

Comments submitted via [E-mail](#)

January 31, 2012

Mr. Steve Larsen
Deputy Administrator and Director
Center for Consumer Information and Insurance Oversight
Centers for Medicare and Medicaid Services
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

Re: Essential Health Benefits Bulletin of December 16, 2011

Dear Mr. Larsen:

The National Council for Community Behavioral Healthcare (National Council) welcomes the opportunity to comment on the intended approach that the Department of Health and Human Services has outlined for implementing the Essential Health Benefits provision of the Affordable Care Act (ACA). For more than 40 years, the National Council, a non-profit association representing more than 1,950 community-based mental health and addiction treatment providers, has been dedicated to fostering clinical and operational innovation and promoting policies that ensure that the more than 8 million low-income children, adults, and families our members serve have access to high quality services. Our community mental health and addiction organizations have experience and expertise in providing a range of services and recovery supports for millions of individuals with multiple chronic conditions.

The Essential Health Benefits provision of the ACA is forward-thinking in its mandate that certain categories of benefits be covered. In particular, its requirement that mental health and substance use treatment services be among the mandated benefit categories is critical for advancing access to care for the millions of people with untreated mental illness and/or substance use disorders. We deeply appreciate that the bulletin highlighted the requirement that all qualified health plans comply with the Mental Health Parity and Addiction Equity Act (MHPAEA) and the additional parity requirements established under the ACA.

We are, however, concerned that the December 2011 bulletin ("Bulletin") does not include sufficient protections to ensure adequate access to mental health and substance use disorder treatment services. On behalf of our members and the consumers they serve, we offer the following recommendations for strengthening the Essential Health Benefits guidance and HHS' monitoring of its implementation:

- Oversight for Determining EHB Packages
 - Develop and enforce safeguards to ensure that affording state flexibility for development of EHB plans does not undermine the nature of an EHB package to which every individual should have nondiscriminatory access
 - Assure a transparent and inclusive determination process
 - Review experiences of current individuals covered by states' small group plans
 - HHS should establish an oversight board to annually update the EHB categories and ensure meaningful opportunities for consumer and provider input

 - Establish stronger oversight for Parity implementation and adherence, including issuance of guidance for Medicaid Managed Care Organizations
 - HHS should release its EHB guidance for Medicaid without delay

- Benefit Categories and Coverage Determinations

- Rehabilitation and habilitation benefits should be defined in the EHB packages to explicitly include services to maintain, as well as improve, daily functioning
- HHS should require chronic disease management to be person-centered and involve interdisciplinary care coordination
- HHS should require early intervention and appropriate care as necessary
- HHS should require a Standard of two drugs per Therapeutic Class and adopt the Part D Patient Protection Clause
- To help ensure adequate health insurance coverage for children, HHS should require states to mirror the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and Medicaid benefits when they establish the EHB plans
- HHS should require plans to use medical criteria to make benefit determinations and disclose to consumers those medical criteria

Oversight for Determining EHB Packages

The ACA included several safeguards for determining EHB packages, including the requirements that EHB packages:

- Reflect an appropriate balance among the categories described in each subsection, so that benefits are not unduly weighted towards any category;
- Do not make determinations that discriminate against individuals because of their age, disability, or expected length of life;
- Take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups; and
- Ensure that health benefits established as essential are not subject to denial to individuals 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.

While we appreciate HHS' intention to balance affordability and comprehensiveness of care with state flexibility, we think it is important that HHS develop and implement policies that assure that the safeguards outlined above are met. The following provides a more detailed explanation of the recommendations provided above.

Develop and enforce safeguards to ensure that affording state flexibility for development of EHB plans does not undermine the nature of an EHB package to which every individual should have nondiscriminatory access. The Bulletin states that HHS is considering allowing substitutions both within and between EHB categories of care, including for qualified health plans that are not the benchmark plans. Substitutions between categories undermine the non-discrimination standards set in the ACA, and such substitutions could result in inadequate coverage of one of the categories of care. HHS should remove the proposed approach of permitting an insurance issuer to substitute benefits within and across benchmark plan essential health benefit categories, as such plan flexibility could be used for risk selection. Plans should view the benchmark plan as a set benefit “floor,” and not be permitted to adjust the benchmark plan benefits except to add benefits.

Assure a transparent and inclusive determination process. Currently available information is not sufficient for making EHB plan determination. As the Bulletin states, even after an internal HHS analysis of plan packages, “the extent to which plans and products cover behavioral health treatment, a component of the mental health and substance use disorder EHB category, is unclear.” Additionally, cost-sharing was not directly addressed in the Bulletin, yet there is significant variance across plans and cost-sharing can be a prohibitive barrier to accessing services. When such information is not readily available, it is unclear how HHS can assure the “balance” and “diverse needs” provisions of the ACA.

While we appreciate HHS' release of the list of the largest small-group plans for each state, stakeholders should have access to key plan information on cost-sharing and actuarial value. If they have not already, insurers should be required to make available via HealthCare.gov the details of the plans, including benefits covered, out-of-pocket limits and cost-sharing information.

Review experiences of current individuals covered by states' small group plans. HHS should compile the experiences of current individuals that are covered by the state's small group plans, particularly for people with disabilities and chronic conditions, including mental health and substance use disorders. HHS should not assume that benchmark plans comply with the nondiscrimination safeguards included in the ACA; in the experience of our members, plans routinely deny medically necessary services to individuals with disabilities and chronic conditions. It is vital that the EHB packages be adequate to cover people with disabilities in, or entering, the workforce. Restrictive coverage definitions, impediments to early intervention, and arbitrary limitations on benefits unfairly restrict access to services and benefits that enable people with disabilities to remain in, or enter, the workforce and live independently.

HHS should establish an oversight board to annually update the EHB categories and ensure meaningful opportunities for consumer and provider input. The decisions being made around EHB will have far-reaching consequences, and transparency and accountability will be critical when making determinations about benchmarks plans, oversight criteria, and enforcement. HHS should create and utilize an advisory and oversight board subject to the Federal Advisory Committee Act as a regular and integral resource to provide input to design considerations, obtain feedback on benefit packages, and share information. The board should include individuals with disabilities and chronic health problems, including individuals with mental health and substance use disorders, family members, and providers. It should include representatives of all disability groups – sensory, physical, mental and cognitive. The opportunity to participate should be meaningful, with the real ability to influence the decisions of the HHS Secretary on an ongoing basis. Similarly, states should be required to offer meaningful opportunities for stakeholders to participate in EHB benchmark plan selection and oversight.

Establish stronger oversight for Parity implementation and adherence, including issuance of guidance for Medicaid Managed Care Organizations. We are appreciative of the Bulletin's explicit recognition of the requirement that EHB be implemented in a manner consistent with the Mental Health Parity and Addiction Equity Act (MHPAEA). However, there are still significant problems with implementation of existing regulations and it is imperative that HHS work closely with states and its federal partners that also have enforcement responsibility to ensure full enactment of MHPAEA, both overall and within the context of the EHB implementation. Two areas of weakness in existing parity regulations are the lack of clarity with respect to scope of services and the absence of guidance for Medicaid Managed Care Organizations. Both of these areas are important to ensuring beneficiaries with mental health and substance use disorders have access to critically necessary services.

HHS should release its EHB guidance for Medicaid without delay. Guidance for Medicaid benchmark plans were noted as forthcoming in the Bulletin. EHB package decisions for Medicaid will be critical for assuring the comprehensiveness of services available to the approximately 16 million people anticipated to be a part of the Medicaid expansion group by 2014.

Benefit Categories and Coverage Determinations

Rehabilitation and habilitation benefits should be defined in the EHB packages to explicitly include services to maintain, as well as improve, daily functioning. This is consistent with the Medicaid definition of habilitation and with the National Association of Insurance Commissioners' definitions adopted by HHS for use in health exchange consumer information documents. The NAIC defines rehabilitation as "health care services that help a person *keep*, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled" and habilitation as "health care services that help a person *keep*, learn, or improve skills and functioning for daily living." Rehabilitative and habilitative services for people with mental health and substance use disorders include therapeutic foster care/treatment foster care for children, crisis residential

services for adults, intensive in-home supports for children, peer and family support services, and personal assistants for in-home respite care.

If benchmark plans do not currently cover habilitative services, HHS should require habilitative services to be offered at parity with rehabilitative services. The only meaningful difference between habilitation and rehabilitation is the reason for the need for the services, and plans should not be permitted to deny these benefits based on an individual's condition.

HHS should require chronic disease management to be person-centered and involve interdisciplinary care coordination. The inclusion of Chronic Disease Management among the ten covered benefit categories will improve access to care for people with chronic physical and mental health and substance use disorders, which are oftentimes co-occurring with other conditions. A report released last year by the Robert Wood Johnson Foundation found that 68% of adults with a mental health disorder have at least one comorbid medical problem, and 29% of adults with a medical problem have a comorbid mental health condition (Druss & Reisinger, 2011).

Individuals with chronic conditions should be treated in the least restrictive setting and have access to coordinated primary and specialty benefits. For many individuals with long term disabilities, the specialists become the focal point for that individual's health care, particularly when treatment is given over a lifetime. A growing number of children suffer from chronic conditions that affect their development and that require specialized attention in order to generate, maintain, and restore age-appropriate functioning.

HHS should require early intervention and appropriate care as necessary to ensure health care costs are contained and individuals can live independent lives with chronic conditions. By treating the conditions early and appropriately, patients can prevent developing secondary conditions that require further treatment and added costs. For example, identifying early onset of depression can prevent later episodes of major depression.

HHS should require a Standard of two drugs per Therapeutic Class and adopt the Part D Patient Protection Clause. In the "Benefit Design Flexibility" section of the Bulletin, HHS proposes a standard for prescription drug benefits based on the Medicare Part D program. However, HHS is proposing a standard of only a single drug per therapeutic class – a dramatically lower standard that could result in 50% fewer covered drugs on plan formularies relative to Part D. The HHS Bulletin also states that the EHB will not integrate a key patient protection that currently exists in Part D for plan formularies – the requirement for plans to include on their formularies "all or substantially all" of the drugs in 6 specific therapeutic classes. This rule in Part D is a critical protection for various disability populations including individuals with HIV-AIDS, epilepsy, transplant patients and people with mental illness.

To help ensure adequate health insurance coverage for children, HHS should require states to mirror the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and Medicaid benefits when they establish the EHB plans. Private plans routinely exclude the types of treatments needed by children with long-term developmental disabilities. EPSDT, on the other hand, ties medical need to a child's condition and requires coverage consistent with the goal of ensuring healthy child development.

HHS should require plans to use medical criteria to make benefit determinations and disclose to consumers those medical criteria. Further guidance and regulation are particularly important because the Bulletin fails to comment on how medical necessity will be determined to limit coverage. Medical necessity definitions commonly used by insurers today often impede access to appropriate mental health and substance use disorder treatment, making federal medical necessity standards critically important.

Our recommendations for a federally-defined medical necessity standard are consistent with the Institute of Medicine's Report *Essential Health Benefits: Balancing Coverage and Cost*, released October 7, 2011, which discusses a framework for HHS to address medical necessity within the essential health benefit, stating: "The

committee believes that the concepts of individualizing care, ensuring value, and having medical necessity decisions strongly rooted in evidence should be reemphasized in any guidance on medical necessity. Inflexibility in the application of medical necessity, clinical policies, medical management, and limits without consideration of the circumstances of an individual case is undesirable and potentially discriminatory.”

Given the chronic nature of many mental health and substance use problems, the Essential Health Benefits provide an opportunity for individuals with these illnesses to receive comprehensive coverage of their health care needs. Not only will they have access to services that directly treat their mental illness and substance use disorders, but they will be assured their coverage includes services from other benefit categories that will support whole health wellness. The potential societal gains are enormous when considering that individuals with mental health and substance use problems will have access to timely health services that promote their ability to engage in society through gainful employment and meaningful contributions to their communities.

If you have questions about these comments please contact: Chuck Ingoglia, Vice President, Public Policy at ChuckI@thenationalcouncil.org or 202-684-7457 ext. 249.

Sincerely,



Linda Rosenberg, MSW
President and CEO