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September 13, 2023

Dr. Ellen Montz
Deputy Administrator and Director
Center for Consumer Information and Insurance Oversight
Department of Health and Human Services
7500 Security Blvd.
Baltimore, MD 21244-8016

Re: Potential Changes to Essential Health Benefits Regulations in the Notice of Benefit and Payment Parameters for 2025

Dear Director Montz:

The National Health Law Program (NHeLP) protects and advances the health rights of low-income and underserved individuals, by advocating, educating, and litigating at the federal and state level. We thank the Center for Consumer Information and Insurance Oversight (CCIIO) for the willingness to engage in conversations with health consumer advocates regarding potential improvements to coverage of Essential Health Benefits (EHBs) in the individual and small-group market and in Medicaid Alternative Benefit Plans (ABPs).

We appreciate the administration's efforts to address unmet health needs and fulfill the promise of the Affordable Care Act (ACA) regarding access to comprehensive health coverage through EHB.

Our purpose with this letter is to highlight specific regulatory changes that we believe the U.S. Department of Health and Human Services (HHS) should adopt through the rulemaking process. We have previously submitted various letters to HHS and CCIIO underscoring the policy reasons to incorporate several changes regarding the EHB benchmarking process and related requirements.¹ In addition, in our response to the Request for Information RIN 0938–AV14, we discussed concerns with the current framework and the need for HHS to evaluate EHB coverage and take action to close remaining

gaps. We have also joined sign-on letters with other organizations highlighting the need to reform the current EHB enforcement framework.² Given that context, below we discuss several priority areas where we believe HHS should modify the current rules surrounding EHB.

Rescinding or Modifying Regulatory Provision Barring Adult Oral Health Services as EHBs

Public health experts increasingly recognize that oral health is inextricably linked to overall health. In 2009, the World Health Organization (WHO) Global Conference on Health Promotion issued a call for the integration of oral health services and primary care.³ Since then, evidence continues to overwhelmingly demonstrate that oral health care is a critical, essential part of health care.

In the ACA, Congress provided for pediatric oral care as part of EHB, but made no mention of oral health services for adults.⁴ Congress also required HHS to periodically review and update the ten EHB categories “to address any gaps in access to coverage or changes in the evidence.”⁵ Factors HHS must examine include whether enrollees are facing any difficulty “accessing needed services for reasons of coverage or cost,” and “changes in medical evidence or scientific advancement.”⁶

¹ Nat’l Health Law Prog., *Letter to Sec. Becerra, Re: Advancing Health Equity Through Essential Health Benefits* (Dec. 6, 2021), <https://healthlaw.org/resource/nhelp-letter-to-hhs-sec-becerra-re-advancing-health-equity-through-essential-health-benefits/>; Nat’l Health Law Prog., *Letter to CCIIO Director Ellen Montz, Re: Request for Modifications to the Federal Prescription Drug and Maternity Care Essential Health Benefits Standards* (Aug. 19, 2022), <https://healthlaw.org/resource/nhelp-letter-to-cciio-director-ellen-montz-re-request-for-modifications-to-the-federal-prescription-drug-and-maternity-care-essential-health-benefit-standards/>.

² Community Catalyst, *Groups Urge Biden Administration to Expand Decade Old Coverage Requirements of Essential Health Benefits to Include Dental and Gender-Affirming Care* (July 20, 2023), <https://communitycatalyst.org/news/groups-urge-biden-administration-to-expand-decade-old-coverage-requirements-of-essential-health-benefits-to-include-dental-and-gender-affirming-care/>.

³ Petersen PE, Kwan S. The 7th WHO Global Conference on Health Promotion-towards integration of oral health (Nairobi, Kenya 2009). *Community Dental Health* 2010; 27(Suppl 1):129–36, [https://scholar.google.com/scholar_lookup?journal=Community+Dental+Health+2010&title=The+7th+WHO+Global+Conference+on+Health+Promotion-towards+integration+of+oral+health+\(Nairobi,+Kenya+2009\)&author=PE+Petersen&author=S+Kwan&volume=27&issue=Suppl+1&pages=129-36&](https://scholar.google.com/scholar_lookup?journal=Community+Dental+Health+2010&title=The+7th+WHO+Global+Conference+on+Health+Promotion-towards+integration+of+oral+health+(Nairobi,+Kenya+2009)&author=PE+Petersen&author=S+Kwan&volume=27&issue=Suppl+1&pages=129-36&).

⁴ 42 U.S.C. § 18022(b)(1)(j).

⁵ *Id.* at § 18022(b)(4)(H).

⁶ *Id.* at § 18022(b)(4)(G)(i)(ii).



The ACA does not bar HHS from adding adult oral health services pursuant to its EHB review and updating authority. (By contrast, Congress expressly excluded coverage for most dental services in Medicare.)⁷ Yet, through regulation, HHS enjoins itself, and states through the benchmarking process, from including adult oral health services as part of EHB. In 2013, HHS finalized a rule that prohibits EHB plans from offering routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, and non-medically necessary orthodontia as EHB.⁸ This provision not only forecloses the possibility that plans offer additional and important health benefits, but it also curtails states' ability to require plans to cover these benefits and services.

When promulgating § 156.115(d), HHS provided a one sentence explanation that “[i]n contrast with the benefits covered by a typical employer health plan, [routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, and non-medically necessary orthodontia] often qualify as excepted benefits.”⁹ However, we note that the ACA did not tie EHB to excepted benefits. As we have previously discussed, the typical employer plan provision is designed as a floor or minimum, not a cap or basis to exclude benefits.¹⁰ Because employer plans have traditionally excluded the very same services the ACA meant to improve access to, including mental health and substance use disorder services, maternity and newborn care, and rehabilitative and habilitative services, reading the typical employer provision as a hard cap on benefits would effectively make the EHB provisions meaningless.

Nothing in the ACA prohibits coverage of adult dental, adult vision, and long-term care services as EHBs because plans are allowed to exceed what is considered typical employer plan coverage. Likewise, under the benchmarking approach, we see no reason not to allow states to require coverage of these services as EHBs, just as HHS could do when reviewing and updating EHB coverage. Accordingly, we urge HHS to rescind § 156.115(d).

Alternatively, we ask that HHS limit the scope of 45 C.F.R. § 156.115(d) to harmonize the rule with long-standing statutory provisions regarding excepted health benefits. “Excepted benefits” is a term introduced in the Health Insurance Portability and Accountability Act (HIPAA) to exempt certain plans from the statute’s obligations. In its definition of excepted benefits, the HIPAA statute and implementing regulations include limited-scope dental

⁷ See 42 U.S.C. § 1395y(a)(12). A discussion by the Centers for Medicare and Medicaid Services (CMS) of the narrow cases where the Medicare program covers oral health services is available at www.cms.gov/Medicare/Coverage/MedicareDentalCoverage/index.html.

⁸ 45 C.F.R. § 156.115(d). While we support rescinding this regulatory provision in total, for the purposes of this discussion, we focus primarily on non-pediatric dental services.

⁹ See Dept. of Health and Human Svcs., *Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation Proposed Rule*, 77 Fed. Reg. 70644, 70651 (Nov. 26, 2012), <https://www.govinfo.gov/content/pkg/FR-2012-11-26/pdf/2012-28362.pdf>; 78 Fed. Reg. 12845.

¹⁰ See Nat’l Health Law Prog., *NHeLP Comments on Essential Health Benefits (EHB) Request for Information (RFI)* (Feb. 2, 2023) at 7–14, <https://healthlaw.org/resource/nhelp-comments-on-essential-health-benefits-ehb-request-for-information-rfi/>.

benefits, limited-scope vision benefits, or long-term care benefits “*if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of a group health plan...*” (emphasis added).¹¹

The ACA, however, did not change the definition of excepted benefits, nor did it explicitly state that already defined excepted benefits were to be excluded from the definition of EHBs. As a result, a plain reading of the EHB statute and other provisions related to Qualified Health Plans (QHPs) lends no support to the notion that under no circumstance could vision, dental, and long-term care benefits be considered EHBs.

Even if Congress intended to apply the HIPAA excepted benefits provision to the EHB requirement, the original definition of excepted benefits is more specific than the HHS regulation in § 156.115(d). The HIPAA excepted benefits provision extends to benefits that are not an integral part of a group plan. Benefits are not considered an integral part of a group plan if either (1) enrollees may decline coverage for the specific services, or (2) if “claims for the benefits are administered under a contract separate from claims administration for any other benefits under the plan.”¹² However, § 156.115(d) bans coverage of these excepted benefits as EHBs regardless of whether these requirements are met, exceeding the limitations on excepted benefits added by the HIPAA statute. Therefore § 156.115(d) is simply not supported by the statutory language in the ACA or HIPAA.

HHS should read the HIPAA excepted benefits provision as written, applying to specific types of *plans* rather than types of benefits. While the HIPAA statutory provision in question talks about “benefits,” Congress’ unambiguous intention was to exclude limited-benefit *plans* (such as stand-alone dental and stand-alone vision plans) from HIPAA requirements, not the benefits themselves. At a minimum, then, HHS should modify the EHB rule to limit the exclusion of adult vision, dental, and long-term care to those benefits that are provided under

¹¹ 45 C.F.R. § 146.145(b), See 26 U.S.C. § 9832(c)(2)(A), the HIPAA provision introducing the concept of dental and vision benefits counting as excepted benefits not subject to HIPAA requirements *only if offered separately* from a group health plan, 45 C.F.R. § 146.145(b), defining excepted benefits as “Limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits” that are “provided under a separate policy, certificate, or contract of insurance”, 62 Fed. Reg. 16893, 16903 (April 8, 1997), qualifying dental benefits as excepted only *if provided under a separate policy or otherwise not an integral part of a plan* (“Limited-scope dental benefits, limited-scope vision benefits, and long-term care benefits are excepted if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of the plan”), H. Rept. No. 104-80 at 95 (June 27, 1995) (“Medical benefit plans are inherently different from dental plans. All medical benefit plans are first and foremost intended to provide insurance against catastrophic events that could bankrupt the average family... on the other hand, dental expenses are not catastrophic in nature. In fact, the standard dental benefit plan is really not an insurance plan at all, but a prepayment plan. . . this bill supports the ADA’s position that the integrity of free-standing dental plans must not be threatened”).

¹² 45 C.F.R. § 146.145(b)(3)(ii).

a separate policy for individual and small-group plans, and to benefits that are not an integral part of a group health plan in the case of small-group plans.

To be clear, we are not suggesting at this time that HHS define adult vision and dental services as EHB. Rather, by rescinding the rule prohibiting coverage of these excepted benefits as EHBs or limiting its reach, HHS would allow plans to cover such services if they wish to do so and, most importantly, would allow states to change their EHB base-benchmark plans in order to require coverage of vision, dental, and/or long-term care as long as the addition of these benefits meets the actuarial requirements HHS has outlined.

In sum, § 156.115(d) unduly limits the ability of HHS to review and update EHB as required by the ACA; it unduly limits states in updating their EHB benchmark plans to meet urgent and emerging health needs in states; and the regulation has no statutory basis. Accordingly, we suggest HHS consider the following two alternative approaches:

Option 1 (preferred):

§ 156.115 Provision of EHB.

~~(d) An issuer of a plan offering EHB may not include routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, or non-medically necessary orthodontia as EHB.~~

Option 2:

§ 156.115 Provision of EHB.

~~(d) An issuer of a plan offering EHB may not include routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, or non-medically necessary orthodontia as~~ **EHB benefits that meet the definition of limited excepted benefits pursuant to 45 C.F.R. § 146.145(b)(3).**

Ending Unlawful Limits on Durable Medical Equipment

Through the authority to define EHB, the Secretary of HHS has the responsibility to “ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life.”¹³ One key example of benefit designs that discriminate against individuals with disabilities is the practice

¹³ 42 U.S.C. § 18022(b)(4)(B), (C).

of severely restricting coverage of durable medical equipment (DME) to a limited number of devices and imposing restrictions on use for coverage to kick in.

For example, California's base-benchmark plan only covers twelve devices as DME and excludes essential services such as wheelchairs and oxygen tanks.¹⁴ In addition, the plan restricts access to DME to those that are designed for use in the home.¹⁵ As a result, most individual and small group market plans in the State have implemented similar restrictions in their benefit designs, with harmful consequences for individuals who need wheelchairs on a daily basis in and outside the home, hearing aids, oxygen pumps, among other DME. Such limits on coverage discriminates against people with disabilities in violation of the EHB nondiscrimination requirement and HHS has the responsibility to address those violations.

We recommend the following modifications to the EHB rule regarding coverage of rehabilitative and habilitative services and devices:

§ 156.115 Provision of EHB.

(a) Provision of EHB means that a health plan provides benefits that –

(5) With respect to **rehabilitative and** habilitative services and devices—

(i) Cover **services and devices for both rehabilitative and habilitative purposes. Habilitative services and devices are** health care services and devices that help a person keep, learn, or improve skills and functioning for daily living (~~habilitative services~~). Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings;

(ii) Cover durable medical equipment, services, and repairs that are needed inside or outside the home. Examples include manual and power wheelchairs, hearing aids, ventilators, and blood glucose monitors;

~~(iii) (ii)~~ Do not impose limits on coverage of habilitative services and devices that are less favorable than any such limits imposed on coverage of rehabilitative services and devices; and

~~(iv) (iii)~~ For plan years beginning on or after January 1, 2017, do not impose combined limits on habilitative and rehabilitative services and devices.

¹⁴ See Kaiser Permanente for Small Business, Evidence of Coverage, 2014, p.29.

¹⁵ *Id.*

Clarifying Federal Compliance Provision to Allow States to Enact Mandates Without Defrayal

The ACA allow states to enact new mandates as long as the state defrays the cost of covering the new services in QHPs.¹⁶ The defrayal rule, however, incorporates an exception that has remained significantly underutilized. Specifically, the rule exempts from defrayal new mandates that are enacted for the purpose of complying with federal requirements. The purpose of the ACA's defrayal requirement is to avoid uncontrolled addition of new coverage requirements that would result in significant increases in plan costs that, in turn, lead to higher premiums and other costs for consumers. The defrayal exception incorporated in the rule is important because it recognizes that compliance with federal law should not be subject to financial considerations. When a state merely seeks to enforce federal requirements, cost considerations should not apply because the requirement stands independent of financial and actuarial limits. Despite its importance, however, HHS has offered little guidance about the scope of the defrayal exception. As a result, states often desist from enacting new mandates through state action.

We therefore urge HHS to clarify the meaning of the defrayal exception through rulemaking or guidance and provide examples of federal requirements that states may want to address through state action without being subject to defrayal. In particular, we recommend highlighting federal non-discrimination requirements (e.g., Sections 1557 and 1302 of the ACA) and mental health and substance use disorder parity requirements as examples of areas in which enforcement is lacking and, thus, states may want to take action to ensure compliance.

In addition, HHS should address state authority to enforce federal requirements. Many federal requirements rely on states for proper enforcement and this role extends to state legislatures and executive departments. Nothing in the current EHB rules requires a court finding of noncompliance before a state can enact new mandates without being subject to defrayal. HHS should clarify that states have significant authority in enforcing both EHB requirements, as well as other federal requirements. To that end, states should have wide latitude to adopt new coverage mandates through state action when the state reasonably believes that the mandate will improve compliance with a federal requirement. The rule should clarify that such action would not be subject to defrayal.

We recommend clarifying the defrayal exception and the following changes to the rule:

¹⁶ 42 U.S.C. § 18031(d)(3)(B)(ii); 45. C.F.R. § 155.170.

§ 155.170 Additional required benefits.

(a) Additional required benefits.

(2) A benefit required by State action taking place on or before December 31, 2011 is considered an EHB. A benefit required by State action taking place on or after January 1, 2012, other than for purposes of **ensuring** compliance with Federal requirements, is considered in addition to the essential health benefits. **Examples of federal requirements that states may seek to enforce through state mandates and that would not be subject to defrayal include federal nondiscrimination requirements and requirements under section 2726 of the Public Health Service Act.**

Clarifying Generosity Limit and Requirements to Ensure Compliance with Federal Law

The current benchmarking rules allow states to modify their benchmark plans to address unmet health needs by adding coverage requirements as long as the proposed benchmark plan does not exceed the generosity of the most generous among a set of comparison plans.¹⁷ While this actuarial requirement limits states' ability to significantly expand coverage requirements, we appreciate its intent to control increased plan costs that would then be passed on to consumers in the form of higher premiums. For that reason, we are not recommending elimination of the generosity limit at this moment.

Nonetheless, we believe there are areas in which CCIO can limit the generosity limit's reach. Specifically, we recommend that HHS clarify that, similar to defrayal, when a state proposes a new coverage requirement for the purpose of ensuring compliance with federal requirements and such requirement is being proposed through the benchmarking process, the requirement shall not be subject to the generosity limit. For example, a state that seeks to ensure that plans do not discriminate against certain individuals by proposing coverage requirements that address potential discriminatory benefit designs should not have to worry about exceeding the generosity limit. Exempting benchmarking changes for compliance with federal rules from the generosity limit also ensures that states can focus their attention on other gaps they may want to address that are not necessarily violations of federal requirements. In so doing, this action would strengthen states' role as EHB enforcers.

We suggest the following language in the regulation, but we strongly recommend explaining the need for this change and providing examples in the preamble to the rule:

¹⁷ 45 C.F.R. § 156.111(b)(2)(ii).



§ 156.111 State selection of EHB–benchmark plan for plan years beginning on or after January 1, 2020.

(b) A State's EHB–benchmark plan must:

(3) Scope of benefits.

(ii) ***Except when benchmark changes are proposed for the purpose of complying with federal requirements, Not*** exceed the generosity of the most generous among a set of comparison plans, including:

(A) The State's EHB–benchmark plan used for the 2017 plan year, and

(B) Any of the State's base-benchmark plan options for the 2017 plan year described in § 156.100(a)(1), supplemented as necessary under § 156.110.

Conclusion

We look forward to working with CCIIO and HHS during this next stage of the process and we thank you for your consideration to the proposals outlined in this letter and other communication from advocates and stakeholders. If you have any questions about our recommendations, please feel free to contact us at hernandez-delgado@healthlaw.org or turner@healthlaw.org.

Sincerely,



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