AMERICAN ACADEMY OF FAMILY PHYSICIANS

January 30, 2023

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

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

**Re: CMS-9898-NC; Request for Information; Essential Health Benefits**

Dear Secretary Becerra and Administrator Brooks-LaSure:

On behalf of the American Academy of Family Physicians (AAFP), representing 127,600 family physicians and medical students across the country, I write in response to the Request for Information on Essential Health Benefits as posted in the December 2, 2022 version of the Federal Register.

Family physicians provide continuing and comprehensive medical care, health maintenance, and preventive services to patients across the lifespan. They frequently serve as a patient's first contact for health concerns and are equipped to directly address most health care needs. Their unique training allows them to practice across care settings and modify their personal practice to meet the needs of their communities. While many family physicians provide comprehensive, longitudinal primary care, many also practice in hospitals, emergency departments, urgent care centers, long-term care facilities, and other health care settings. As such, family physicians know firsthand that the implementation of essential health benefit (EHB) requirements in the Affordable Care Act (ACA) have significantly benefited patients and population health outcomes.

The AAFP has long supported the requirement for health plans to cover essential health benefits, in addition to related efforts to reduce the cost of accessing these benefits. The implementation of these policies has significantly advanced the AAFP and HHS' shared goal of improving affordable, equitable access to high-quality health care for everyone. AAFP policy indicates that essential health benefits are a central, critical policy that must be included in any health care reform efforts. The ACA gives the Health and Human Services (HHS) Secretary the authority to update EHBs. We applaud HHS for taking steps to begin the process for updating EHBs by soliciting public comments for the first time since enactment in 2014.

There has been undeniable change to the health care landscape since the ACA was enacted and implemented. A years' long pandemic, heightened awareness of health equity and social determinants, increased mental and behavioral health needs, and major shifts in care delivery via telehealth have significantly altered our nation's health care needs and considerations. **The AAFP strongly urges HHS to strengthen essential health benefits, including by ensuring these requirements keep pace with the latest clinical and scientific evidence.** It is with these goals in mind that we offer the following comments on the request for information.

***Benefit Descriptions in EHB-Benchmark Plan Documents***

*We seek public comment on this understanding, including to what extent States may require additional guidance on how to ensure that plans are interpreting the EHB-benchmark plan documents in a manner that provides EHB coverage to consumers, consistent with applicable requirements.*

**AAFP Response:**

The RFI acknowledges concerns about the current EHB-benchmark plan approach creating a patchwork of coverage, such that any particular benefit may have disparate coverage nationwide across all 51 EHB-benchmark plans. While current regulations allow and encourage states to revisit and update their benchmark plans, they are not required to do so. If a state does not make updates or select a new plan, their previously selected benchmark plan is the default. As a result, several states are using EHB benchmark plans that have not been updated for years. The vast majority of states – 42, plus the District of Columbia – use a small group plan as their EHB-benchmark.[i,ii] Small group plans are typically the least generous benchmark plans to select from, meaning many of these states could strengthen the benefits they cover. **To address the wide-ranging variation in coverage and ensure more individuals have access to more comprehensive EHBs, HHS could begin requiring states to update their EHB-benchmark plans more regularly.** The Academy also recommends that HHS withdraw small group plans as an allowable option upon which states can base their benchmark plans.

We also strongly encourage HHS to take additional steps to address this variation by implementing more specific coverage standards and requirements across all of the EHB categories, including a baseline of specific services, as authorized by Congress. This includes establishing comprehensive coverage of pediatric services, which is currently one of the ten categories, as some states fail to do so in their current EHB-benchmark plans. **In developing their national benchmark standard, the AAFP recommends that HHS use Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit as the model for EHB coverage for children.**

***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 EHB? 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 health care services?*

**AAFP Response:**

**The AAFP strongly supports strengthening EHB coverage of mental and behavioral health services, but we acknowledge that significant barriers to access are likely to persist.** For example, it's likely patients will continue to struggle finding and securing appointments with behavioral health providers even if behavioral health EHBs were strengthened. There is a well-documented shortage of behavioral health clinicians and uneven distribution of existing providers, many of whom have long wait times due to patient volume or unwillingness to accept insurance. While family physicians are trained to provide certain high-quality, whole-person behavioral health services, including substance use disorder (SUD) treatment, patients and physicians sometimes benefit from

care coordination with other behavioral health professionals or more intensive, specialized care. The ongoing shortage of behavioral health professionals has made it difficult, and sometimes impossible, for family physicians to integrate behavioral health into their practice and to make referrals for patients requiring additional care. The AAFP has supported several legislative and regulatory proposals to address workforce and other access challenges.

Additionally, limited parity enforcement remains a major challenge to ensuring that mental and behavioral health services that are meant to be covered under EHBs are actually accessible. A joint report from the Departments of Labor, Treasury, and HHS on agency parity enforcement for non-Medicaid plans concluded that, in 2021, none of the non-quantitative treatment limits comparative analyses submitted by employer-sponsored plans and insurers, upon initial agency review, contained information sufficient to meet the standards required under parity law. More robust enforcement of mental health parity requirements is needed to improve timely, equitable access to behavioral health care.

The AAFP is concerned that behavioral health EHB requirements are being applied inconsistently across states, leading to inequitable coverage and access nationwide. For example, research has shown that many state EHB-benchmark plans do not include coverage of naloxone and comprehensive SUD treatment options.[iii] **HHS should take steps to address this variation and more explicitly require uniform coverage of evidence-based SUD services and reversal agents.** We recommend this in addition to bolstering the behavioral health workforce, strengthening parity enforcement, and continuing the Department's ongoing work to measure and address narrow networks and long appointment wait times.

The AAFP has previously encouraged HHS to implement appointment wait time standards for SUD treatment services and other behavioral health services across programs. We are pleased that HHS has begun to implement such standards and other network adequacy improvements in the qualified health plan market and in Medicare Advantage.

We have also recommended HHS consider measuring the availability of integrated behavioral health services in primary care. Integrating behavioral health services into primary care can improve enrollees' access to and utilization of needed behavioral health services, can help mitigate disparate access to behavioral health clinicians, and has shown significant cost-savings for payers and physicians. Unfortunately, lack of upfront funding for technology, workflow changes, and hiring staff, as well as the shortage of behavioral health providers makes it difficult for primary care to integrate mental health and SUD services. The AAFP urges HHS to continue strengthening network adequacy and access standards for behavioral health services across programs and to provide additional support to practices looking to integrate behavioral health.

Finally, telehealth has undeniably improved access to EHB-covered mental and behavioral health services during the COVID-19 pandemic. **The AAFP recognizes that telehealth visits are often uniquely suited for behavioral health care, and there is a robust evidence base supporting this modality**.[iv,v] This includes audio-only and telehealth appointments for SUD treatment, as detailed in SAMHSA's recent proposal to allow buprenorphine initiation via telehealth. Telehealth for behavioral health care serves as an important tool to provide more equitable access to services and have been shown to increase treatment initiation due to decreased stigma.[vi,vii] HHS should consider strengthening EHB coverage for tele-mental health services, including audio-only modalities, while also ensuring the care offered through these modalities is high-quality, patient-centered, and

coordinated with patients' primary care physicians. We provide additional recommendations and considerations for telehealth coverage and access below.

*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?*

**AAFP Response:**

Family physicians deliver broad-scope, comprehensive care to infants, children, youth, adults, and the elderly. Accordingly, family physicians manage a wide range of health conditions requiring medications for a broad spectrum of diseases. Due to the breadth of this care, family physicians are subjected to an overwhelming number of prior authorizations. Unfortunately, many of the high-value services offered within the 10 categories of EHBs are regularly subject to burdensome insurer prior authorization processes.

Prior authorization and step therapy are currently manual, time-consuming procedures that burden family physicians, divert valuable resources from direct patient care, and can inadvertently lead to negative patient outcomes by delaying the start or continuation of necessary treatment. According to a 2020 survey, 85 percent of physicians report that the burden associated with prior authorization is "high" or "extremely high" and 30 percent of physicians report that prior authorization has led to a serious adverse event for a patient in their care. Ninety-three percent of respondents experienced care delays due to prior authorizations and 82 percent reported that prior authorizations can lead to treatment abandonment. Therefore, **the AAFP believes family physicians using appropriate clinical knowledge, training, and experience should be able to prescribe and/or order treatments without being subjected to prior authorizations.** We are encouraged that CMS has proposed regulations to automate prior authorization requirements and address inappropriate use of prior authorization in Medicare Advantage. The AAFP strongly advocates for comprehensive prior authorization reform, including by reducing the overall volume of prior authorization requirements.

However, family physicians indicate that prior authorization and step therapy requirements for prescription medications are one of the most significant burdens they face and neither of the aforementioned proposed regulations address prescription drugs. We reiterate that these utilization management requirements negatively impact timely, affordable access to evidence-based care included in EHBs. The AAFP believes that generic medications should not require prior authorization and maintains that step therapy should not be mandatory for patients already on a course of treatment. Ongoing care should continue while prior authorization approvals or step therapy overrides are obtained. Patients should not be required to repeat or retry step therapy protocols failed under previous benefit plans.

***Changes in medical evidence and scientific advancement***

*How should the EHB advance health equity by taking into consideration economic, social, racial, or ethnic factors that are relevant to health care access (for example, access to appropriate language services)?*

In September 2022, a U.S. federal district court judge ruled in *Braidwood Management v. Becerra* that the ACA's mandate for no-cost coverage of preventive services with a Grade A or B from the U.S. Preventive Services Task Force (USPSTF) is unconstitutional. **The Academy is deeply concerned about the potential negative impacts this ruling will have on affordable, equitable access to preventive services, depending on the terms and scope of the remedy.** USPSTF recommendations include cancer and depression screenings, preventive medication for chronic diseases, nutrition and weight management counseling, tobacco cessation services, and prenatal services among others.

Approximately 233 million individuals are currently enrolled in health plans that must cover preventive services without cost-sharing because of the ACA.[viii] This coverage requirement has had a significant positive impact on increasing equitable access to preventive services, particularly among low-income populations and those who experience the greatest financial barriers. Evidence has shown that it has improved health outcomes and utilization of preventive services among patients of color, as well.[ix]

USPSTF recommendations keep close pace with current scientific/medical evidence and allow coverage to do so as well. If the remedy delivered in *Braidwood* effectively removes the coverage requirements for Grade A or B services from the USPSTF, it could result in covered services being unaffordable for many and coverage failing to keep pace with the latest evidence. CMS also currently defines preventive services within EHBs as the same services required for private insurance plans – including USPSTF recommendations. Therefore, this case could result in individual states being able to determine which preventive services are covered based on their EHB-benchmark plan and create even further variation in coverage across states. **The AAFP calls on policymakers, insurers, and employers to ensure continuous, equitable, and affordable access to evidence-based preventive services. HHS should use updated EHB requirements to close preventive service coverage gaps that may be created by the *Braidwood* decision.**

Additionally, HHS highlighted in the 2023 Notice of Benefits and Payment Parameters their intention to ensure that benefit design reflects clinical evidence rather than an effort to discriminate against people with high health care needs. In response, the Academy recommended that HHS clarify that the requirement for EHB benefit design to be based on clinical evidence also applies to utilization management processes, such as step therapy and prior authorization. **Evidence indicates that prior authorization requirements may be discriminatory and worsen health disparities**, as documented in one study examining access to treatment for HIV pre-exposure prophylaxis and a white paper which examined the disproportionate impact of prior authorization requirements on cardiovascular care for Black and other patients of color.[x,xi] We are concerned that the unnecessary increase in prior authorization requirements, even among evidence-based, medically necessary services and medications, is creating barriers to care that disproportionately impact medically underserved patients, patients of color, those identifying as LGBTQ+, and those at-risk for poor health outcomes. We urge HHS to clarify that utilization requirements can create discriminatory barriers to covered services and conduct oversight to address discriminatory practices.

**The AAFP is strongly supportive of permanently expanding equitable, affordable access to telehealth services, including services provided through audio-only modalities**. Family

physicians consistently report that the availability of telehealth services has improved equitable access to timely, language appropriate care for patients who face transportation barriers, need translators, or otherwise experience challenges obtaining timely, person-centered care in-person. HHS should consider how updated EHB requirements could ensure equitable access to telehealth for physical and mental health services.

However, the AAFP believes telehealth is best utilized when it is provided by a patient's usual source of care and utilized as a component of, and coordinated with, longitudinal care. The Academy has thanked HHS for noting that benefit designs incentivizing enrollees to seek telehealth services instead of in-person services, including by offering to waive co-pays for telehealth services provided by a telehealth vendor, could be inadvertently discriminatory. We continue to reiterate our concerns that this type of benefit design could result in care fragmentation and disproportionately disadvantage low-income enrollees, those lacking access to transportation, or other populations at-risk for poor health outcomes. As such, HHS should continue to ensure that issuers are not steering enrollees away from primary care physicians in favor of direct-to-consumer telehealth providers.

Thank you for the opportunity to comment on this RFI. Should you have any questions, please contact Meredith Yinger, Manager, Regulatory Affairs at myinger@aafp.org or (202) 235-5126.

Sincerely,

Sterling N. Ransone, Jr., MD, FAAFP
Board Chair, American Academy of Family Physicians

---

[i] Turner W, Hernández-Delgado H. Essential Health Benefits: Best Practices in Benchmark Selection. National Health Law Program. July 28, 2022. https://healthlaw.org/resource/essential-health-benefits-best-practices-in-benchmark-selection/

[ii] Centers for Medicare and Medicaid Services. Final List of Benchmark Plans. https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/Final-List-of-BMPs_4816.pdf

[iii] Tovino, SA. "State Benchmark Plan Coverage of Opioid Use Disorder Treatments and Services: Trends and Limitations" (2019). Scholarly Works. 1219. https://scholars.law.unlv.edu/facpub/1219

[iv] Pew Trust. (2021, December 14). State Policy Changes Could Increase Access to Opioid Treatment via Telehealth | The Pew Charitable Trusts. https://www.pewtrusts.org/en/research-and-analysis/issuebriefs/2021/12/state-policy-changes-could-increase-access-to-opioid-treatment-via-telehealth

[v] SY, L.-T., J, E., D, C., & PY, C. (2018). A Systematic Review of Interventions to Improve Initiation of Mental Health Care Among Racial-Ethnic Minority Groups. Psychiatric Services (Washington, D.C.), 69(6), 628–647. https://doi.org/10.1176/APPI.PS.201700382

[vi] Lingley-Pottie P, McGrath PJ. Telehealth: a child and family-friendly approach to mental health-care reform. Journal of Telemedicine and Telecare. 2008;14(5):225-226. doi:10.1258/jtt.2008.008001

[vii] Peterson, A.L., Mintz, J., Moring, J.C. *et al.* In-office, in-home, and telehealth cognitive processing therapy for posttraumatic stress disorder in veterans: a randomized clinical trial. *BMC Psychiatry* **22**, 41 (2022). https://doi.org/10.1186/s12888-022-03699-4[vii] McManus KA, Powers S, Killelea A, Tello-Trillo S, Rogawski McQuade E. Regional Disparities in Qualified Health Plans' Prior Authorization Requirements for HIV Pre-

exposure Prophylaxis in the United States. JAMA Netw Open. 2020;3(6):e207445. doi:10.1001/jamanetworkopen.2020.7445

[viii] *Braidwood Management v. Becerra.* Brief amicus curiae of American Medical Association et al. November 30, 2022. https://www.aafp.org/dam/AAFP/documents/advocacy/amicus_brief/AB-BraidwoodVBecerra-113022.pdf

[ix] Ibid.

[x] McManus KA, Powers S, Killelea A, Tello-Trillo S, Rogawski McQuade E. Regional Disparities in Qualified Health Plans' Prior Authorization Requirements for HIV Pre-exposure Prophylaxis in the United States. JAMA Netw Open. 2020;3(6):e207445. doi:10.1001/jamanetworkopen.2020.7445

[xi] Association of Black Cardiologists. Identifying How Prior Authorization Impacts Treatment of Underserved and Minority Patients. Available at: http://abcardio.org/wp-content/uploads/2019/03/AB-20190227-PA-White-PaperSurvey-Results-final.pdf