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January 27, 2023

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-9898-NC
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Request for Information; Essential Health Benefits (CMC-9898-NC)

Dear Administrator Brooks-LaSure:

The Association of American Medical Colleges (AAMC or the Association) welcomes the opportunity to submit comments on the request for information (RFI) entitled “Essential Health Benefits” 87 Fed. Reg. 74097 (December 2, 2022), issued by the Centers for Medicare & Medicaid Services (CMS or the Agency). The AAMC supports the Agency’s potential regulatory changes to the requirements plans must meet to satisfy the essential health benefits (EHBs) requirements. Changes should focus on consumers’ access to health insurance products that provide meaningful coverage at an affordable price.

The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, health care, medical research, and community collaborations. Its members comprise all 157 accredited U.S. medical schools; 13 accredited Canadian medical schools; approximately 400 teaching hospitals and health systems, including Department of Veterans Affairs medical centers; and nearly 80 academic societies. Through these institutions and organizations, the AAMC leads and serves America’s medical schools and teaching hospitals and the millions of individuals across academic medicine, including more than 191,000 full-time faculty members, 95,000 medical students, 149,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Following a 2022 merger, the Alliance of Academic Health Centers and the Alliance of Academic Health Centers International broadened the AAMC’s U.S. membership and expanded its reach to international academic health centers.

The Affordable Care Act (ACA) requires certain health plans¹ that participate in the individual and small group markets, both on and off the Exchange, to cover ten essential health benefits: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral health

¹ Health insurance plans that were not in existence or purchased on or before March 23, 2010.

treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.² While CMS has some discretion in determining what constitutes EHBs, the benefits must include coverage of items or services within the 10 basic categories. This standard of benefits ensures that consumers have a uniform level of coverage among of health plans and prohibits insurers from cutting benefits just to reduce costs.

As noted in the RFI, CMS provides flexibility for states to substitute benefits within the same EHB category and between EHB categories as long as the substituted benefit is actuarially equivalent to the benefit being replaced and is not a prescription drug benefit. (p. 74101). The RFI acknowledges that CMS is unaware whether health plans are using this flexibility. The RFI seeks feedback on whether health plans should continue to be permitted to substitute EHB benefits. The AAMC is concerned that consumers will likely not understand the nuance of EHB substitutions and potentially select plans that do not meet their health care needs. Since it seems that plans and states may not have utilized the flexibility to substitute EHBs, CMS should eliminate the option to ensure that consumers are protected. If this flexibility is continued, then CMS must safeguard consumers' access to insurance coverage that meets their needs by requiring health plans and states to use plain language to inform consumers of the changes to the EHBs.

However, insurance coverage alone does not guarantee access. Increases in premiums and cost sharing, plans with limited benefits, utilization management tools, and narrow networks can all limit consumers' ability to afford and access medically necessary care; sometimes forcing them to forgo needed care. Consumers in 13 states and the District of Columbia could see premium increases of 10 percent, on average, in 2023.³ Employers could also expect to see an increase in medical plan costs per employee of 5.6 percent on average in 2023.⁴ As these costs rise, consumers are likely to bear much of the increase through both higher premiums and more cost sharing.

Health plans use cost sharing – deductibles, copayments, coinsurance – as a way to drive patients' utilization of care. Consumers with higher cost sharing may delay or forgo needed care, including initiation and continuance of prescription drugs, due to costs.⁵ In some cases, delays in care result in some patients requiring acute care to treat exacerbations of chronic medical conditions. The AAMC believes that insurance reforms should provide access to affordable insurance products that meet the health care needs of consumers.

Finally, as premiums and cost sharing increase, consumers may find it hard to balance affordability and coverage. They may turn to short-term, limited duration plans or “skinny plans” that are not subject to the EHB requirements. These plans offer less comprehensive

² <https://www.cms.gov/ccio/resources/data-resources/ehb>

³ <https://www.healthsystemtracker.org/brief/an-early-look-at-what-is-driving-health-costs-in-2023-aca-markets/>

⁴ <https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/health-plan-costs-expected-to-rise-in-2023.aspx>

⁵ <https://pubmed.ncbi.nlm.nih.gov/35389285/>

insurance products; segment the insurance market, leading to de-stabilization and premium increases for sicker individuals; leave patients with inferior health insurance coverage, potentially limiting access to care; and leave providers who treat these patients either underpaid or not paid at all. The AAMC urges CMS to eliminate health insurance plans that are not subject to the EHB requirements.

The comments below respond to proposals addressed in the RFI.

BARRIERS TO ACCESSING SERVICES DUE TO COVERAGE OR COST

Utilization Management Tools Should Not Be Used to Limit Access to Needed Medical Care and Prescription Drugs

Insurers routinely employ utilization management tools – including prior authorization and step therapy – to control utilization of certain services. However, both tools can cause delays in patients’ ability to receive timely, medically necessary care. These tools routinely impose time-consuming administrative burden on providers by often requiring them to spend additional time to fulfill prior authorization or step therapy requirements imposed by insurers. Utilization management tools that require providers to submit additional information to insurers, oftentimes delaying consumers access to medically necessary care, does not support the Agency’s goal of reducing provider burden.

Utilization management tools should not impose added strain on an already stressed health care system. Plans should be required to limit the use of utilization management tools that simply seek to decrease utilization and costs without regard to medical necessity. CMS should set up a system where patients and providers can submit documentation showing how utilization management tools delayed needed care. Plans should be required to post on their websites what items, services, and prescription drugs require prior authorization for a plan year and any mid-year changes to prior authorization requirements. Mid-year changes should be limited to ensure beneficiaries continue to have access to needed medical care. This information should also be available to potential enrollees during annual enrollment periods to allow those seeking to change plans information on whether an item, service, or prescription drug they currently use will be subject to prior authorization or step therapy under the new plan. Utilization tools can also result in decreased patient adherence to treatment plans. Some patients stop taking prescription medications or fail to fill prescriptions due to delays caused by utilization management. For example, low-income Medicare beneficiaries may not fill a prescription due to formulary restrictions such as prior authorization and step therapy imposed by the Medicare Part D plan.⁶

⁶ <https://www-healthaffairs-org.eu1.proxy.openathens.net/doi/10.1377/hlthaff.2021.01742>

Step Therapy or “Try and Fail” Should Be Prohibited for Patients Stable on Current Medical and Medication Regimens

Step therapy is often used to manage access to certain therapies and prescription drugs, specifically high-cost and specialty drugs. Under step therapy requirements, patients are required to “try and fail” alternatives before an insurer will authorize dispensing a prescription medication or approving a certain therapy or treatment. Although the use of some step therapy protocols *may* steer patients to more appropriate medications or therapies, often it is used as a cost-control measure driving utilization of certain medications or therapies based on price. Patients required to try and fail alternative therapies may experience delays in receiving effective and appropriate treatments which may result in disease progression and potentially negative long-term effects.⁷ Studies have found that although step therapy protocols can reduce pharmacy costs, savings may be offset by increased health care costs such as inpatient admissions or increased outpatient visits.⁸

New plan enrollees should not be required to undergo step therapy for medications they currently take. Requiring patients with complex medical and behavioral health conditions to undertake step therapy for medications they currently take and are stable on can be detrimental to their health and wellbeing. CMS should prohibit plans from requiring step therapy for patients stable on their current medication regimen. Further, if the physician’s judgment is that a particular medication is best for managing a patient’s medical condition, then the patient (and provider) should not have to undertake step therapy.

Utilization Management Tools Add to Clinician Burden and Burnout

The American Medical Association surveyed more than 1,000 practicing physicians regarding their experience with prior authorization; 88 percent reported that prior authorization interferes with continuity of care. More than 80 percent reported that in the last five years they have seen an increase in the number of prior authorizations for medical services and prescription drugs, with almost 20 percent of prescription drugs requiring prior authorization.⁹ Consumers currently undergoing treatment that transition to a new insurance plan should not be subject to prior authorization requirements that could potentially disrupt ongoing treatments. To minimize disruptions in care the AAMC supports sufficient protections for continuity of care during transition periods – such as for changes in formulary or health plan – when patients are undergoing an active course of treatment.

Further, clinicians increasingly cite the use of electronic health records, including prior authorization requests, as a cause of burnout. To meet billing rules the medical record has become bloated, thereby impeding physicians’ ability to focus on delivering high quality care. Adding to this burden is the requirement for clinicians to navigate coverage requirements for an

<https://www.healthaffairs.org/eu1.proxy.openathens.net/doi/epdf/10.1377/hlthaff.2021.00822>

⁸ Ibid.

⁹ American Medical Association. Measuring progress in improving prior authorization. Update 2021. <https://www.ama-assn.org/system/files/prior-authorization-reform-progress-update.pdf>.

array of insurance plans and a lack of standardized transmissions for this information, including the submission of prior authorization requests. CMS should consider aligning prior authorization procedures for Marketplace plans with those recently proposed for Medicare Advantage plans to minimize burden on providers.¹⁰ Also, the Agency should evaluate the process and clinical workflow factors contributing to the burden associated with utilization management tools to see how these factors can be reduced. CMS also should evaluate the expanded use of prior authorization in the Medicare fee-for-service program to better understand the impact of prior authorization requirements on patients' timely access to medically necessary care and prescription drugs.

Narrow Networks Exacerbate Problems with Patients' Access to Medically Necessary Care

Insurers expanded use of narrow networks has exacerbated access issues. Narrow networks often exclude teaching hospitals and their associated providers who furnish primary, specialty and sub-specialty care and behavior health services. Teaching hospitals and their associated physicians and other providers are an important part of ensuring access to high-quality, cutting-edge treatments. Excluding these institutions and physicians from networks limited patients' access to specialized and sub-specialized care and behavioral health services that often is only furnished at teaching hospitals. To address access and ensure the availability of these services, the AAMC urges CMS to curtail the use of narrow networks and implement and enforce more robust requirements for network adequacy standards.

ADDRESSING GAPS IN COVERAGE

Expand the Use of Telehealth to Ensure Access to Care, including Behavioral Health Services

The COVID-19 public health emergency (PHE) has revealed the value of telehealth to maintain continuity of care for many patients. Congress acknowledged this value and extended telehealth coverage under Medicare through December 31, 2024.¹¹ AAMC members and their associated providers have mobilized to expand the use of telehealth to ensure access to medically necessary coverage, including behavior health. Most insurers provide coverage for some telehealth services. The use of telehealth must continue and be expanded for enrollees in private health insurance, Medicare and Medicaid. The ability for providers to use telehealth expands access to medically necessary care, especially for beneficiaries in rural and other underserved areas. Further, it benefits patients who are unable to attend an in-person visit due to an inability to take time off from work, lack of care for dependents, and do not have reliable transportation, for example. The Association supports efforts to expand telehealth to reach patients who may otherwise go without care.

¹⁰ <https://www.federalregister.gov/documents/2022/12/27/2022-26956/medicare-program-contract-year-2024-policy-and-technical-changes-to-the-medicare-advantage-program>

¹¹ Consolidated Appropriations Act, 2023. Pub.L. 117-328, Sec. 4113(b).

The COVID-19 PHE has negatively affected many individuals' mental health. The increase in demand for mental health services has added to the strain currently felt by mental health providers to meet these demands leaving many without access. Expanding the use of telehealth can also increase the capacity of the existing workforce, including the behavioral health workforce, to respond to patients' care needs. The AAMC supports efforts to enable providers to effectively leverage technology, including telehealth, to reach more patients.

As part of the COVID-19 PHE response, CMS has allowed providers to be reimbursed by Medicare for telehealth services across state lines with permission from the individuals states. This waiver creates an opportunity to improve patient access to services and to help improve continuity of care for patients that have relocated or who have traveled to receive their surgery or other services from a specialist in another state. While CMS has the authority to allow for payment, states need to act to allow practice across state lines to occur. We encourage CMS to work with states to participate in interstate medical licensure compacts or other mechanisms that would allow care delivery across state lines in the future after the pandemic ends.

CMS should require plans to expand telehealth coverage and to include audio-only telecommunications to furnish services to some patients. The AAMC strongly supports the use of audio-only communication to provide mental health services. During the PHE, coverage and payment for audio-only calls have been critical to ensure access to care for many patients. Providers have been able to provide a wide array of services efficiently, effectively, and safely to patients using audio-only technology. Plans should acknowledge this and allow for the continuation of audio-only communication. CMS should also consider requiring plans to use a modifier to track the use of audio-only services, similar to the Medicare fee-for-service behavioral health modifier (CPT 93/FQ).

Increase Reimbursement Rates for Telehealth Services

Reimbursement rates for telehealth services, including behavioral health, should be the same as in-person visits. Providing telemedicine services requires the same, if not more, resources as in-person visits. Providers continue to incur fixed operating costs regardless of whether a patient is seen in-person or via telecommunication. Staff including nurses, medical assistants and other staff are required to engage patients before, during, and after telehealth visits to coordinate care pre- and post-visit and ensure a seamless experience. Adequate staffing is necessary to ensure effective appointment scheduling, notifications, reminders for providers and staff, and learner supervision, as necessary. Protocols and infrastructure must be in place for managing patients' emergencies. Further, providers must establish and maintain a video platform that is HIPAA compliant, accessible, user-friendly, and compatible with patient-owned devices and that integrates with electronic medical records scheduling and enables multiple concurrent participants (e.g., learners, patients' family members). Sufficient internet access and bandwidth for providers and patients and appropriate devices – such as webcams, headsets, smartphones – for providers and in some instances patients is essential. Effective technology training is required for providers and staff, including real-time technical support for providers and patients,

with contingency plans for connectivity failures as well as private locations where others cannot hear or see the patient during the video visit.

For telehealth to successfully enable access to care for patients to receive timely and effective management of their health care needs, reimbursement for services must be commensurate with the costs of providing care through video visits. For many providers, telehealth will no longer be sustainable if rates continue to lag as compared to in-person visits. Limiting the availability of telehealth services could significantly impact patients' access to care. Patients unable to attend an in-person visit will likely forgo care, resulting in poor health outcomes that cost the health care system more when they seek care in the emergency department. CMS should ensure that commercial insurance and Medicare and Medicaid payment rates are the same for telehealth services, including behavioral health, as for in-person visits.

CONCLUSION

Thank you for the opportunity to comment on this Request for Information. We would be happy to work with CMS on any of the comments discussed in this letter or other topics that involve the academic medicine community. If you have questions regarding our comments, please feel free to contact Mary Mullaney at mmullaney@aamc.org.

Sincerely,

A handwritten signature in black ink, appearing to read 'J. Jaffery', written in a cursive style.

Jonathan Jaffery, M.D., M.S., M.M.M., F.A.C.P.
Chief, Health Care Affairs

Cc: David Skorton, M.D., AAMC President and Chief Executive Officer
Ivy Baer, JD, MPH, Senior Director and Regulatory Counsel