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Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9898-NC, Mail Stop C4-26-05
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Baltimore, MD 21244-1850

Submitted Electronically

RE: RIN 0938-AV14; CMS-2022-0186
Request for Information; Essential Health Benefits

The National Women's Law Center appreciates the opportunity to comment on the Request for Information regarding essential health benefits (EHB).[1] Since 1972, the National Women's Law Center has fought for gender justice in the courts, in public policy, and in our society. We have worked to protect and advance the progress of women and their families in core aspects of their lives, including health and reproductive rights, income security, employment, and education, with an emphasis on the needs of people who face multiple and intersecting forms of discrimination. Through our work to develop and implement the Affordable Care Act, we have seen the impact it has had on gender equity in health care, and we firmly believe that robust enforcement of its provisions, including essential health benefits, will continue to improve access to critical services.

EHB requirements have helped address deficiencies in the insurance market, including discriminatory benefit designs and coverage gaps that have disproportionately affected women. There remains, however, a great deal of variation in EHB benchmark plans across states. Many exclude critical services, rely on outdated medical evidence, and are insufficient to meet the needs of underserved patients. As a result, some people with benchmark-based plans—especially women, people of color, and disabled people—continue to contend with limited coverage, unaffordable costs, and other barriers to care.

The Department of Health and Human Services ("the Department") has both the opportunity and the statutory obligation to improve EHB coverage. To that end, the Department should:

- use its authority to adopt a strong federal definition for each EHB category;

[1] Request for Information; Essential Health Benefits, 87 Fed. Reg. 74097 (proposed Dec. 2, 2022) (to be codified at 45 C.F.R. pt. 156) (hereinafter "Proposed Rule").

- reduce disparities in access to mental health services, pregnancy and postpartum care, and prescription drugs; and
- further improve EHB coverage by limiting utilization controls, mandating detailed benefit descriptions in benchmark plans, clarifying requirements related to defrayal and generosity limits, and establishing regular EHB reviews.

I. Defining a Robust Federal Standard for EHB

a. The Department has a statutory obligation to define each EHB category.

The Affordable Care Act calls upon the Secretary of Health and Human Services to "define the essential health benefits" and provide standards for at least ten EHB categories.[2] The statute makes it clear that Congress intended for the Department to exercise significant authority in determining the details of each category. The Department, however, delegated much of that authority to the states, leaving each state to determine its own benchmark plan. The result has been a patchwork of inconsistent standards, with many plans offering inadequate coverage and failing to meet the needs of underserved people.

In accordance with its obligations under the ACA, the Department should establish minimum federal standards for each EHB category, including at least the ten categories identified in the statute. We recognize that the Department has sought to provide states with flexibility in defining benchmark plans. However, the federal standards would offer a floor rather than a ceiling, and states will still be able to build upon them to advance health equity, innovate, and meet the specific needs of their populations.

b. Improving federal EHB standards can help reduce disparities in insurance coverage.

In the absence of robust federal standards, many people with plans subject to EHB requirements continue to face barriers related to cost and coverage. While more data is needed to shed light on the specific experiences of people with EHB-tied plans, existing data across different types of private insurance suggests there are pronounced disparities by gender and race, both in access to care and the consequences of inadequate insurance coverage.

Women in particular report frequent problems with their insurance coverage. In a recent survey conducted by the Kaiser Family Foundation, women across all insurance types were more likely than men to report experiencing problems with their insurance in the prior year, like noncoverage of key services.[3] Women with individual insurance were more likely than women with other types of insurance to report these problems: 36% of them experienced an insurance problem in the previous year, compared with 21% of Medicaid enrollees and 34% of women with employer-sponsored insurance. Since individual plans are generally subject to EHB requirements, this

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[2] 42 U.S.C. § 18022(b)(1).

[3] Michelle Long et al., *Experiences with Health Care Access, Cost, and Coverage: Findings from the 2022 KFF Women's Health Survey* (Dec. 20, 2022), https://www.kff.org/womens-health-policy/report/experiences-with-health-care-access-cost-and-coverage-findings-from-the-2022-kff-womens-health-survey.

disparity may suggest concerns specific to some EHB-based plans or barriers faced by the population most likely to rely on them.

In part as a result of insurance problems or limitations, many women continue to face cost as a barrier to care. In 2022, women (27%) were more likely than men (23%) to report that they or someone in their household family had trouble paying medical bills in the past 12 months, with Black women (32%) and Latinas (32%) being especially likely to report this. Women with individual health plans (30%) were again more likely than women enrolled in Medicaid (26%) or employer-sponsored plans (24%) to experience this problem.[4]

The consequences of these cost burdens can be extensive and long-lasting. A 2022 survey found that more than four in ten adults (41%)—including 44% of insured people aged 18 to 64—had medical debt.[5] Women (48%) were substantially more likely than men (34%) to say they had medical debt, and about half of Black (56%) and Latine (50%) people had debt due to medical bills, compared to 37% of white people.[6] This debt not only impacts one's ability to pay for basic necessities, but also impedes access to future care. For example, one in seven (15%) people with medical debt are denied care by a provider because of their debt, a rate that rises to 22% among Black adults. And about eight in ten (79%) of those with medical debt report skipping or delaying care or medications in the prior year due to cost, compared with 49% of those without medical debt.[7]

This data highlights persistent disparities in both the scope of covered benefits and the consequences of inadequate coverage. While EHB requirements have been instrumental in reducing such disparities, the data suggests that there is a significant need for further improvements. Strengthening federal EHB standards is one of the most critical steps that the Department can take to address these gaps.

II. Recommendations for Specific EHB Categories

In this section, we discuss disparities in several EHB categories—mental health services, pregnancy and postpartum care, and prescription drugs—and offer recommendations improved federal standards for each one.

a. Mental health services

EHB benchmark plans across many states fail to adequately cover mental health services, often perpetuating pre-ACA coverage gaps. A comprehensive study of EHB coverage documents from all states found substantial state-by-state variation in coverage of mental health services, with many states falling substantially short of the widely accepted standards of care.[8] Many plans, for

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[4] *Id*.
[5] Lunna Lopes et al., *Health Care Debt in the U.S.: The Broad Consequences of Medical and Dental Bills* (Jun. 16, 2022), https://www.kff.org/report-section/kff-health-care-debt-survey-main-findings.
[6] *Id*.
[7] *Id*.
[8] Charley E. Willison et al., *Double-Edged Sword of Federalism: Variation in Essential Health Benefits for Mental Health and Substance Use Disorder Coverage in States*, 16 HEALTH ECONOMICS, POLICY AND LAW 170 (Apr. 2021), https://doi.org/10.1017/S1744133119000306.

example, exclude or severely limit certain types of care, restrict covered services to only a subset of diagnoses, or require a level of demonstrated need that is incompatible with clinical guidelines.[9]

Inadequate coverage of mental health services has a disproportionate impact on women, who are more likely than men to report a need for them. In 2022, women (50%) were significantly more likely than men (35%) to say they needed mental health services in the previous two years.[10] Women experience several mental health conditions more commonly than men; depression, for example, is twice as prevalent among women as men.[11] Racial disparities exist both for prevalence and access to treatment for many mental health conditions. For instance, Black and Latina mothers are more likely to experience postpartum depression, but they are about half as likely to receive care for the condition.[12]

In a forthcoming analysis of Household Pulse Data, the National Women's Law Center found disparities by gender, race, disability, and LGBT status in access to care among people with symptoms of depression or anxiety. Women (30%) were more likely than men (23%) to say that they needed access to mental health services but did not receive them. Black, Latina, and Asian women were more likely than white women to say they needed but did not receive mental health services. Among disabled women with depression or anxiety symptoms, 38% did not receive needed mental health care, with higher rates among Black and Latina disabled women. Additionally, 40% of LGBT people across all genders did not receive needed mental health services, a rate that rises to 49% among disabled LGBT people.[13]

In part as a result of insufficient coverage, cost remains one of the biggest barriers to accessing mental health services. Affordability is the most commonly cited reason for not seeking mental health services, with one study finding that among those who did not receive needed mental health care, more than 40% attributed their unmet need to the cost of treatment.[14] Similarly, in a

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[9] Brief for the National Health Law Program Supporting Petitioners, *Wit v. United Behavioral Health Care*, No. 20-17363(L), 20-17364, 21-15193, 21-15194 (9th Cir. *filed* May 19, 2021), https://healthlaw.org/resource/wit-v-united-behavioral-health-care-u-s-court-of-appeals-ninth-circuit.

[10] Long et al., *supra* note 3.

[11] Debra J. Brody et al., *Prevalence of Depression Among Adults Aged 20 and Over: United States 2013–2016*, NCHS Data Brief No. 303 (Feb. 2018), https://www.cdc.gov/nchs/products/databriefs/db303.htm.

[12] *See* Robert H. Keefe et al., *Having Our Say: African-American and Latina Mothers Provide Recommendations to Health and Mental Health Providers Working with New Mothers Living with Postpartum Depression*, 14 SOCIAL WORK IN MENTAL HEALTH 497 (Apr. 2016), https://doi.org/10.1080/15332985.2016.1140699; Katy Backes Kozhimannil et al., *Racial and Ethnic Disparities in Postpartum Depression Care Among Low-Income Women*, 62 PSYCHIATRIC SERVICES 619 (Jun. 2011), https://doi.org/10.1176/appi.ps.62.6.619; Ana Sandoiu, *Postpartum Depression in Women of Color: 'More Work Needs to be Done'*, MEDICAL NEWS TODAY (Jul. 17, 2020), https://www.medicalnewstoday.com/articles/postpartum-depression-in-women-of-color-more-work-needs-to-be-done.

[13] NWLC calculations based on weeks 34 to 45 (July 21, 2021–May 9, 2022) of the U.S. Census Bureau, "Measuring Household Experienced During the Coronavirus (COVID-19) Pandemic, 2020-2023 Household Pulse Survey," https://www.census.gov/data/experimental-data-products/household-pulse-survey.html.

[14] Substance Abuse and Mental Health Services Administration, *Key Substance Use and Mental Health Indicators in the United States: Results from the 2021 National Survey on Drug Use and Health* 61 (Jan. 2023), https://www.samhsa.gov/data/report/2021-nsduh-annual-national-report. *See also* Nicholas C. Coombs et al.,

survey where one in six women (16%) who sought mental health care were unable to obtain it, respondents most commonly cited cost, together with the lack of providers accepting new patients, as the main reason why they could not obtain care.[15] Affordability can be a barrier even for those who have insurance coverage for the services they need, since many plans only cover a small portion of the cost. Among privately insured women who found a provider that accepted their insurance, only 36% said that their insurance covered the full cost of their most recent visit.[16]

Recommendation: The Department should set detailed minimum federal requirements for mental health services that provide coverage for the entirety of the continuum of care. Among other requirements, the federal standard should explicitly include community-based services like Assertive Community Treatment, which are crucial for providing continuous behavioral health care in the least restrictive settings. Community-based services are rarely covered by marketplace plans, leading to more utilization of inpatient and residential services, which are less effective, more restrictive, and raise concerns of non-compliance with the *Olmstead* integration mandate.[17] The Department should also require plans to include a minimum percentage of community-based mental health providers to ensure there is a sufficient number to serve the coverage area. Additionally, plans must be required to cover:

- community-based crisis intervention that includes, at a minimum, the services outlined by the Substance Abuse and Mental Health Administration, such as regional call centers and mobile crisis services[18];
- supported employment and housing-related services;
- intensive case management, focusing on the coordination of behavioral health services, non-behavioral health services, and other supportive services;
- peer support services, provided by culturally competent individuals and organizations; and
- behavioral health emergency services, provided on equal footing as physical health emergency services and with an emphasis on community-based emergency services.

The Department should also ensure that medical necessity criteria are consistent with current standards of care. Specifically, it must prohibit the use of prior authorization for all mental health services. It should also urge states to remove all other utilization controls through the benchmarking process. As discussed further in Section IIII of this comment, the Department should assure states that removing utilization controls would not count against the generosity limit when done to comply with federal parity requirements.

Barriers to Healthcare Access Among U.S. Adults with Mental Health Challenges: A Population-Based Study, 15 SSM - POPULATION HEALTH 100847 (Jun. 2021), https://doi.org/10.1016/j.ssmph.2021.100847.

[15] Long et al., *supra* note 3.

[16] *Id.*

[17] *Olmstead v. L.C.*, 527 U.S. 581 (1999).

[18] Substance Abuse and Mental Health Services Administration, *National Guidelines for Behavioral Health Crisis Care* (Feb. 24, 2020), https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-services-executive-summary-02242020.pdf.

b. Pregnancy and postpartum care

Robust coverage of pregnancy and postpartum care is critical for reducing disparities and is often life-saving. It is especially important for Black and Native women, who are more likely to experience severe maternal morbidity and are around three times more likely than white women to die from pregnancy-related complications.[19]

But while EHB standards require coverage of maternity and newborn care in general, there are significant differences in state benchmark plans' approach to these services. A Center for American Progress study of EHB plans found that although some states offer comprehensive coverage of a range of services, many benchmark plans have harmful restrictions or provide coverage that falls short of current clinical recommendations. For example, some benchmark plans cover only one or two ultrasounds, restrict coverage of midwives or doulas, or exclude coverage of non-manual breast pumps.[20]

Additionally, some insurance plans exclude pregnancy coverage for individuals claimed as dependents, running afoul of requirements under Section 1557 of the ACA. Through our CoverHer hotline, the National Women's Law Center has heard from a number of people whose plans will not cover pregnancy-related services because they are adult dependents on their parents' plans. In some cases, these individuals have tried to switch to a different plan (like their own employer-sponsored plan) in order to get coverage, but found themselves in a bind: Their parents' insurance would not allow them to leave without proof of other insurance coverage, while the second insurance plan would not allow them to join when they are already enrolled in a plan. This common problem underscores the need for coverage of all pregnant individuals enrolled in a plan, regardless of their dependent status.

The common exclusions of doula care are also very concerning. Doula care is highly effective for reducing disparities in pregnancy-related complications and improving health outcomes, especially for parents of color.[21] Community-based doulas, for example, can provide culturally congruent care to Black pregnant people and others at greater risk of complications and mistreatment. Doulas can serve as important advocates for pregnant people, particularly women of color, who are more likely to experience mistreatment and institutional bias during childbirth.[22] Doula support is connected to improved birth outcomes, such as a lower likelihood of a need for cesarean deliveries or pain medication[23] and higher rates of spontaneous birth and

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[19] Nora Ellman & Jamille Fields Allsbrook, *States' Essential Health Benefits Coverage Could Advance Maternal Health Equity* (Apr. 30, 2021), https://www.americanprogress.org/article/states-essential-health-benefits-coverage-advance-maternal-health-equity.
[20] *Id*.
[21] Laurie Zephyrin et al., *Community-Based Models to Improve Maternal Health Outcomes and Promote Health Equity* (Mar. 4, 2021), https://www.commonwealthfund.org/publications/issue-briefs/2021/mar/community-models-improve-maternal-outcomes-equity.
[22] Saraswathi Vedam et al. *The Giving Voice to Mothers Study: Inequity and Mistreatment During Pregnancy and Childbirth in the United States*, 16 REPRODUCTIVE HEALTH (2019). https://doi.org/10.1186/s12978-019-0729-2.
[23] Asteir Bey et al., *Advancing Birth Justice: Community-Based Doula Models as a Standard of Care for Ending Racial Disparities* (Mar. 2019), https://everymothercounts.org/wp-content/uploads/2019/03/Advancing-Birth-Justice-CBD-Models-as-Std-of-Care-3-25-19.pdf.

satisfaction with the birth experience.[24] Coverage of doula care is therefore an essential component of reducing disparities in pregnancy and childbirth.

Recommendation: The Department should improve the federal standard for what pregnancy and postpartum care must be covered, following clinical standards like the joint guidelines by the American Academy of Pediatrics and American College of Obstetricians and Gynecologists.[25] Among other services, the federal standard should require plans to cover:

- every type of qualified midwife and full-spectrum doula care, including at least three prenatal and three postpartum doula visits;
- all necessary prenatal visits and ultrasounds;
- all three main types of breast pumps (electric, manual, and battery-operated) without cost-sharing;
- key health education services, such as childbirth and breastfeeding classes;
- services related to home births and birth centers;
- comprehensive maternal oral health; and
- postpartum services, including all needed postdelivery hospital stays and home health visits.

Additionally, plans should be required to cover services for pregnant individuals claimed as dependents, as required by Section 1557 of the ACA. Plans should also be required to cover prenatal services regardless of pregnancy outcomes, including for pregnancies that result in miscarriage or abortion.

c. Prescription drug coverage

Many benchmark plans offer inadequate coverage of prescription drugs. The current standard, where benchmark plans are required to cover only one drug per U.S. Pharmacopeia (USP) class and category,[26] permits many plans to exclude a range of necessary medications from coverage. For example, some plans do not cover single-tablet treatment for HIV, even though it is the current standard of care for a condition and, as the Department has previously noted, its exclusion is a "potentially discriminatory practice."[27]

Plans that cover an insufficient number of drugs particularly disadvantage women, who are more likely than men to take prescription medication: 63% of non-elderly women take at least one prescription medication on a regular basis, compared to 48% of men.[28] They also harm people with many types of disabilities and chronic conditions, who may need specific drugs that are less

[24] Meghan A. Bohren et al., *Continuous Support for Women During Childbirth*, 7 COCHRANE DATABASE OF SYSTEMATIC REVIEWS CD003766 (Jul. 2017), http://doi.org/10.1002/14651858.CD003766.pub6.
[25] American Academy of Pediatrics & American College of Obstetricians and Gynecologists, *Guidelines for Perinatal Care* (Sep. 2017), https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx.
[26] 45 C.F.R. § 156.122(a)(1).
[27] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10750, 10822 (Feb. 27, 2015) (codified at 45 C.F.R. pts. 144, 147, 153, 154, 155, 156, and 158).
[28] Long et al., *supra* note 3.

commonly covered. Additionally, because women, people of color, and people with certain disabilities are underrepresented in drug trials,[29] many of the more commonly covered drugs are less effective or appropriate for their needs, and these patients may be particularly likely to need access to non-covered drugs.

Further, the Department's continued reliance on the USP creates substantial gaps in coverage of medically necessary drugs. The USP Medicare Model Guidelines (MMG) were designed for Medicare Part D beneficiaries, most of whom are age 65 and older. They are inappropriate for the needs of much of the population enrolled in EHB plans, which is primarily composed of non-elderly people. The Department asks if it should instead follow the USP Drug Classification (USP DC), a list created in 2017 to assist with formulary support outside of Medicare Part D. This list, however, uses the MMG as a baseline and perpetuates many of its inadequacies.

In particular, the USP DC continues to exclude many medications and supplies critical for reproductive and sexual health, including by failing to include the full range of contraceptives. The USP does not set the standard for contraceptive coverage in EHB plans: Any plan that must comply with EHB must also comply with the ACA's Women's Preventive Services Guidelines, including by covering all Food and Drug Administration-approved, granted, or cleared contraceptives. If the USP DC *were* to be used as a basis, it would be deeply inadequate. In contrast with the minimum of 19 contraceptive methods recognized by the FDA, the USP DC has only three drug classes: combination oral contraceptives, progestin-only oral contraceptives, and "other" contraceptives, a catchall class that includes IUDs, rings, patches, emergency contraception, injectable contraception, and pH modulation gel. The active ingredient in the sponge and spermicide is not included at all. Using the USP DC as a basis for coverage could therefore create confusion regarding plans' obligations to cover the full range of contraceptives and encourage them to run afoul of the requirements of § 2713.

Recommendation: Rather than relying on drug classification standards developed by private entities like the USP, the Department should develop its own classification standards. In the interim, it should expand the number of drugs EHB plans must cover under the USP. For example, it can require EHB plans to cover at least two drugs per USP class and category, as well as "all or substantially all" of the drugs in the six protected classes of drugs that have been identified as critical to vulnerable populations.[30] We encourage the Department to build on this standard, such as by adding protected classes of drugs, with a particular focus on conditions that disproportionately impact underserved communities and inclusive of prescription drugs critical for reproductive and sexual health. Additionally, we urge the Department to thoroughly enforce the requirement to cover the preventive services in § 2713 of the Public Health Service Act,

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[29] *E.g.,* Alexandra Z. Sosinky, *Enrollment of Female Participants in United States Drug and Device Phase 1–3 Clinical Trials Between 2016 and 2019*, 115 CONTEMPORARY CLINICAL TRIALS 106718 (Apr. 2022), https://doi.org/10.1016/j.cct.2022.106718; Mikhaila Alegria et al., *Reporting of Participant Race, Sex, and Socioeconomic Status in Randomized Clinical Trials in General Medical Journals, 2015 vs 2019*, 4 JAMA NETWORK OPEN e2111516 (May 2021), https://doi.org/10.1001/jamanetworkopen.2021.11516.

[30] The six categories are anticonvulsants, antidepressants, antineoplastic, antipsychotics, antiretrovirals, and immunosuppressants. *See* 42 U.S.C. § 1395w-104(b)(3)(G)(iv).

including the full range of contraceptives outlined in the HRSA Women's Guidelines, as many plans are still not in full compliance.[31]

III. Additional Recommendations to Improve Coverage

a. Limits on utilization controls

Excessive utilization controls allow insurers to evade the full scope of EHB requirements, leading to delays or denials of medically necessary care, with particular harms for individuals with significant health needs. For example, an American Medical Association survey of physicians found that over a third reported that use of prior authorization led to a severe adverse event for their patient, like hospitalization or death.[32] Another physician survey by the Association of Black Cardiologists focused on the impact of prior authorization on patients of color, and it found that prior authorization frequently resulted in delayed care, reduction in medication adherence, and worse outcomes for these patients.[33]

Utilization controls are not applied equitably. Not only are women of color, LGBTQI+ people, and disabled people are more likely to have significant health needs, but also the specific conditions that are commonly targeted with more stringent utilization management techniques—like HIV,[34] diabetes, cancer,[35] gender-affirming care, and mental health conditions[36]—disproportionately impact women of color and LGBTQI+ people. For example:

- Nearly two-thirds of Native and Black transgender women have been diagnosed with HIV,[37] an astronomical rate compared to the HIV prevalence in the general population of

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[31] *See* National Women's Law Center, *Access to Birth Control Without Out-of-Pocket Costs: Improving and Expanding the Affordable Care Act's Contraceptive Coverage Requirement* (Nov. 2021), https://nwlc.org/wp-content/uploads/2021/11/final_Long_nwlc_2021_BC_AffordCareAct-003.pdf; U.S. House of Representatives Committee on Oversight and Reform, *Barriers to Birth Control: An Analysis of Contraceptive Coverage and Costs for Patients with Private Insurance* (Oct. 25, 2022), https://oversightdemocrats.house.gov/sites/democrats.oversight.house.gov/files/2022-10-25.COR%20PBM-Insurer%20Report.pdf.

[32] American Medical Association, *2021 AMA Prior Authorization (PA) Physician Survey* 1 (2022), https://www.ama-assn.org/system/files/prior-authorization-survey.pdf.

[33] Association of Black Cardiologists, *Identifying How Prior Authorization Impacts Treatment of Underserved and Minority Patients* 6 (2019), http://abcardio.org/wp-content/uploads/2019/03/AB-20190227-PA-White-Paper-Survey-Results-final.pdf.

[34] Douglas B. Jacobs & Benjamin D. Sommers, *Using Drugs to Discriminate – Adverse Selection in the Insurance Marketplace*, 372 NEW ENGLAND JOURNAL OF MEDICINE 399 (Jan. 2015), https://doi.org/10.1056/NEJMp1411376.

[35] *See* Nerissa George et al., *Burden Associated with Selecting and Using Health Insurance to Manage Care Costs: Results of a Qualitative Study of Nonelderly Cancer Survivors*, 78 MEDICAL CARE RESEARCH AND REVIEW 48 (Feb. 2021), https://doi.org/10.1177/1077558718820232.

[36] National Alliance on Mental Illness, *A Long Road Ahead: Achieving True Parity in Mental Health and Substance Use Care* 7 (Apr. 2015), https://www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/A-Long-Road-Ahead/2015-ALongRoadAhead.pdf.

[37] Centers for Disease Control and Prevention. *HIV Infection, Risk, Prevention, and Testing Behaviors Among Transgender Women—National HIV Behavioral Surveillance, 7 U.S. Cities 2019–2020* 5 (Apr. 2021), https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-special-report-number-27.pdf.

less than half of one percent.[38] Black women overall, who account for 15% of women in the U.S., make up 60% of all new HIV infections among women.[39]

- Native women are more than twice as likely as white women to be diagnosed with diabetes,[40] and Black and Latina women are nearly twice as likely.[41]
- LGBTQI+ people, particularly transgender people, are more likely to experience depression and anxiety than non-LGBTQI+ people.[42]

Limiting utilization controls for these conditions is crucial for ensuring that underserved groups get access to care and reducing the disparities they face.

Recommendation: The Department should adopt restrictions on utilization management techniques in EHB plans to ensure they are not used to deny medically necessary care, and in particular to limit them for conditions that disproportionately impact underserved populations. It should also require medical necessity determinations to align with expert clinical recommendations in the field. For example, it should prohibit clinically inappropriate age limits for services like fertility treatments, hearing aids, services for autistic people, and it should cover gender-affirming care based on up-to-date medical guidelines. As noted, it should also ban prior authorization for mental health services and encourage states to remove other utilization controls for that category, especially when similar controls are not applied to physical health services.

b. Benefit descriptions in EHB-benchmark plan documents

The Department seeks comment on ambiguous or sparsely detailed benefit descriptions in benchmark plans. Lack of clarity and detail in benchmark plans makes it harder for consumers to anticipate which services are covered, leaving many to discover that a benefit is excluded only when it is denied. This can result in unexpected out-of-pocket expenses, delays in access to care, and denials of medically necessary services. Recent studies suggest that women are more likely to face unexpected denials of coverage than men: for example, a 2022 survey found that 31% of women—including 36% with individual insurance—said that their plan did not cover care they thought was covered or the plan paid less than expected, a higher rate than among men (26%).[43]

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[38] Centers for Disease Control and Prevention, HIV Surveillance Report: Statistics Overview, *HIV* (2021), https://www.cdc.gov/hiv/statistics/overview/index.html.

[39] Bisola O. Ojikutu & Kenneth Mayer, *HIV Prevention Among Black Women in the US—Time for Multimodal Integrated Strategies*, 4 JAMA NETWORK OPEN e215356 (2021), https://doi.org/10.1001/jamanetworkopen.2021.5356.

[40] HHS Office of Minority Health, *Diabetes and American Indians/Alaska Natives* (Mar. 1, 2021), https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=33.

[41] HHS Office of Minority Health, *Diabetes and African Americans* (Mar. 1, 2021), https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=18; *Diabetes and Hispanic Americans* (Mar. 1, 2021), https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=63.

[42] Thom File & Matthew Marlay, *Regardless of Household Type, LGBT Adults Struggled More With Mental Health Than Non-LGBT Adults* (Jun. 16, 2022), https://www.census.gov/library/stories/2022/06/lgbt-adults-report-anxiety-depression-during-pandemic.html; American Psychiatric Association, *Mental Health Disparities: LGBTQ* 2 (2017), https://www.psychiatry.org/File%20Library/Psychiatrists/Cultural-Competency/Mental-Health-Disparities/Mental-Health-Facts-for-LGBTQ.pdf

[43] Long et al., *supra* note 3.

We disagree with the Department's suggestion that a lack of consumer complaints indicates that ambiguous or bare-bones benchmark plans are not creating hardships. Many consumers do not have the time and resources to file complaints, while others may not be aware that a coverage denial or limitation violates EHB requirements and merits a complaint.

We stress that the problem of inconsistent and ambiguous benefit descriptions in state benchmark plans would be obviated if the Department were to adopt a robust minimum standard for each EHB category. Until it does so, we urge the Department to issue guidance requiring state benchmark plans to have clear, detailed benefit descriptions.

c. Defrayal requirements and generosity limits

Some states have been hesitant to add coverage requirements or adjust their benchmark plans because they are concerned that they would run afoul of defrayal requirements or the generosity limit—including when changes to the benchmark plans are necessary in order to cure violations of federal law. For example, concerns about defrayal and generosity limits have deterred some states from changing benefits to ensure compliance with the Mental Health Parity and Addiction Equity Act, Section 1557 of the ACA, or the EHB nondiscrimination requirements.

We encourage the Department to clarify that when states pass a mandate for the purpose of ensuring that health plans comply with federal requirements, such as parity or nondiscrimination standards, they would not need to defray the cost of the mandate. Additionally, the Department should clarify that when a new benefit is added through the benchmarking process in order to ensure compliance with federal requirements, that change would not be counted towards the generosity limit.

d. EHB reviews and updates

Despite its statutory obligation to conduct periodic reviews of EHB requirements and submit a report to Congress, the Department appears to have done neither to date. This review is necessary to respond to gaps and problems consumers face in coverage, address persistent disparities, and account for changes in medical evidence and scientific advancement. To ensure that this requirement is met, the Department should establish a standard framework for reviewing and updating EHBs, with a review conducted at least every other year. The review process should be transparent and allow for public review and comment.

IV. Conclusion

We appreciate the opportunity to comment on this proposed rule. We request that the supporting documentation that we have made available through direct links in our citations be considered part of the formal administrative record for purposes of the Administrative Procedure Act. For further information, please contact Ma'ayan Anafi, Senior Counsel for Health Equity and Justice at the National Women's Law Center, at manafi@nwlc.org.