

## **1. What is your interpretation of the word “essential” in the context of an essential benefit package?**

The success of national health care reform will be judged on its ability to provide essential services to all Americans, improve overall health outcomes, and control costs. Identifying mental health and substance use disorder benefits as essential benefits in the Affordable Care Act demonstrates clear understanding that meeting individuals’ mental health and substance use disorder needs is integral to improving and maintaining overall health. For health care reform to be meaningful, Congress acknowledged that it is essential for there to be good coverage for and access to substance use disorder and mental health care.

Substance use disorders and mental illnesses are preventable, treatable health conditions, as accepted by the American Medical Association, all other public health and medical standards, and decades of scientific research. To be an “essential” mental health and substance use disorder benefit, this benefit must ensure good coverage and access to the full range of quality mental illness and substance use disorder prevention, treatment, rehabilitation, and recovery support. A meaningful mental health and substance use disorder benefit developed under the Affordable Care Act must include all of the services, interventions and strategies to help people avoid disease and to help those individuals with these illnesses to achieve and maintain long-term wellness. An essential mental health and substance use disorder benefit should, as with those for other chronic diseases, ensure that people have good coverage for and access to on-going supports to help people manage their disease for the lifetime.

With passage in 2008 of the federal “Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act” (MHPAEA), Congress recognized the long history of people seeking care for mental illness and substance use disorders experiencing widespread discrimination in insurance coverage of their mental health and substance use disorder benefits and sought to remedy this inequity. The Affordable Care Act extends MHPAEA’s requirements that preclude group health plans from offering substance use disorder and mental health benefits in a more restrictive way than other medical and surgical benefits to plans providing the essential benefits package. Implicit in the concept of an “essential” mental health and substance use disorder benefit is the ability of individuals to be able to access the type, level and amount of care that their treating professionals determine they need.

To more narrowly constrain essential health benefits would result in vast numbers of privately insured persons realizing too late that their essential health care needs are not met when a health care conditions strikes. This will prompt significant out-of-pocket costs on behalf of the affected person or result in the person going without needed care. Depending on the severity of not receiving needed services, in some instances, a person will ultimately be required to “spend down” and join Medicaid and other publicly supported programs in order to access needed care. In this manner, an essential benefits package that is too narrowly defined will subvert the intent of national health care reform.

In addition to examining the “typical employer plan” for guidance in defining the essential benefits package, the IOM and the Secretary of Health and Human Services should examine the benefit packages of the major publicly-supported programs as another point of reference. The Medicare program, the Veterans Health Benefits program, the Department of Defense health program and the standard option under the Federal Employee Health Benefits Program (FEHBP) all cover significant benefits relevant to people with disabilities and chronic conditions. The benefit packages of these plans should be considered in the development of the essential health benefits package.

In order to reflect a range of experience and accurately capture all essential benefits, we strongly recommend the development of a patient-centered, reasonable person definition of “essential health benefits” that focuses not only on acute and primary care, but also on a patient’s functional capabilities and their needs over a lifetime and on a treatment continuum.

## **2. How is medical necessity defined and then applied by insurers in coverage determinations? What are the advantages/disadvantages of current definitions and approaches?**

The National Council believes the definition of medical necessity is critical if the essential benefits package is going to be meaningful. A generous benefit package can be easily rendered insufficient if a restrictive definition of medical necessity is employed. The definition of medical necessity must balance the need for consistency with the need to apply the medical necessity definition to each individual, given the totality of that person’s health condition.

With passage in 2008 of the federal “Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act,” (MHPAEA) Congress recognized the long history of mental health and addiction benefits being targeted for more stringent review than other medical and surgical benefits and the corresponding unacceptably large treatment services gap. In addition to stigma being a major factor contributing to disparate insurance coverage of mental health and substance use disorder benefits, plans have often sought to manage mental health and substance use disorder benefits through an acute, not chronic disease, care lens despite clear scientific research that serious mental illnesses and substance use disorders are preventable, treatable chronic health conditions that should be managed over the lifetime.

MHPAEA and its implementing regulations seek to eliminate this systemic discrimination in insurance coverage of mental health and substance use disorder benefits and to ensure that people with mental health and/or substance use disorder treatment needs receive the clinically appropriate type, level and amount of care needed to get and stay well. Congress’s decision to extend the MHPAEA requirements to plans offering the substance use disorder and mental health benefits in the Affordable Care Act’s essential benefit package demonstrates the understanding that these benefits must be provided in a way that ensures good access to these critically important services.

The MHPAEA statute and implementing regulations state that mental health and substance use disorder benefits cannot be subject to more restrictive treatment limitations than other medical or surgical benefits. MHPAEA's regulations explicitly identify medical management tools as non-quantitative treatment limitations that must comply with the law's parity analysis. Congress, in their consideration of MHPAEA, identified these medical management tools as a fundamental means through which plans limit treatment.

As MHPAEA is still in the early stages of implementation, many plans are just beginning the shift to making medical necessity determinations for mental health and substance use disorder benefits in no more restrictive a way than decisions made for other medical and surgical benefits. Under the Affordable Care Act, medical necessity criteria should reflect the chronicity of serious mental illnesses and substance use disorders. Care should be available to individuals and their family members that responds to their health needs over their lifetime. The essential benefits should reflect the chronicity of serious mental illness and substance use disorders and should provide coverage for the full continuum of care to ensure that people get the clinically appropriate level of care.

Whatever definition of medical necessity that is used by health plans, it is critically important that the definition does not trump the physician-patient relationship. Medical necessity determinations about who needs what services, levels of care, and lengths of stay should be driven by decisions made by qualified treatment professionals, and medical management tools including utilization review, criteria for review and approval of evidence-based treatment services, preferred provider networks and preauthorization should not be used to deny needed care that is determined by a treating professional. Plans should use outcome measures that focus on whether the patient's quality of life and ability to function well are both improving. Plans should also consider the individual treatment needs of the patient as medical necessity determinations are made.

MHPAEA also seeks to provide consumers with better information about how medical necessity decisions are made by requiring that criteria for medical necessity determinations and reasons for denial of reimbursement or payment for substance use disorder or mental health benefits be made available to participants and beneficiaries. In extending these requirements of MHPAEA, under the Affordable Care Act, medical necessity criteria and reasons for denials should be clearly defined to patients and providers.

Under the Affordable Care Act, there should be strong clear disclosure requirements for participants and beneficiaries. Limitations and restrictions on coverage under group health plans should be disclosed in a timely manner to group health plan sponsors and communicated in a timely manner to participants and beneficiaries under such plans in a form that is easily understandable. Criteria and reasons for denial must be disclosed and subject to a meaningful, independent review process that accesses plan benefit utilization patterns and enables individuals to effectively challenge a denial.

In addition, State laws which provide better coverage, rights, methods of access to treatment and consumer protections from the standpoint of the insured must remain in effect and not be preempted as the Affordable Care Act is implemented. Work between the federal governments and the States to ensure plans comply with these provisions of the Affordable Care Act must be strong and on-going.

**3. What criteria and methods, besides medical necessity, are currently used by insurers to determine which benefits will be covered? What are the advantages/disadvantages of these current criteria and methods?**

Additional criteria and methods used to determine benefits include decisions based on evidence-based medicine or the use of comparative effectiveness research; coverage limitations such as “step” therapy, fail-first polices or other cost-effectiveness policies; and extra-contractual service provisions in contracts of insurance. Finally, a recent legal settlement is instructive as to the meaning of medical necessity and is cited below.

The National Council believes that evidence based medicine or comparative effectiveness research is, and should continue to be, an important tool in helping patients and providers distinguish between the effectiveness of treatment options. Having better evidence to support the clinical effectiveness of a wide range of health care interventions has the potential to lead to improvements in the quality of care and could potentially maximize the impact of the healthcare dollars spent in this country. This research should be applied in a manner that does not lead to inappropriate restrictions in coverage of and access to assistive devices, therapies, treatments, medications, and long term services and supports for people with disabilities, behavioral, mental health and substance abuse disorders and chronic illnesses.

Research on evidence-based practices to prevent and treat mental illness and substance use disorders, and to help individuals sustain their long-term recovery from these chronic diseases, should be considered. These include: the Comprehensive Community Mental Health Services Program for Children and Families and the Community Support Program (CSP); the National Quality Forum’s Standards of Care for Treatment of Substance Use Disorders, various Institute of Medicine (IOM) reports, including “Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities,” and “Improving the Quality of Health Care for Mental and Substance Use Conditions,” the U.S. Preventive Services Task Force (USPSTF) and Health Resources Services Administration’s Bright Futures guidelines; and several Surgeon General Reports, including “Mental Health: A Report of the Surgeon General” and Mental Health: Culture, Race and Ethnicity.” These reports, as well as others, continue to document the effectiveness of treatment for and prevention of mental health and substance use disorders.

Insurers should consider the clear scientific research on medications as effective tools in the treatment of individuals with mental illness and/or substance use disorders. All medications that have been scientifically proven to be effective in helping to treat individuals with mental illness and/or substance use disorders should be covered. There should be a process for expedited

consideration of promising new medications for the treatment of mental illness and substance use disorders.

The National Council believes that coverage decisions, incentive programs, and benefit design must not discriminate against individuals because of their age, *disability, including mental illness*, or expected length of life. Coverage limitations that rely largely on cost effectiveness are of great concern, because they can ignore the patient's long-term health care needs and limit coverage by directing benefits to the short-term, least-costly options. For instance, the Medicare Part D program and many private insurers often use "fail first" or step therapy policies for prescription drug coverage that do not take into account the patient's health, history or physician choice of the most appropriate care. But this is not necessary. In private plans and public programs that do take these factors into account, the plans ultimately save money by reducing negative health outcomes while meeting the individual patient's unique healthcare needs.

A recent, major legal settlement also helps define the term "medical necessity." Aetna, CIGNA, Health Net, Prudential, Anthem/WellPoint, and Humana agreed with the following general definition in a settlement agreement with 900,000 physicians during the time period of the suit, 2003 through 2006.

"Medically Necessary" or "Medical Necessity" shall mean health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: a) in accordance with generally accepted standards of medical practice; b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and c) not primarily for the convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment. Further, the court stated that "unless the contrary is specified, the term "medical necessity" must refer to what is medically necessary for a particular patient, and hence entails an individual assessment rather than a general determination of what works in the ordinary case. But where, as here, the plan administrator presents sufficient evidence to show that a treatment is not medically necessary in the usual case, it is up to the patient and his or her physician to show that this individual patient is different from the usual in ways that make the treatment medically necessary for him or her." See, *Defining Medical Necessity*, Janet L. Kaminski, Attorney

<http://www.cga.ct.gov/2007/rpt/2007-r-0055.htm>

#### 4. What principles, criteria, and process(es) might the Secretary of HHS use to determine whether the details of each benefit package offered will meet the requirements specified in the Affordable Care Act?

The key principles and criteria the Secretary should use to ensure appropriate benefits packages are found in the ACA itself and include the following:

- The Secretary may not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of, among other things, disability. [See Section 1302(b)(4)(B) of the ACA]
- The Secretary must take into account the health care needs of persons with disabilities, among other segments of the population. [See Section 1302(b)(4)(C) of the ACA]
- The Secretary must ensure that health benefits established as essential are not subject to denial to individuals against their wishes on the basis of the individual's present or predicted disability, degree of medical dependency or quality of life. [See Section 1302(b)(4)(D) of the ACA]

For many years, the Consortium for Citizens with Disabilities (CCD) has used the following principles to guide the assessment of healthcare reform proposals and the National Council recommends that the Secretary use these same principles to ensure that these statutory provisions are fully implemented:

- **Non-Discrimination:** People with disabilities and chronic conditions of all ages and their families must be able to fully participate in the nation's health care system.
- **Comprehensiveness:** People with disabilities and chronic conditions must have access to benefits that provide an array of health, rehabilitation, assistive device and support services across service categories and sites of service delivery.
- **Continuity:** People with disabilities and chronic conditions of all ages and their families must have access to healthcare that responds to their needs over their lifetimes, and provides continuity of care that helps treat and prevent chronic illness.
- **Appropriateness:** People with disabilities and chronic conditions and their families must be assured that comprehensive health, rehabilitation, and long term support services are provided on the basis of individual need and patient choice.
- **Equity:** People with disabilities and chronic conditions and their families must have equitable access to health coverage programs and not be burdened with disproportionate out-of-pocket costs.

- **Efficiency:** People with disabilities and chronic conditions and their families must have access to health care that is effective and high quality with a minimum of administrative waste.

When determining whether the details of the benefits packages meet the requirements specified in the Affordable Care Act, the Secretary of HHS should keep several issues in mind. It is imperative that the essential benefits package provides the services necessary to cover all populations including people with mental illness, substance use disorders, physical disabilities, as well as the aging, low-income populations and children. The Secretary of HHS must remain cognizant of the challenges and difficulties that may be experienced by such persons in accessing benefits. We encourage the IOM and the Department of HHS to design an essential benefits package that is comprehensive enough to meet the needs of people with physical disabilities, chronic conditions, mental health and substance use disorders, as well as developmental, sensory, and intellectual disabilities.

As to mental health and substance use disorders, the National Council asks that the Department make clear to health insurance plans that the ACA requires a robust benefits package for mental health and substance use disorders that includes the full range of Mental Health /Substance Use Disorders (MH/SUD) prevention, early intervention, treatment, and rehabilitative and recovery support services. Limits on benefits may be no more restrictive than those allowed under the *Wellstone/Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)* and that law's corresponding regulations. The Parity Law requires virtually all financial requirements and treatment limitations for MH/SUD benefits to be no more restrictive than the "predominant" financial requirements and treatment limitations that apply to "substantially all" medical/surgical benefits. These requirements must be addressed in the essential benefits packages to ensure that the full range of individuals is able to receive benefit from them.

Criteria to determine whether the essential benefits packages meet the Affordable Care Act requirements should be developed. The criteria should examine whether the essential benefits package information is clear and easily understandable and also whether the package includes adequate numbers and types of providers. In determining these criteria, the Secretary of HHS should include consumers and providers of mental health and substance use disorder services.

There are many ways in which the Secretary of HHS can measure how the essential benefits packages are meeting the requirements of the Affordable Care Act as well as to continue to monitor them over time. The Secretary should create and utilize Advisory Groups as a regular and integral resource to provide input to design considerations, obtain feedback on benefit packages, and share information with people with disabilities, mental health and substance use disorders. This group should include individuals with disabilities, family members and caregivers, and providers. It should also include representatives of all disability groups – sensory, physical, mental and cognitive. The Advisory Group should have real ability to influence the decisions of the HHS Secretary on an ongoing basis.

The Secretary should also meet with members of state organizations, non-profit associations, advocates, providers and other important stakeholders who are devoted to furthering the rights of those populations in order to inform the process. Advice should also be solicited from providers of services as to “best practices.”

The most important mechanism the Secretary should establish is a formal process to appeal to HHS to add, modify, or delete coverage of a particular service or device to the essential benefits package. The benefits packages should be evaluated annually to identify patterns in order to encourage parity and compliance with the principles that are listed above. This evaluation can be facilitated by the development of a survey or checklist of requirements of the essential benefits packages that can be used by the Department and by insurance companies in the future.

**5. What types of limits on specific or total benefits, if any, could be allowable in packages given statutory restrictions on lifetime and annual benefit limits? What principles and criteria could/should be applied to assess the advantages and disadvantages of proposed limits?**

The National Council is concerned that benefit-specific limitations (*e.g.*, dollar or treatment frequency) could be imposed to subvert the intent of restrictions on lifetime and annual limitations. Different types of illnesses or injuries may require different levels of medical intervention, treatment, or care. Accordingly, it is important that health plans and health insurance issuers not sidestep restrictions on lifetime and annual limits by either imposing caps on costs related to a specific treatment, or by limiting treatment frequency.

The Secretary should require that health plans and health insurance issuers act in good faith and impose no restriction or limitation designed to subvert the intent of the annual and lifetime limit restrictions. Such a finding by the Department or state Insurance Commissioners should render these types of limitations null and void.

As the Affordable Care Act is implemented, regulators should ensure that the new law addresses the multiple needs of the individual and recognizes that no single treatment for mental illness and substance use disorders is effective for all individuals. Serious mental illnesses and substance use disorders, like other chronic diseases, frequently require multiple episodes of treatment of varying intensity and duration. Remaining in treatment for an adequate period of time is critical for treatment success, as recovery can be a long process. To help individuals enter into and sustain their long-term recovery, the full continuum of quality treatment, rehabilitative, and recovery support services should be available to individuals and their family members without imposition of benefit limits.

**6. How could an “appropriate balance” among the ten categories of essential care be determined so that benefit packages are not unduly weighted to certain categories? The ten categories are: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorders services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; pediatric services, including oral and vision care.**

An appropriate balance among the ten categories of benefits in the essential benefits package will be achieved, in part, if the Secretary takes into account the very specific parameters in which she must operate under the ACA statutory language. Provisions in the ACA specify that in defining essential health benefits, the Secretary must ensure that such essential benefits reflect an appropriate balance among the categories so that benefits are not unduly weighted toward any category. This provision also requires parity in the provision of all categories of benefits. [See Section 1302(b)(4)(A) of the ACA.] Thus, those people who need mental health and substance use disorder services, including behavioral health treatment, should not be hampered by unreasonably restrictive coverage policies in their ability to access appropriate treatment, especially if these same arbitrary limitations do not apply to other types of services.

In addition, the Secretary may not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of, among other things, disability. [See Section 1302(b)(4)(B) of the ACA.] The Secretary must take into account the health care needs of persons with disabilities, among other segments of the population. [See Section 1302(b)(4)(C) of the ACA.] The Secretary must ensure that health benefits established as essential are not subject to denial to individuals against their wishes on the basis of the individual’s present or predicted disability, degree of medical dependency or quality of life. [See Section 1302(b)(4)(D) of the ACA.] This is very powerful language that is designed to ensure that normative judgments about the quality of life of a person with a disability are not used against people with disabilities when decision makers determine the essential benefits package.

Under the ACA, the following benefits—in addition to others—are required by statute to be included under the essential benefits package:

- Mental health and substance use disorders services, including behavioral health treatment;
- Rehabilitative and habilitative services and devices;
- Chronic disease management;
- Prevention and wellness services, and;
- Pediatric services, including oral and vision care.

These categories are the very benefits that many private insurance plans typically either do not cover or place significant limitations on coverage. The very fact that these categories of benefits must be included in the essential benefits package will help ensure an appropriate balance of

benefits under private plans. These categories have profound implications on the ability of the private insurance system to meet the needs of people with disabilities, mental health, substance use and chronic conditions. The Secretary should scrutinize coverage of these benefits and not permit plans to place arbitrary barriers and unrealistic limitations on benefits in these categories. If, in fact, limits are placed on these types of benefits in order to achieve cost savings, the Secretary should ensure that similar limits are placed on all categories of benefits, so an appropriate balance of benefits is achieved.

Comprehensive health care reform should fully incorporate the prevention, treatment and rehabilitation of substance use disorders and mental illness as both primary disabling conditions and co-occurring conditions with other chronic diseases. Designing a robust essential benefit on preventive and wellness services and chronic disease management is particularly important for people with mental illness and substance use disorder prevention needs. The wellness benefit should recognize that individuals with histories of serious mental illness and/or untreated substance use disorders often suffer from other chronic health conditions and that providing care for the primary mental illness and substance use disorder will help reduce the occurrence of other chronic diseases such as obesity, heart disease, pulmonary disorders, and hypertension in individuals and, as research has shown, their family members.

The wellness benefit should also promote effective mental health check-ups, screening for substance use disorders and mental illness, and early intervention for mental health and substance use disorders across the lifespan, recognizing that half of all lifetime cases of mental illness begin by age 14 and adolescents who use alcohol and other drugs are much more likely to misuse drugs and alcohol as adults. Pre-natal and peri-natal screening for maternal depression and substance use disorders should be reimbursed and encouraged, as well as referral into treatment for those who need care.

The wellness benefit must also promote overall health and wellness by addressing the full array of services needed to support sustained, long-term recovery from substance use disorders and/or mental illness. Successful recovery management includes life supports such as housing, transportation, education, employment and social connectedness and is among the full array of services needed to support sustained, long-term recovery from mental illness and/or substance use disorders. Peer-to-peer recovery support services help individuals in their communities initiate and sustain recovery and gain overall wellness. Support for community resources, including these peer services and other systems that are integral to sustaining recovery, must be included in the essential wellness services benefit.

In order to determine whether plans are appropriately balanced, the Secretary could require plans to annually undergo a certification process that requires releasing all relevant plan details and complaints/appeals lodged during the course of that year, particularly as it pertains to benefit design and patient populations served. HHS could compare the data and evaluate patient and consumer surveys and public health assessments regarding vulnerable patients and their access to

needed benefits. If a plan fails to provide an appropriately balanced benefit package, the Secretary should require the plan to expand access to benefits.

**7. How could it be determined that essential benefits are “not subject to denial to individuals against their wishes” on the basis of age, expected length of life, present or predicted disability, degree of medical dependency or quality of life? Are there other factors that should be determined?**

Prohibiting denial of benefits based on these factors is critical to creating a health care system that meets the needs of people with mental health and substance abuse disorders. Implementing these provisions will help ensure that people with chronic diseases, including serious mental illness and substance use disorders, have all of their complex health needs met.

The National Council interprets the phrase “against their wishes” to be a reference to the importance of the health care delivery system to be patient-centered and consumer directed to the maximum extent possible. A health care delivery system that is person-centered and consumer directed has informed consumer choice in relation to providers and services, an appropriate amount, duration and scope of services, devices and related benefits and access to trained, qualified and appropriately credentialed health care personnel among other features.

To ensure that health plans are complying with this and other requirements related to the essential benefits requirements, the Secretary must establish an oversight system for receiving consumer and provider feedback, collecting and analyzing data, and evaluating plan performance. Collecting information about who is being denied services, what types of services are being denied, and other information will help determine if unacceptable patterns of service denials are developing. The state and federal government need to ensure that a meaningful and independent external appeals program is established. Information about internal appeals and external appeals must be part of the data collection efforts as well. This information will be crucial to evaluating plan performance and ensuring that the plans are meeting the high standards for access, nondiscrimination, comprehensiveness and quality that the ACA establishes.

**8. How could it be determined that the essential health benefits take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities and other groups?**

The structure of the new health care marketplace created by the ACA (*i.e.*, the Exchanges) along with performance measures will help to expose whether essential health benefits have taken into account the needs of diverse segments of the population such as people with disabilities.

The new marketplace, the insurance products that will be available in the exchanges, and providers who participate in health plans will need to demonstrate they are both physically and programmatically accessible to people with disabilities, mental health and substance use disorders, and chronic conditions if the benefit package is going to truly meet the needs of

diverse segments of the population. The Exchanges and the plans offered through the Exchanges will need to:

- Be patient-centered and consumer-directed to the maximum extent so that informed choices can be made;
- Provide access to trained, qualified and appropriately credentialed health care personnel to allow for the best outcomes for special populations;
- Utilize providers that understand the unique health needs of different populations so that they can help plan and coordinate care to better address the needs of the individual; and
- Be trained and aware of disability culture and the unique needs of the disability population.

Treatment for substance use disorders and/or mental illness should be comprehensive and offer a continuum of quality services for the individual and his/her family including, where appropriate, assessment services, detoxification, residential care, hospitalization, outpatient, case management, skills training and other rehabilitation services, transitional housing, education, vocational, primary medical services, family counseling, family unification, and continuing care. Care models should attend to the multiple needs of the individual and recognize that no single treatment for mental illness and substance use disorders is effective for all individuals.

Services that assist individuals with mental illness and/or substance use disorders in their recovery and that improve their functioning should be available to all in need. Successful recovery management includes other life supports such as housing, transportation, education, employment and social connectedness. Case management services and the full continuum of mental health and substance use disorder services should be available to all those in need.

Research shows that mental illness and substance use disorders prevention and early interventions reduce the incidence of other costly co-occurring chronic illnesses such as diabetes, hypertension, heart disease and certain cancers in both individuals and their family members. Individuals and families, across the lifespan, should have coverage to receive education about preventing, treating and recovering from substance use and/or mental health disorders. Chronic disease management practices that keep families healthy will improve public safety as well as contain skyrocketing health care costs.

Individuals should have choices regarding their health, mental health, and substance use disorder care that foster recovery and wellness through individualized community-based services and supports. As recommended by the Institute of Medicine, there should be a formal mechanism to ensure that individuals with substance use disorder and/or mental health needs and their family members are partners with care providers in designing service plans, including how services are delivered. Policies should be in place to implement informed, client-centered participation and decision-making in prevention, treatment, illness self-management and recovery plans and strategies. Clients and their families should be educated participants in the design, administration and delivery of prevention, treatment, rehabilitation, and recovery support services.

Strategies aimed at ensuring that individuals in special populations have good access to the full range of services they need should be employed. Intensive outreach, limited or no co-payments, and enhanced services should be recognized as important components of chronic care management that will be particularly helpful for individuals with barriers, including those with mental illnesses and substance use disorders. In addition, as the Affordable Care Act is implemented, there must be specific work to ensure that vulnerable individuals with barriers to getting care, such as those transitioning from the criminal justice system back to the community, have good access to the healthcare they need, including the full range of mental health and substance use disorder services.

In order for mental health and substance use disorder care to be effective, it must be accessible to consumers and provided by highly trained individuals. Other health care providers, such as primary care physicians and trauma professionals, must receive the requisite education and training to provide appropriate interventions and ensure that people with mental illness and/or substance use disorders receive the care they need.

Performance measures will be integral to determining whether the health care needs of diverse populations are being met by the essential benefits package. Data collection and information from both providers and consumers about the use of services will provide insight into access and utilization. This data will help determine which complaints are being brought forward, where patterns of care provision are forming, what types of care or services are being denied, and how complaints are being resolved.

**9. By what criteria and method(s) should the Secretary evaluate state mandates for inclusion in a national essential benefit package? What are the cost and coverage implications of including current state mandates in requirements for a national essential benefit package?**

State mandated benefit laws should be respected to the greatest degree possible as the Secretary develops the essential health benefits package. Exclusion of significant numbers of state mandated benefits will result in the preemption of a large number of state mandated benefit laws, thwarting the legislative intent of numerous states. These benefit laws were duly enacted by elected officials to protect the needs of consumers in their respective states. The goals of efficiency, consistency, and cost reduction that come with a national standardized benefit package should not summarily lead to the invalidation of years of state lawmaking in the benefits area.

State mandated benefit laws arise for a reason. Residents of a particular state rely on the fact that their health plan covers a particular benefit and when they discover that their needs are not met, they petition the government for protection of themselves and similarly-situated health care consumers. State mandated benefit laws exist because the private insurance market has failed to cover health benefits that duly-elected legislators and Governors subsequently deem worthy of coverage. The HHS Secretary should be very careful and deliberate when determining how state mandated benefit laws can be incorporated into the essential health benefits package and err on

the side of inclusion of as many mandated benefits as possible. To the extent that such laws are included as essential benefits, concern for the federal preemption issue is significantly decreased.

For individuals with mental health and substance use disorders, mandated benefit laws can remedy coverage determinations that reflect bad health policy. Arbitrary determinations of medical necessary, routine denials of mental health/substance use disorder benefits, exclusions in benefits based on flimsy evidence, and faulty judgments that specific treatments are experimental or investigational in nature, can entirely shut out vulnerable populations from access to health care. One benchmark for evaluating mandates should be their efficacy in improving benefits and services to populations at risk of poor health outcomes.

Another factor to consider is the benefit of a mandate law relative to its cost. Market decisions regarding coverage may place undue emphasis on short-term economic costs rather than longer-term gains. A broad-based calculus should be used when evaluating mandates; extended life, reduced disability, and community savings should be considered when evaluating mandates. The National Association of Insurance Commissioner's most recent draft American Health Benefit Exchange Model Act supports such an approach ("For States choosing to require additional benefits and defray the cost, it is recommended that the costs of the additional benefits be measured on a 'net cost' basis to the extent permitted by federal law or regulations or guidance, considering both the costs of the service and any associated savings, based on an evidence-based methodology to determine the net cost, if any, of each additional benefit, and the value of the benefit to the State's residents.").

In the case of existing state mandates, continuity of care should also factor into decisions about mandates. Millions of Americans with disabilities rely on existing state mandates to ensure access to quality health care. Failure to include state mandates in the national essential benefits package that protect these individuals could result in a net reduction of coverage and potentially jeopardize their health and functional status. For these reasons, as implementation moves forward it is critically important that the necessary steps are taken to ensure that state laws which provide better coverage, rights, methods of access to treatment and consumer protections, from the standpoint of the insured, remain in effect and are not preempted.

**10.) What criteria and method(s) should HHS use in updating the essential package? How should these criteria be applied? How might these criteria and method(s) be tailored to assess whether: (1) enrollees are facing difficulty in accessing needed services for reasons of cost or coverage, (2) advances in medical evidence or scientific advancement are being covered, (3) changes in public priorities identified through public input and/or policy changes at the state or national level?**

Updates to the essential benefit package must be inclusive of all new benefits that deliver improved health, wellness, rehabilitative and functional outcomes for beneficiaries. New preventive services that have demonstrated effectiveness should also be included in updates of the essential benefit package and should be provided with no cost sharing for beneficiaries in

keeping with current law. Preventive services should be focused on primary conditions as well as conditions that are secondary to a disability.

In order to assess the challenges of beneficiaries in accessing services, it will be necessary to implement a system of data collection to document the nature of scope of difficulty faced by beneficiaries, including beneficiaries with disabilities and chronic conditions. Coverage criteria must keep pace with advances in treatments and technologies that deliver improved beneficiary outcomes. To demonstrate efficacy, all forms of medical evidence should be considered and weighted appropriately, so that services that are not necessarily backed by double-blinded, randomized controlled studies are not immediately denied consideration for inclusion in the essential health benefits package.

In order to ensure that beneficiaries have access to the most effective and appropriate treatments, services, and devices, the Secretary of HHS should establish an open, public process for the regular review and update of the essential benefits package. The review and update should be performed on a schedule adequate to ensure timely beneficiary access to new interventions without unnecessary delay. The specific schedule for review should be established by the Secretary with provision for making immediate updates to the essential benefits package when important breakthroughs in interventions are developed that promise significantly improved preventive, health, rehabilitative, wellness or functional outcomes for beneficiaries.

This public process should be transparent, unbiased and should be established by formal regulation. It should allow for public comment and permit stakeholder input from consumer and provider organizations and individuals. Official comment periods should be offered for proposed changes to this process that allow for transparency and comment before implementation of any changes that would potentially reduce or limit access to established benefits. The legislative process within states and Congress would continue to have the ability to amend the ACA statute and provide guidance to the Secretary with respect to implementation of health policy, including policies related to updating the essential benefits package. Finally, an appeals mechanism should be established to ensure due process.