December 26, 2012

Marilyn Tavenner, Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 445-G
Washington, DC 20201

RE: [CMS-9980-P], Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value and Accreditation of Qualified Health Plans

Dear Administrator Tavenner:

We write you today to offer comments in response to the Proposed Rule on Standards Related to Essential Health Benefits. The Mental Health Liaison Group (MHLG) is a coalition of national organizations representing consumers, family members, advocates, professionals and providers. As trusted leaders in the behavioral health community, we engage in education and advocacy efforts relating to mental health, mental illness and addiction disorders.

As advocates for mental health, we were very supportive of Congress's passage of The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), a measure aimed at ensuring insured Americans' access to mental health treatment. As HHS implements the Affordable Care Act, it must work to ensure that states' essential health benefits (EHB) comply with the federal mental health parity law, MHPAEA, which through statutory language in the ACA expands MHPAEA's reach to EHB. Thus far, an Interim Final Rule issued in 2010 remains the only regulatory guidance stemming from MHPAEA. We continue to seek final regulatory guidance which will clarify many of the issues ambiguously addressed in the IFR. These issues include the scope of mental health services a plan governed by MHPAEA must include, as well as "when" and how an exception to MHPAEA may apply (*eg*, the "recognized and clinically appropriate standard of care" exception), rules regarding disclosures insurers must make to consumers regarding the medical necessity criteria they apply to the medical/surgical services and mental health/substance use services covered in their health plans, and what authority HHS and states have to enforce MHPAEA, as well as standards to be used to assess health plans' compliance with MHPAEA.

The Affordable Care Act (ACA) took a major step toward ensuring high-quality health coverage for all Americans with its requirement that most health insurance plans meet a minimum floor of coverage known as essential health benefits (EHB). We believe that the EHB is a critically important opportunity to address the health needs of Americans with mental illness or substance use disorders. A robust and well-designed EHB package has the potential to make behavioral

health treatment and prevention accessible to millions of Americans for the first time, improving their health and wellness and helping them along the path to recovery.

The MHLG commends the Department of Health and Human Services (HHS) for its thoughtful approach to determining the process by which EHB should be defined and for taking into account many of the comments it received in response to last year's Bulletin on this topic. However, we believe that further revisions to the rule are necessary in order to ensure that all individuals – particularly those with chronic illnesses and serious and persistent behavioral health conditions – have access to a comprehensive range of medically necessary 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.

Mental Health and Addictions Parity

The MHLG greatly supports HHS's emphatic declaration in the Proposed Rule that MHPAEA applies to EHB. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) was a watershed moment for those living with mental illness and addictions, ensuring for the first time health plan issuers could not impose discriminatory limitations on the behavioral health treatment services they covered. The ACA goes one step further, by requiring most plans to cover mental health and addictions services – and to do so at parity with medical/surgical benefits.

Nonetheless, HHS's selected approach to defining EHB presents several challenges when it comes to parity. Because the 2008 law did not apply to small-group insurance plans, many of the EHB benchmark options offer mental health and substance use treatment at substantially lower levels than comparable medical/surgical treatment. States will have to undergo what may be a complicated process of determining specific benefits that must be added to their plans in order to satisfy parity requirements.

This problem is compounded by a lack of information about treatment limitations and exclusions among the base-benchmark plan options. In its July 2012 Final Rule on data collection standards, HHS concluded that requesting such information would place too great a burden on plan issuers. While we are cognizant of the burden that reporting requirements can impose, unfortunately, the result is that states and stakeholders have insufficient access to the information that would be needed to conduct a parity analysis on the base-benchmark plans. We continue to hear from mental health professionals and patients who have informed us that they are struggling to obtain the plan summaries, contracts, and plan descriptions that are needed to precisely determine levels of coverage and limitations on the amount, duration, and scope of services. We additionally continue to see that parity violations commonly involve non-quantitative treatment limitations (including prior authorizations, provider networks, payment rates, step therapies). While HHS does acknowledge treatment limitations of a quantitative nature in its Proposed Rule, we ask that HHS issue a Final Rule which acknowledges the presence of treatment limitations of a non-quantitative nature and how inappropriate application of these treatment limitations to the mental health and substance use disorder services EHB category can violate the federal parity law, MHPAEA. For this reason, we additionally ask that as part of its data collection standards, HHS require states to collect and assess the non-quantitative treatment limitations used by issuers of EHB.

Even should such information be readily available, the Proposed Rule does not outline the process by which states should supplement the base-benchmark plan so as to comply with parity. Instead, it only offers a process by which states may supplement a category of benefits when that entire category of coverage is missing from the base-benchmark plan. Of the 50 states' selected or default base-benchmark plans, only two exclude mental health and substance use benefits entirely. This means that other states are faced with the question of how to supplement this category when a limited number of benefits are already in place – a question that the proposed rule does not answer. We are very concerned at this lack of information. We believe that unless the Final Rule provides necessary details regarding the application of parity to EHB, mental health and substance use coverage in these plans will not be at parity due to discriminatory and illegal practices, as well as well-intentioned practices that fall short because the state did not realize they were deficient.

State Coverage Mandates

The MHLG appreciates the HHS's decision to include state mandates enacted before December 31, 2011 as part of the EHB package, to be covered at no additional cost to the state. We note that this will have an especially positive impact for individuals living with autism or with mental health and substance abuse conditions in states that have elected to require coverage of the treatment for these conditions.

Prescription Drug Coverage

The Proposed Rule improves upon the prescription drug approach outlined in the December 16, 2011 sub-regulatory guidance, in the form of a Bulletin on Essential Health Benefits, which indicated that issuers would only be required to cover at least one drug in each category and class in which the benchmark plan covered at least one drug. We appreciate that HHS has expanded this approach so as to ensure greater coverage of prescription drugs. However, the prescription drug provisions in the proposed rule remain insufficient to adequately meet the needs of individuals who are in need of multiple drugs per class, particularly people with serious and persistent mental illness, chronic conditions, and disabilities.

The ACA's requirement that the EHB not discriminate based on age, disability, or expected length of life is meant to ensure that the benefits package meets the needs of individuals with complex health needs as sufficiently as it meets the needs of those without these conditions. However, the proposed rule requires that plans offering EHB coverage meet only a target number of drugs within a specified class, without regard to which drugs are covered. This approach would allow plans to avoid covering specific drugs that may have unique and important therapeutic advantages in terms of efficacy or safety. This approach is particularly problematic for individuals with serious mental illness. Antipsychotic medications are not clinically interchangeable, and providers must be able to select the most appropriate, clinically indicated medication for their patients. Physicians may need to change medications over the course of an illness as patients suffer side-effects or their illness is less responsive to a particular drug, and patients requiring multiple medications may need access to alternatives to avoid harmful interactions.

The proposed rule makes clear that HHS is concerned about the affordability of EHB coverage and that this concern is driving the development of the prescription drug requirements that have been proposed. However, allowing plans to exclude certain drugs from their formularies ultimately results in higher

health system costs. Policies that restrict choice and access to psychiatric medications have been shown in multiple studies to cause increases in hospitalizations, lengthier hospital stays, more emergency room visits, more outpatient hospital visits, and more physician visits – and this base of evidence continues to grow. Recently, a study[1] by Joyce West, Ph.D in *General Hospital Psychiatry* analyzed Medicaid data from 10 states and found that psychiatric patients who reported access problems with their medication visited the emergency department 74 percent more often than those who had no difficulties accessing their medications. Rates of suicidal behavior and homelessness also rise among consumers who report difficulties accessing their needed medication.

A better approach to prescription drug coverage is the one already in effect in the Medicare Part D program. Medicare Part D identifies six classes of drugs within which it is important for patients to have access to a comprehensive range of medications. Health plans must cover "substantially all" FDA-approved drugs in each of these six protected classes. This approach ensures that all beneficiaries will be able to access the most appropriate medication at the right time and allows prescribers a full range of options in determining which treatments to prescribe. Medicare Part D also reduces spending in other areas of healthcare: a recent Congressional Budget Office report showed that an increase in the number of Part D prescriptions filled is associated with declines in overall Medicare spending.[2] We strongly urge the HHS to adopt the Medicare Part D approach in its final EHB rule, requiring plans to cover substantially all drugs in the six protected classes of immunosuppressants, antidepressants, antipsychotics, anticonvulsants, antiretrovirals, and antineoplastic drugs.

Supplementation of Benefits within Base Benchmark Plans

The proposed rule and the Department's recently issued *Frequently Asked Questions on Exchanges, Market Reforms and Medicaid* clearly outline a process by which base-benchmark plans should be supplemented in the event that they do not cover any services within one of the ten required categories of benefits. However, it is unclear from the proposed rule exactly what constitutes a missing category of benefits. For example, in categories where the ACA lists more than one type of benefit (e.g. "mental health and substance use disorder services, including behavioral health" or "rehabilitative and habilitative services and devices"), the guidance does not specify whether the base-benchmark plan must include both types of services in order to meet EHB criteria, or if it could meet the criteria by including only one type of service. This question is critically important to individuals living with substance use disorders, mental illness, and disabilities, including psychiatric disabilities. Without clear guidance, it is possible and even likely that plans will offer insufficient substance use disorder coverage or habilitative services coverage – two types of services that are not commonly covered in small-group plans.

Related to this issue, the proposed rule appears to indicate that a plan could cover only a single service within a category and still be in compliance with EHB. The ACA's balance and non-discrimination

[1] West May 2009 *Psychiatric Services*, Huskamp May 2009 *Psychiatric Services*, Zhang April 2009 *Psychiatric Services*, Soumerai April 2008 *Health Affairs*, West May 2007 *American Journal of Psychiatry*, Murawski Abdelgawad 2005 *American Journal of Managed Care*, and others.

[2] Congressional Budget Office. Offsetting Effects of Prescription Drug Use on Medicare's Spending for Medical Services. November 2012.

requirements suggest that a much stronger minimum set of benefits in each category would be required – yet, there is no guidance within the proposed rule about whether there is a minimum standard of coverage within each category and how to supplement benefits should existing coverage be inadequate.

We strongly encourage HHS to clarify in its Final Fule that where two types of services are listed under a category of benefits, both must be covered to an equal degree. The Proposed Rule already takes this approach with pediatric dental and vision healthcare services, specifying a process by which states must supplement each type of benefit if it is not already included in the base-benchmark plan.

We further request that HHS indicate a minimum standard of coverage within each category such that plans will not meet EHB unless they offer sufficient benefits. As we noted in our second recommendation above, additional guidance is needed to outline the process by which states should supplement their base-benchmark plans within a given category even if a limited number of services in that category are covered.

Habilitation

HHS has noted in its December 16, 2011 Bulletin on Essential Health Benefits and the Proposed Rule that habilitative services are not often identified as covered services in health insurance plans, and that HHS has struggled to determine how habilitative services are to be defined within its proposed EHB framework. The Proposed Rule allows states to determine which habilitative services are to be included in that category if the base-benchmark plan does not include coverage for habilitative services. Alternatively, the Proposed Rule would allow a plan issuer to either provide habilitative services equal in amount, duration, and scope to rehabilitative services or simply determine the habilitative services it will cover and report its intention to HHS. We are concerned that HHS would allow issuers to define the habilitative services they will cover, and we do not believe that adopting this approach would adequately cover enrollees with habilitative service needs. We urge HHS to establish a minimum federal definition of what constitutes habilitative benefits, and hold plan issuers to that baseline standard. This definition should ensure that plans include meaningful coverage of habilitative services at parity with rehabilitative services.

Nondiscrimination

The ACA requires that the EHB be designed in a way that does not discriminate against individuals. Given the history and often current practice of discriminatory insurance coverage for individuals with mental health and substance use conditions, we are particularly concerned about the effective implementation of the non-discrimination provisions of the ACA. We are concerned that the proposed rule appears to leave it entirely up to states to monitor and identify discriminatory benefit design and implementation. In addition, while we appreciate HHS's recognition that the EHB benchmark plan must not include benefit designs that discriminate on the basis of an individual's medical condition or against the specific populations identified in statute, additional federal standards are necessary to prevent discriminatory benefit design or practices.

However, the proposed rule does not identify a standard to determine if coverage complies with the non-discrimination requirements of the law, nor does it establish a process for bringing discriminatory base-benchmark coverage into compliance. The proposed rule also does not provide much detail regarding what would constitute discriminatory practices by issuers of EHB subject plans. There is no definition of *discrimination* in the statute nor any guidance to states as to when they should find a plan to be discriminatory. The rule also fails to establish a process to bring discriminatory benefit design into compliance with the law.

We request HHS identify a non-discrimination standard, provide examples of what would constitute violations, and provide a framework to ensure compliance. We encourage HHS to include at least the following elements in its non-discrimination standard:

- Cost-sharing is not more burdensome on some categories of benefits than others;
- There are no unreasonable and arbitrary visit and dollar limits on specific categories of benefits that would discourage participation by people with disabilities or chronic conditions; and
- There is no targeting of utilization management techniques on certain categories or types of benefits that would discourage participation.

Benefit Substitutions

The Proposed Rule allows plans substantial flexibility to substitute benefits within the EHB categories. We are concerned that this approach could undermine coverage for certain enrollees, including those with mental health and substance use needs, if a plan is able to use its substitution flexibility to reduce or eliminate medically necessary components of the continuum of care for these conditions.

Should plans be permitted to substitute benefits in this way, it could harm individuals who have mental health and/or substance use treatment needs that their health plans may not want to cover, resulting in gaps in coverage and potential issues related to cherry-picking. For example, we are concerned that under HHS's intended approach a plan may be able substitute out medically necessary services required by individuals with more complicated conditions or health needs, and enhance benefits used by those with less severe conditions, in hopes of attracting a healthier risk pool. In the absence of clarity and guidance from HHS on the non-discrimination provisions of the law we are especially concerned about allowing substitution flexibility. We ask the Department to make clear in the final rule that such practices are unacceptable.

At a minimum, we urge HHS to develop careful standards governing substitution flexibility to ensure that plans cannot use this flexibility to avoid higher-risk enrollees or undermine coverage, and aggressively enforce those standards. Additionally, we ask HHS to clarify how application of parity requirements to the mental health/substance use benefits would limit substitution flexibility of the benefits in that category, and how the Department would ensure strong parity protections remain in place if substitution flexibility is allowed. We believe the six classifications required for inclusion under the MHPAEA IFR as part of a health plan's mental health and substance use disorder category must preempt HHS's Proposed Rule guidance on substitutions. It would not be consistent with the requirements in the IFR

operationalizing MHPAEA for a mental health and substance abuse disorder services category of EHB to not include the six classifications of services outlined in the IFR.[3]

Conclusion

We greatly appreciate the opportunity to submit comments regarding the standards for EHB. Please do not hesitate to contact our groups if we can be of further assistance in explaining the recommendations we have made for EHB design that promotes mental health access and treatment.

Sincerely,

[3] *See* 45 CFR Part 146, Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. These regulations specify in paragraph (c)(2)(ii) six classifications of benefits, including 1) inpatient, in-network; 2) inpatient, out-of-network; 3) outpatient, in-network; 4) outpatient, out-of-network; 5) emergency care; and 6) prescription drugs.