

January 27, 2023

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

Via Regulations.gov

To Whom It May Concern:

We submit the following comments on the request for information (RFI) on issues related to the Essential Health Benefits (EHB), as published in the Federal Register on December 2, 2022. We make this submission on behalf of the members of the National Association of Insurance Commissioners (NAIC), which represents the chief insurance regulators in the 50 states, the District of Columbia, and five United States territories.

We applaud CMS' interest in gathering information on the EHBs and support efforts to update them. We agree that the state-focused process for setting EHBs based on existing plans has been largely successful. The RFI seeks input on a number of relevant issues, but it does not contemplate a wholesale change to the process for establishing EHBs through state choices. We support continuing the lead role for states in selecting EHBs while adding additional clarity and flexibility to the process.

State insurance regulators have observed many of the same issues with the EHBs outlined in the RFI. Descriptions of benefits and their limitations are not always comprehensive. Using existing benefits and carrying them forward each year has led to some that fail to capture advances in medical treatments and local standards of care, diverge from the currently typical employer plan, or are otherwise out-of-date.

State insurance regulators have encountered other issues with EHBs and their definitions, as well. As enforcers of EHB requirements in the vast majority of states, state insurance regulators must make determinations on how exactly to define the benefits when the description of an EHB is unclear or insufficient. States seek to do so in compliance with federal law, regulations, and guidance, but have not always received consistent guidance from federal officials. States sometimes lack access to guidance provided to another state. Further, states make determinations on how to define EHBs with recognition of the requirement at 45 CFR 155.170 for the state to defray the cost of state-mandated benefits in addition to EHBs. State officials

have some uncertainty regarding where their authority to define EHBs ends. Some states are concerned that, in exercising their authority to define a benefit, they could trigger the defrayal requirement if the state's determination on what constitutes EHBs differs from a federal interpretation. While states recognize their authority under 155.170(a)(3) to identify which benefits require defrayal, the concern remains.

Given these concerns, state regulators support the development of more detailed and standardized descriptions of the EHBs. However, states should maintain their primary role in selecting and defining the benefits. Each state should continue to have the opportunity to select EHBs for its own markets. Even with more detailed descriptions, regulators expect there will continue to be situations where the precise extent of a benefit is ambiguous or uncertain. State regulators should continue to have authority to determine what is covered under the EHBs in such cases. They will continue to do so using available federal guidance—we urge CMS to assure that all relevant guidance is published and publicly available.

As detailed in the RFI, the current process for defining EHBs has limited opportunities for the benefits to be updated over time. This can lead to the EHBs failing to take into account changes in the standard of medical care offered in a state and coming to differ from the benefits available in a typical employer plan. When a new medical technology or standard of care becomes prevalent, its impact on a plan's overall generosity may be small. Nonetheless, coverage for the new item or service is important for affected enrollees. For instance, technological advancements in mammography have made more effective methods available, but the newer methods are not always clearly covered by older EHB descriptions. Employer plans have the flexibility to update their benefits frequently to cover such advances, but EHB updates do not occur as often.

CMS has interpreted cost-sharing, provider type, benefit delivery method, and method of reimbursement as not constituting a new benefit mandate.¹ We urge CMS to consider an issuer's medical management of a covered benefit, and state rules governing such management, to be part of the benefit delivery method. As advances in technology and new evidence regarding clinical effectiveness emerge, regulators expect issuers to update their clinical review criteria to be consistent with emerging evidence. The EHB should not limit the delivery of medical advances. State legislators often pursue legislation that requires coverage of, for example, technological advances in mammography or evidence-based advances in the type of diagnostic imaging appropriate for people at high risk of breast cancer. This type of legislation should be considered as addressing benefit delivery method, i.e. medical necessity criteria for diagnostic imaging. This would provide important added adaptability and state flexibility in the EHBs, allowing states to assure issuers are covering up-to-date services.

CMS has offered states the opportunity to update their EHBs through the process outlined in 45 CFR 156.111. This process, however, can be overly burdensome for states. It requires

¹ 78 F.R. 12834, at 12838 (February 25, 2013), accessed on Oct. 20, 2022, at <https://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf>; and 77 Fed. Reg. 70644, at 70647 (November 26, 2012), accessed on Oct. 20, 2022, at <https://www.govinfo.gov/content/pkg/FR-2012-11-26/pdf/2012-28362.pdf>; HHS Notice of Benefit and Payment Parameters for 2019; Final Rule, 83 Fed. Reg. 16930 (April 17, 2018)

engagement of actuaries to assess the generosity of a wide range of comparison plans and measure a state's proposed updated EHBs against them. It also raises the defrayal concerns cited above due to this language in the preamble of the 2019 Notice of Benefit and Payment Parameters (emphasis added):

State-required benefits mandated by State action taking place after December 31, 2011, other than for purposes of compliance with Federal requirements, would continue to be considered in addition to EHB **even if embedded in the State's newly selected EHB-benchmark plan** under the proposals at §156.111. Therefore, their costs would be required to be defrayed by the State. 83 FR at 16977

While a few states have made use of this process, in the majority of states the EHBs have not been updated.

To address defrayal concerns, state insurance regulators recommend repealing or modifying 45 CFR 155.170(a)(2), which categorically deems all state mandates enacted in 2012 and beyond, other than for purposes of compliance with Federal requirements, to be "benefits in addition to EHB" for purposes of the defrayal requirement. The Affordable Care Act does not require states to bear the costs of all "new" mandates, but rather to bear the costs of all mandates that are not "essential." Applying the date-based determination of which mandated benefits are addition to EHB creates an inconsistency between Sections 155.170 and 156.111. It could lead to some benefits being considered "essential" for purposes of the issuer requirement to offer the EHB package, but "not essential" for purposes of the defrayal requirement.

Further, state insurance regulators request that CMS adopt a more flexible process for states to make updates to EHBs. A more flexible process would allow states to make updates to their EHBs for a variety of reasons. States may choose to update one or more EHBs when issuers or consumers need more clarity in the extent of benefits, when standards of medical care evolve, when the benefits included in a typical employer plan change, or when the state identifies needed updates in support of health equity or to respond to a public health emergency.

To make the process more flexible, we recommend that CMS consider eliminating the generosity test required under 156.111(b)(2)(ii). While the ACA requires that EHBs be equal in scope to a typical employer plan, it does not require that updated EHBs be no more generous than the existing EHBs. The generosity test also creates inequities across states. States whose typical employer plan and benchmark choices were more generous have more "room" to make adjustments and stay within the generosity cap, which regulation ties to 2017 benefits. States with less generous benchmark choices remain constrained by 2017 plans, even if typical employer plans in the state become more generous over time. The typical employer plan requirement is sufficient to keep benefits and costs in line with other health insurance markets. As long as a state demonstrates that its proposed EHB update is consistent with a typical employer plan in the state (or another state as provided in 156.111(a)(1) and (2)), it should be permitted to adopt the EHB update.

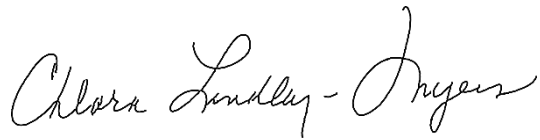
The RFI requests comment on whether there are significant barriers for consumers to access mental health and substance use disorder services that are EHB. State insurance regulators have received reports of such barriers. Enrollees may face limits to covered EHB mental health services based on the provider's credentials. Specifying that a covered benefit may be delivered by qualified counsellors and therapists even if they lack a particular state-issued credential may help to improve access to services. Regulators have also heard reports that utilization management tools complicate access to necessary mental health and substance use disorder services. While enforcement of the Mental Health Parity and Addiction Equity Act is beyond the scope of the RFI, we believe that attention to parity in benefits and particularly benefit limitations across the categories of EHB can help in improving access to services.

State insurance regulators also have a role to play in successful implementation of the behavioral health crisis system, including the 988 Suicide & Crisis Lifeline. That system will not succeed without access to stabilization services for individuals who call the crisis line and require follow up services. The states appreciate the tri-agency interpretation of the No Surprises Act that allows states to license behavioral health crisis services in a manner that meets the definition of "freestanding emergency department" and thereby makes them subject to the NSA's requirements related to coverage of emergency services. CMS could support these efforts in two ways with regard to EHBs. First, a state's definition of these services as "emergency services" under the EHB should not be considered a state mandate in addition to EHBs subject to defrayal. Secondly, CMS itself could define behavioral health crisis services as emergency services under the EHB.


The RFI further seeks comment on issuer substitution of benefits. While state regulators agree that issuers have shown little interest in substitution to date, there may be some value in retaining an avenue for substitution. Substitution within a category of EHBs that is nondiscriminatory has the potential to serve as an additional source of flexibility and innovation in benefits. Consumers, though, need to be fully aware of the benefits of plans they are considering for purchase. We ask CMS to consider retaining an option for substitution of benefits within a category provided an insurer receives authorization from the state's chief insurance regulator and demonstrates that it will adequately disclose benefit changes in marketing materials.

Thank you for seeking public input on these issues related to EHBs before proposing updated regulations. We look forward to continued collaboration between state and federal regulators on this important aspect of health insurance regulation.

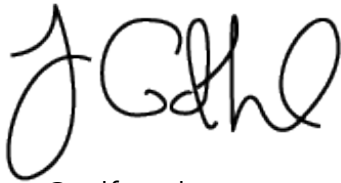
Sincerely,



Chlora Lindley-Myers
NAIC President
Director
Missouri Department of Commerce
and Insurance



Andrew N. Mais (He/Him/His)
NAIC President-Elect
Commissioner
Connecticut Insurance Department



Jon Godfread
NAIC Vice President
Commissioner
North Dakota Insurance Department



Scott White
NAIC Secretary-Treasurer
Commissioner
Virginia Insurance Department