January 31, 2012

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

Dear Mr. Larsen:

Mental Health America of Wisconsin (MHA) appreciates the opportunity to comment on the Essential Health Benefits Bulletin ("the Bulletin") released by the Center for Consumer Information and Insurance Oversight on December 16, 2011. We thank you for your strong commitment to making mental health (MH) and substance use disorder (SUD) care a top priority and for working to ensure that individuals with MH/SUD needs receive quality care.

MHA is an advocacy organization providing mental health information, education and advocacy on behalf individuals living in Wisconsin and their families. We are an affiliate of Mental Health America, and together with our national organization and its 250 other affiliates from around the country, we look forward to working with you to ensure the Essential Health Benefits (EHB) are adequate for addressing the needs of all Americans, and especially those living with MH/SUD.

The design of the EHB will have a direct impact on the health and well-being of over 70 million Americans. EHB design will also have tremendous impact across our health care system and is a central component of the Patient Protection and Affordable Care Act (ACA). We believe that the EHB is a critically important opportunity to address the health needs of the 25 million Americans with untreated mental illness and/or SUD, prevent these diseases in millions more, and provide necessary services to those seeking care for or in recovery from mental illness or SUD to improve their health and wellness and reach their full potential.

Thank you for the Bulletin's explicit recognition of the ACA requirement for the EHB to include MH and SUD services, and in a manner consistent with the requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA). As noted in the Bulletin, MHPAEA applies to covered MH and SUD benefits but does not require that they be offered in the first place, and prior to the ACA it did not require small group or individual plans to meet the parity requirements. However, by requiring coverage of MH and SUD benefits as one of the EHB categories and extending MHPAEA to those plans, Congress mandated that all public and private plans subject to the EHB, inside and outside insurance Exchanges, be required to offer MH and SUD benefits at parity with the medical/surgical benefits offered by the plan. We appreciate the Department's clear recognition of these critically important ACA requirements.

www.mhawisconsin.org

600 West Virginia Street, Suite 502, Milwaukee, WI 53204 • P: 414.276.3122 • F: 414.276.3124
133 S. Butler St., Room 330, Madison, WI 53703 • P: 608.250.4368 • F: 608.442.7907

In addition to our strong support for the clear language in the Bulletin on inclusion of MH and SUD benefits at parity, we particularly appreciate the inclusion of the following:

- Allowing States the ability to require compliance with State benefits mandates without financial penalty from the federal government. The Department should work closely with all States to ensure they have accurate estimates of their potential financial obligations to the federal government if they choose a benchmark plan that is not subject to any or all of the benefit mandates in the State. Wisconsin does have a fairly robust state parity law, although as discussed below it is not clear that plans are currently in compliance.
- Reemphasizing that each of the ten EHB categories is covered and providing guidance to States about how to supplement coverage if a category is not covered in the particular benchmark plan option chosen by the State.
- Limiting benefit design flexibility beyond the benchmark flexibility for States and health insurance issuers to the same standards and measures applied to CHIP. As you know, both the CHIP flexibility standards and the application of the MHPAEA preclude downward actuarial adjustments to MH and SUD benefits.

However, we also offer the following comments and recommendations to the Department in response to the EHB Bulletin. Our consideration of these issues is informed by our experiences with health insurance coverage for MH/SUD, which has historically been provided at extremely low levels, if at all.

1. Many advocates anticipated that the Department would define a standard comprehensive benefit package to be used in all states. The failure to do so means that we will continue to see a patchwork of benefits across states. As a result some people have called for <u>a comprehensive essential health benefits package that would serve as a "federal floor."</u> While we support this idea in theory, a "federal floor" that is weaker than the best existing state mandates could result in states watering down those better benefit packages. Such a "federal floor" must include evidence-based psychosocial rehabilitation services for children and adults. Most traditional private health plans do not cover these services with the result that individuals covered by these plans must seek treatment in the very overburdened public system. An essential benefits package must be structured in such a way that individuals with serious disorders can have their needs met through the plan.

2. <u>Should you decide that you will implement the proposal to allow states to use an existing private plan (or combination of plans) as a benchmark, we would very strongly encourage that this be a **large** group plan.</u> The state exchanges are, by design, set up to emulate large group plans by allowing individuals and small businesses to create a larger group through the exchange. While the Bulletin states that small group plans and other potential benchmark options do not differ significantly in the range of services they cover, the Bulletin also acknowledges that, for MH/SUD, "coverage in the small group market often has limits." We encourage the release of this data to allow for independent analysis. Absent the data we cannot be certain that MH/SUD benefits are adequately covered in these plans. Our experience has been that small group plans have leaner benefit packages. While Wisconsin's state parity law now mitigates this problem by extending parity to businesses of 10 or more employees, this is not the case in many states.

3. <u>Aggressively enforce the MHPAEA on the federal level and work with the appropriate State officials to enforce the MHPAEA on the State level to ensure meaningful protection.</u> Your strong statement of support for parity for MH/SUD benefits in the exchanges is of little value without further clarification of

how parity is to be implemented. We ask the Department to work with States and its federal partners to ensure strong enforcement of the MHPAEA. Some States still assert that enforcing parity is solely a federal responsibility. We urge the Department to include language in the final EHB guidance that clearly indicates to States that they have a responsibility to implement and enforce the MHPAEA and the ACA's parity requirement in their State. HHS should clarify the roles and responsibilities of State and federal governments prior to January 1, 2014.

Though the MHPAEA regulations went into effect for all plans on January 1, 2011, providers and consumers are still experiencing discriminatory treatment access. In Wisconsin this is especially the case with regard to less traditional services, such as residential treatment for substance abuse, assertive community treatment for adults with serious mental disorders and crisis services. Lack of clarity in the regulations in four key areas has prevented equitable access to MH/SUD care. These include: disclosure of medical criteria, a standard for implementing parity in medical management, scope of services, and Medicaid managed care parity. Patients and providers are also often unclear about how parity is being applied by plans, and plans are often refusing to disclose the MH/SUD medical necessity criteria and/or the medical/surgical criteria used by the plan to make benefit determinations. HHS should require full disclosure of benefit and medical management criteria from States and plans to ensure MHPAEA compliance. Additionally, final MHPAEA regulations must clarify how plans are to operationalize parity for non-quantitative treatment limitations, such as provider networks and prior approval.

4. Ensure robust prescription drug coverage, including medications for MH/SUD. The Bulletin indicates that the Department is proposing a standard similar to the flexibility permitted in Medicare Part D for prescription drug benefits. We note that Medicare Part D requires prescription drug plans to cover "all or substantially all" medications in six categories – namely, antidepressants, antipsychotics, anticonvulsants, antineoplastics, immunosuppressants and antiretrovirals. The Bulletin does not appear to envision a similar requirement, noting instead, "if a benchmark plan offers a drug in a certain category or class, all plans must offer at least one drug in that same category or class, even though the specific drugs on the formulary may vary."

   Extending plan flexibility beyond the Part D standard for these categories of medications is likely to endanger MH/SUD patients – and other patients – who may only respond to specific drugs. We urge the Department to clarify that all plans must offer "all or substantially all" medications in these six categories, regardless of the prescription drug coverage in the benchmark plan.

5. Annually review and update the EHB in all States to ensure that plan enrollees are being well served, and take appropriate action when plans fail to provide a comprehensive EHB package consistent with the requirements of the ACA. The Department should also provide annual guidance to States requiring that they update their EHBs to reflect the latest medical evidence and scientific advancement. We also believe that the Government Accountability Office and other independent federal agencies should periodically review EHB compliance and effectiveness. Plans should not be able to take advantage of the benchmark flexibility to make harmful coverage determinations that could impact enrollees in a State's qualified health plans. It is also critical that any plan changes reducing or eliminating a given benefit require that individuals receiving services under that benefit be allowed the opportunity to complete their current episode of treatment under that benefit or choose to switch to another service offered under the plan; but the choice must be the beneficiary's.

6. Given the increased flexibility you are ceding to states we think it is imperative that you mandate specific demonstrable requirements for stakeholder review in establishing the EHB. This must minimally include making all of the potential benchmark plans available for review by stakeholders, providing opportunities for input on preferences for an EHB (either by identifying a preferred benchmark plan or by identifying a plan representing elements from each of the benchmark plans), making a summary of such comments available to the public in an easily accessibly format (preferably on the State's website), providing a draft proposal based on the State's review of the comments and their own internal work and specifically providing discussion about why specific choices were made regarding the design of the EHB, and providing an opportunity for review and comment on this proposal. We think the State should be required to meet in an interactive format with people with disabilities, their family members and advocates to review the proposed EHB. People with disabilities will be especially sensitive to the decisions made regarding EHBs. There should also be strong, specific State responsibilities for a consumer and family education campaign to ensure MH and SUD service consumers will be able to access the care they need, understand their coverage, and identify potential violations of their EHB rights. Updates to the EHB packages are important to ensure that newer services or promising practices are covered. There should be a regular process through which new services are considered. Consumers and services providers should have a clearly defined role to provide input in this process.

7. We urge the Department to develop an appeals process at the federal level that can provide recourse to individuals who have been failed by State review. To ensure that the EHB is comprehensive and meaningful for enrollees, there must be an appeals review process that is equally meaningful so that enrollees can realize the benefits to which they are entitled. A quick and strong benefit appeals program at the federal level will be especially important to individuals in need of MH and SUD treatment. Furthermore, we urge the Secretary to review data from this appeals process to uncover patterns of benefit denial which may suggest common access problems faced by enrollees.

8. We urge the Department to aggressively enforce the strong consumer protections applied to the EHB in §1302(b)(4)(A-D) of the ACA, which require the Secretary to:

   - Ensure that the essential health benefits reflect an appropriate balance within and among the categories so that benefits are not unduly weighted toward any category;
   - Not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways 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;
   - Ensure that health benefits established as essential not be subject to denial 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.

9. The Bulletin also explains that the Department is considering permitting substitutions across benefit categories as well as within them. We are concerned that this flexibility could weaken coverage and reduce or eliminate important benefits, dilute categories, and undermine the EHB as a whole. We urge the Department to prohibit substitution of benefits across categories and only allow flexibility to improve and expand benefits. For the purpose of the MH/SUD benefit category, the application of the MHPAEA and CHIP flexibility standards to the EHB would also similarly protect it from across category benefit

substitution, and if the Department allows substitution across categories we ask that the guidance explicitly states this prohibition.

10. We support the comments regarding medical necessity in the Institute of Medicine's Report *Essential Health Benefits: Balancing Coverage and Cost,* released October 7, 2011:

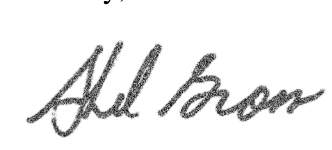
    "The committee believes that the concepts of individualizing care, ensuring value, and having medical necessity decisions strongly rooted in evidence should be reemphasized in any guidance on medical necessity. Inflexibility in the application of medical necessity, clinical policies, medical management,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

    Similarly, each health plan should be required to make public on the internet their particular and complete medical necessity guidelines and list the names and titles of the clinical/medical committee who made medical necessity decisions.

A long history of insurance discrimination against those with MH/SUD has been a barrier for many individuals in need of MH/SUD services across the continuum, including the preventive services, early interventions, timely diagnoses, treatment, and recovery services needed to avoid disease, and to get and stay well. There is also an unacceptably large treatment gap for MH/SUD. Nearly one-third of adults and one-fifth of children have a diagnosable substance use or mental health problem[1], however in 2009, only 4.3 million of the 23.5 million Americans needing treatment for an illicit drug or alcohol problem received it[2], and only 4.1 million of the 9.8 million Americans who needed treatment for a serious mental illness received it.[3] The ACA holds tremendous promise for significantly reducing treatment gaps by increasing early identification and treatment coverage and access for MH/SUD , but without a robust EHB and strong oversight to ensure access to medically necessary MH and SUD care across the continuum this potential will go largely unfulfilled.

Thank you again for the opportunity to provide feedback on the essential health benefits Bulletin. We appreciate your careful consideration of our comments and look forward to working with you further on the development and implementation of the EHB and related provisions. Please contact us if you have any questions or if we can be of further assistance.

Sincerely,



Shel Gross
Director of Public Policy

[1] Garfield, RL. *Mental health financing in the United States: A primer.* Kaiser Commission on Medicaid and the Uninsured. May 2011.
[2] Substance Abuse and Mental Health Services Administration. (2010). *Results from the 2009 National Survey on Drug Use and Health: Volume I. Summary of National Findings* (Office of Applied Studies, NSDUH Series H-38A, HHS Publication No. SMA 10-4856). Rockville, MD.
[3] Substance Abuse and Mental Health Services Administration. (2009). *Results from the 2008 National Survey on Drug Use and Health: National Findings* (Office of Applied Studies, NSDUH Series H-36, HHS Publication No. 09-4434). Rockville, MD.