to work towards the system of care that people want, need, and deserve.**

Section 1301(a)(1)(B) of the ACA requires that beneficiaries of plans offered on the Federally Facilitated Marketplace (FFM) and beneficiaries of a given state's Medicaid expansion program are provided with coverage for ten areas of health care known as essential health benefits (EHBs). All plans on the individual market were required to adopt coverage of EHBs by January 1, 2014.

Currently, EHBs include the following ten categories of coverage without annual or lifetime limits:

- Ambulatory Patient Services
- Emergency Services
- Hospitalization

★ Maternity and Newborn Care
★ Mental Health and Substance Use Disorder Services
★ Prescription Drugs
★ Rehabilitative and Habilitative Services and Devices
★ Laboratory Services
★ Preventative and Wellness Services and Chronic Disease Management
★ Pediatric Services, including Oral and Vision Care

Prior to the establishment of the ten EHB categories under the ACA, most plans were unlikely to cover all ten essential health benefits, and plans that did cover any EHBs usually only did so with strict dollar limitations. 2011 HHS data revealed that 62% of individual market enrollees did not have coverage for maternity services, 34% did not have coverage for substance abuse services, 18% did not have coverage for mental health services, and 9% did not have coverage for prescription drugs. The EHB requirement created a new standard of coverage available to people across the country.

EHBs play an important role in advancing health equity. Strengthening EHBs will ensure that more people have access to the personalized care that they require. Prior to the implementation of the ACA, there was no guarantee that people with disabilities would receive coverage for the services they need in order to go about their daily lives. The Rehabilitative and Habilitative Services and Devices EHB allows this population access to critical care.

USofCare values CMS's commitment to strengthen EHBs in all areas and appreciates the opportunity to comment as CMS reviews and updates EHB requirements. Through our work in states, we are able to identify unique perspectives from people on the ground to amplify on both the state and federal levels. Where possible, we uplift voices of real people engaging with the health care system at the patient level whose input and perspectives have shaped our advocacy work. We focus our comments on the following topics to ensure that EHBs continue to provide people with equitable, affordable, dependable, personalized, and understandable access to care:

1. **Overcoming Barriers Due to Coverage or Cost**
2. **Using Virtual Care to Address Gaps in Behavioral Health Coverage**
3. **Addressing Gaps in Coverage**

Overcoming Barriers Due to Coverage or Cost

> *"I know people who are making over $50,000 a year, but they are unable to afford to live. Add inflation on top of that, and the fact that they don't qualify for any type of assistance; they can't afford many things. This goes for health care as well - people don't seek health care because they can't afford the copays or can't afford the medical bills."*
>
> Black woman living in Denmark, SC

We appreciate CMS's focus on barriers to accessing care, with a particular focus on accessing mental health and substance use disorder (SUD) services. More than half of people seeking mental health (MH) and SUD treatment cite the cost of treatment as a barrier, while 41% report difficulty finding available in-network providers.

In addition to having difficulty affording coverage, we know that people also delay or forego care because of cost. This disproportionately affects people of color, with approximately 60% of Black adults and 65% of Hispanic adults surveyed by the Kaiser Family Foundation in 2022 reporting

difficulty with affording health costs, compared to only 39% of white adults. Additionally, 45% of Black adults and 49% of Hispanic adults indicated that they had skipped or delayed care due to cost, in contrast to 42% of white adults. The same poll found that women were more likely than men to report postponing care due to cost.

To compound access issues for critical MH/SUD treatment, plans often impose strict "medical necessity" criteria or utilization management tools, such as prior authorization, that restrict access to otherwise generally accepted MH/SUD standards of care. Although plans are required to cover MH/SUD services, the reality for many people who depend on this care is much more limited under the state base-benchmark process (BBP). **We urge states to remove utilization controls through the BBP process to ensure people have access to these services as required by law.**

Utilizing Virtual Care to Address Gaps in Behavioral Health Coverage

> *"I felt comfortable using telehealth because I was given the options; you can come in, or you can do this via telemedicine. I opted to go with telemedicine with a particular doctor because I was comfortable with him. I felt that he understood what was going on with me. So that's why I opted for that and there was no problem."*
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> White woman living in Atlanta, Georgia

The use of virtual care, or telehealth, to address gaps in behavioral health access must ensure that barriers to accessing care and disparities are eased, not exacerbated. At USofCare, we believe that a well-designed approach to virtual care — including synchronous video and audio-only telehealth services, asynchronous remote patient monitoring, and other digital forms of communication—has the potential to break down long-standing barriers to health care access. During the pandemic, the most common use of virtual care services during the pandemic was for behavioral health conditions. Virtual care accounted for 40% of mental health and substance use disorder outpatient visits during the pandemics peak compared to 1% pre-pandemic, and still comprised 36% of these outpatient visits in March 2022.

A well-designed, people-centered approach to virtual care can break down long-standing barriers to health care access, especially for mental health and substance use disorders. Some of the barriers people face in accessing behavioral health care, such as long wait times, social stigma, and social factors like transportation insecurity, can be addressed with virtual care. While virtual care is not a panacea and there remain barriers to accessing virtual care, especially among already underserved communities, it can be a tool to address inequities and close gaps in accessing behavioral health services. **CMS should consider requiring plans to establish virtual behavioral health care standards so that people have the option to access these services in a setting that is best suited to their needs – whether virtually or in-person.**

Addressing Gaps in Coverage

In recent years, states have taken advantage of additional flexibilities allowed under the base-benchmark plan (BBP) process to expand coverage of services under the existing EHB structure. Notably, states like Illinois and Oregon modified their existing Mental Health and Substance Use Disorder Services benefit under the BBP to address SUD crises by decreasing barriers to medication-assisted treatment like buprenorphine and requiring plans to cover

naloxone, which reverses the effects of an opioid overdose. Colorado adapted their BBP to explicitly require the coverage of gender-affirming care for transgender people, such as hormone treatments, mental health care, and/or surgery.

Of note, all of these states have updated their BBPs through the federally prescribed pathway, as opposed to the creation of a new benefit category that does not trigger any state-level defrayal obligation (state costs). **USofCare applauds states for expanding coverage via authority first promulgated under the *Notice of Benefit and Payment Parameters for 2019* (2019 NBPP) and encourages CMS to promote this pathway to all states so that they can benefit from expanded, revised BBPs at minimal additional cost to the state.**

Doulas

Despite scientific advances over the past 30 years, the United States' maternal mortality rate has increased and continues to disproportionately impact Black, Indigenous, and additional marginalized groups of people – populations that are already more likely to experience adverse health outcomes and barriers to care. Access to doula care was identified by the American College of Obstetrics and Gynecology (ACOG) as a proven intervention by non-clinical health workers to improve maternity care and outcomes by providing emotional and physical care during the prenatal, labor and delivery, and postnatal periods. **We encourage CMS to consider ways to work with community-based doulas to identify ways to increase access to doula care available through the Maternity and Newborn Care EHB, as this will ensure that a pregnant person's needs are met during this important period.**

Adult Dental Benefits

While pediatric dental benefits have been included as an essential health benefit since the ACA's passage in 2010, dental care services for adults remain a separate, non-required benefit. Despite this, USofCare believes that access to oral health care for all people, no matter their age, is essential to support positive health outcomes. We supported a now-finalized proposal in last year's Physician Fee Schedule to increase coverage of medically necessary dental care for people enrolled in Medicare. Dental coverage amongst adults remains a patchwork nationwide. Most people with dental coverage have a stand-alone dental plan independent of their health insurance. Adult dental benefits under Medicaid are optional, and some states lack Medicaid dental coverage entirely.

Oral health disparities are perpetuated without proper oral health care and disproportionately impact low-income older adults and communities of color, particularly Black and Hispanic people. Opportunities to expand access to this essential form of health care can address these disparities and improve health equity. **We encourage CMS to think creatively – in part by considering the recently finalized Medicare medically necessary dental care provision – in how it can further expand access to adult dental care through EHB and/or other means.** Rates of private dental coverage for children increased after pediatric dental benefits were covered under the ACA's ten EHBs. We are hopeful that further action to expand access to adult dental care would result in a similar uptake in adult dental insurance rates, which lag those of traditional medical health insurance.

Conclusion

Thank you for the opportunity to respond to the Request for Information regarding what the federal government can do to improve coverage of benefits in health plans subject to the EHB requirements of the ACA. We hope that the information provided will guide the agencies through future rulemaking periods, including the 2025 NBPP. We are grateful for the space to share the lessons learned from our work listening to people and our earned expertise from our unique approach to state work.

If you have any questions or are interested in further discussion of the proposed updates, please reach out to Eric Waskowicz, Policy Manager, or Liz Hagan, Director of Policy Solutions, at EWaskowicz@usofcare.org or EHagan@usofcare.org.

Sincerely,

Natalie Davis
Co-Founder & CEO
United States of Care