NASMHPD

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December 26, 2012

Marilyn Tavenner, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: **CMS-9980-P**, Patient Protection and Affordable Care Act Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation

Dear Administrator Tavenner:

The National Association of State Mental Health Programs Directors (NASMHPD) is the only member organization representing state executives responsible for the $38 billion public mental health service delivery system serving nearly seven million people annually in all 50 states, 4 territories, and the District of Columbia. NASMHPD operates under a cooperative agreement with the National Governors Association.

We appreciate the opportunity to comment on the proposed rule detailing standards related to Essential Health Benefits, Actuarial Value, and Accreditation. We thank you for your strong commitment to making mental health (MH) and substance use disorders (SUD) a top priority and for working to ensure that individuals with MH/SUD needs receive quality care.

The design of the Essential Health Benefits (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 millions of 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 allow them to reach their full potential.

Although we have a number of very serious concerns with the proposed EHB rule that we discuss below, we do appreciate the proposed rule'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 you know, 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 continued recognition of these critically important ACA requirements.

In addition to our strong support for the clear language in the proposed rule on inclusion of MH and SUD benefits at parity, we appreciate that the proposed rule improves on the preliminary guidance released last year by including all State mandates that were in place in December, 2011 in the essential health benefits package, regardless of the base-benchmark option chosen by the State. We support allowing States the flexibility to choose the base-benchmark option that works best for their residents while still retaining the benefit mandates that were in place at the end of last year. State mandates exist to protect consumers from common gaps in coverage of important services that health plans often fail to cover otherwise, and including State benefit mandates in the EHB is the right thing to do for consumers. We also appreciate the proposed rule's reassertion that all preventive services described in Section 2713 of the ACA be included in the EHB.

We also thank you for your close and continued work with SAMHSA on the EHB and ACA implementation more broadly, and your work with the MH/SUD fields. We look forward to continuing to work closely with the Department to ensure that health reform is implemented in a way that effectively addresses the MH/SUD needs of all Americans.

On behalf of our members, we offer the below comments and recommendations in response to the proposed rule. Our consideration of these issues is informed by our experiences with private health insurance coverage for MH/SUD, which has historically been weak, if it has been covered at all. The following is a summary of our concerns with the proposed rule and recommendations for the final rule, followed by more detailed comments and recommendations for your consideration.

1. While the proposed rule is clear that the requirements of MHPAEA apply to the EHB, the rule does not provide sufficient clarity about how these requirements apply and what the process to supplement inadequate coverage is. Based on the analysis we have been able to do with the limited information we have available, the scope of MH and SUD coverage appears to be significantly more limited than the medical/surgical coverage in many of the EHB benchmarks. Without complete, detailed plan information about benefit coverage in each of the base-benchmark plans, it is not possible to fully determine whether the MH and SUD coverage in each of the State complies with parity. In the final rule, we urge HHS to provide a detailed framework for States, insurance commissioners, exchanges, consumers, providers, and other stakeholders to detail the process for supplementing plans with deficient MH/SUD coverage to ensure that the EHB meets parity requirements. We also urge HHS to conduct a comprehensive and transparent parity analysis of all EHB packages and release all of this information and other detailed benefit information for all of the States as soon as possible.

2. States continue to express confusion about how to supplement deficient coverage in plans that don't comply with parity and, in the absence of clear rules and an enforcement mechanism, it is likely that States will feel the safest practice is to not act. States are uncertain about what their role is and which actions they should take to bring their base-benchmark plans into compliance with parity. In addition, there is concern, should they supplement a base benchmark to bring it into parity compliance, that they will be held financially responsible for the costs associated with the supplemented services. We urge HHS to provide clear language in the final rule to States that parity is required, identifying the process through which noncompliant coverage must be brought into compliance, and reinforcing that States will not be held financially liable for bringing the EHB into compliance.

3. Section 1302 of the ACA requires the EHB to be designed in a way that does not discriminate against individuals. Although the proposed rule re-states the non-discrimination provisions of the law, the rule does not identify a standard to determine whether the coverage provided complies with those provisions of the law. The proposed rule also fails to establish a process to bring discriminatory benefit design or implementation into compliance with the law. We ask the Department to clearly identify a non-discrimination standard, provide examples of what would constitute violations, and include clear and strong federal enforcement provisions and penalties for violations.

4. The proposed rule states that only if a selected benchmark plan does not cover any services in a category must that category be substituted. There is no further discussion of what that means, what benefit or benefits would constitute coverage in each category, or examples of what actual threshold for substitution might be required or allowed. There is also no explanation of what appears to be the Department's position that a category could include only a single service or benefit and still comply with the EHB requirements of the ACA. We believe that the balance, parity, and nondiscrimination requirements imposed on the EHB, at the very least, would require a much stronger minimum set of benefits in each category. In the final rule, we ask HHS to clarify what benefits would constitute coverage in each category, and explain how the Department intends to define and enforce the non-discrimination and balance requirements in this context.

5. While the proposed rule improved on the language in the EHB Bulletin regarding the prescription drug category, the prescription drug provisions in the proposed rule remain insufficient to ensure that enrollees will have good access to needed medications, and is not sufficiently robust to ensure that individuals in need of multiple drugs per class receive the care they need. We continue to urge the Department to adopt a more comprehensive standard for the prescription drug EHB category.

6. The proposed rule allows plans substantial flexibility to substitute benefits within categories. This approach could undermine coverage for certain enrollees, including those with MH and SUD needs. We ask the Department to limit this flexibility in the final rule.

7. The proposed rule allows States to determine the services included in the habilitative services category or allow issuers to develop their own definitions. We do not believe that allowing issuers to define the habilitative services they will cover is acceptable. We continue to urge HHS to take a stronger role in defining habilitative services, which may include a federal definition of scope of coverage for habilitation.

8. We are concerned that States will have primary enforcement responsibility for the EHB requirements and that the proposed rule does not identify how and when the federal government will intervene if a State is not enforcing the law. We urge HHS to take all necessary steps to protect consumers from parity violations, discrimination, and other violations of the law. In the final rule, HHS should clarify its enforcement role and identify appropriate penalties for health plans that are found to be violating consumer protections.

9. The proposed rule does not require sufficient transparency and stakeholder involvement at the State and federal levels. We urge HHS to work with States to ensure consumers and providers have the opportunity to fully participate in the process of determining and updating EHB benefits.

10. We continue to be concerned about the Department's intended approach to base the EHB on existing large or small group plan coverage in each of the States. We understand that a comprehensive EHB that applies to all small group, individual market, basic health plans, and Medicaid benchmark coverage is not feasible at this late date, however we encourage the Department to adopt this approach in 2016. In the final rule, we urge the Department to explain why the current approach is temporary and by what criteria the current approach will be judged at the end of the two year period.

11. **Inclusion of "Crisis Services" in the "Mental Health and Substance Abuse Services" Category in the Essential Health Benefits Package.** As part of the essential health benefits package, we respectfully request that "crisis services" be included in all benefit packages under the banner of MH/SUD benefits offered by qualified health plans and in new Medicaid expansion benefits in each state. Crisis center services are an essential safety net for our communities, due to its 24/7 crisis care, the expertise of center staff in suicide prevention, and the center's access to emergency health care services in the instance of imminent risk. These services are particularly crucial in communities where emergency mental health clinics or mobile health services are unavailable; making crisis centers the core community behavioral health service.

12. **Inclusion of "Screening and Early Intervention" under the "Preventive and Wellness Services and Chronic Disease Management" Category in the Essential Health Benefits Package.** Appropriate screening and early intervention services should be vetted with the U.S. Preventive Services Task Force so that it becomes part of the standard benefit plan and is available without cost to consumers. Screening services must include, at a minimum, services from the A and B list developed by the USPSTF which includes depression screening and Screening, Brief Intervention and Referral to

Treatment (SBIRT) for alcohol use. Services should also include mental and substance use screens available through Early and Periodic Screening Diagnosis and Treatment (EPSDT). Screening may also be used to identify warning signs for suicide to enable early intervention and suicide prevention.

1. **The final EHB rule should include a detailed framework for regulators, consumers, and others that explains with sufficient specificity and clarity how to apply the requirements of parity to the essential health benefit benchmarking process. This guidance should include specific examples of financial requirements and treatment limitations that would violate the law, including non-quantitative treatment limitations that disproportionately limit the scope of covered MH/SUD services. In addition, the Department should release full, detailed benchmark plan information for all States to allow for benefit and parity analysis. The Department should also conduct a review of all State EHB packages to ensure that the EHB meets all of the requirements of MHPAEA and the ACA.**

With the passage of MHPAEA in 2008, Congress sought to end the long history of insurance discrimination against those with mental health and substance use disorder needs that has prevented so many individuals from receiving the clinically appropriate type, level, and amount of care they needed to get and stay well. However, there are still significant problems in implementation and enforcement of the federal parity law which are not receiving needed consideration from HHS as the Department works to define and implement the EHB.

Though the MHPAEA regulations went into effect for all plans on January 1, 2011, providers and consumers are still experiencing discriminatory treatment access. For example, some plans are claiming to be parity compliant by providing sparse or single levels of inpatient services, sparse or very limited levels and types of outpatient services, and/or disproportionate restrictions on MH and SUD prescription drugs such as "fail first" policies. These cost-containment techniques appear to be applied more stringently with respect to MH/SUD benefits than to other medical benefits. These and other barriers to access are hurting individuals today and also threaten to jeopardize access to MH/SUD benefits for enrollees in plans subject to the EHB beginning in 2014.

As you know, the ACA improved on MHPAEA by extending MH and SUD parity requirements to individual and small group health coverage, and requiring coverage of MH and SUD services as essential health benefits. The MH and SUD coverage and parity requirements of the ACA hold tremendous promise to improve access to care for people with MH/SUD needs. Effective implementation of these EHB and parity protections is critical to ensure that the MH/SUD needs of all enrollees in qualified health plans are appropriately met, and we ask the Department move further on the necessary steps needed to successfully implement the parity requirements of the ACA.

The bulletin released by the Department late last year was clear that the requirements of MHPAEA apply in the context of the EHB, and that the ACA requires any issuer that must meet the coverage standard set in Section 1302(a) must cover MH and SUD services, and do so in a way that is consistent with MHPAEA. The proposed rule also acknowledges that the EHB

requires coverage of MH and SUD services in a manner that complies with the MHPAEA requirements. As stated above, we appreciate the explicit recognition in the proposed regulations of these requirements.

However, the proposed rule does not say anything further about how parity applies to the EHB, who is responsible for monitoring and enforcement of parity in the various EHB subject plans, what the ongoing monitoring process includes, how a base-benchmark plan must be brought into parity compliance, and what enforcement mechanisms will be instituted. We are very concerned at this lack of information. We believe that unless the final rule and/or subsequent guidance provides necessary details regarding the application of parity to the EHB, MH and SUD 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. We therefore strongly urge the Department to take an active role in ensuring that the parity requirements of the law are implemented and enforced.

Further, the State benchmark plan information released by the Department does not provide any discussion of parity compliance, nor does it provide the detailed plan information required for others to conduct a parity analysis. The plan information fails to include complete information about the medical necessity criteria the plan uses to determine which services are covered, consistent information about benefit exclusions, and complete information about the treatment limitations and financial requirements necessary to complete an analysis. The Department should immediately make this information available. The application of parity to the EHB is a central component of ACA, and the proposed rule does not go far enough to ensure that the parity protections will apply to the EHB.

In addition to releasing complete information for the benchmark plans, we also strongly urge the Department to develop and release a parity analysis framework in regulations that federal, State, and other regulators would be required to use to supplement deficient EHB coverage. States, insurance commissioners, insurance exchanges, providers, consumers, and others need to know how the requirements of MHPAEA apply to EHB coverage and what would constitute a violation. We continue to hear from States that they are unclear on their responsibilities regarding parity, and that they do not have the information from HHS that they need to move forward with bringing their base-benchmark plan into compliance. A detailed framework outlining requirements, with examples of violations and a process for bringing coverage into compliance is very much needed. We look forward to working with you to ensure that these measures are well understood and widely implemented.

We also ask the Department to work with its federal partners and States 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 makes clear to States that they have a responsibility to implement and enforce the MHPAEA and the ACA's parity requirement in their State. HHS should further clarify the roles and responsibilities of State and federal governments in the final regulations.

2. **Similarly, States have expressed frustration at the lack of clear direction from HHS regarding States' responsibilities for supplementing a base-benchmark to bring it into compliance with the parity requirements of the law. States have been uncertain about what to do and it is likely that, absent clear federal rules and an enforcement mechanism, States will feel inaction is the safest course. States that have considered supplementing their base-benchmark's coverage to bring it into compliance with parity have also been concerned that any efforts to do so will be viewed as a State benefit mandate by HHS that could result in them being held financially responsible by the federal government. The Department should provide clear language to States in the final rule that MH/SUD parity is required of all EHB packages. The final rule should further define States' roles and responsibilities to bring the EHB into compliance, detail an enforcement process and clarify that States will not be responsible for any of the costs associated with supplementing the EHB to bring it into compliance with all of the required protections.**

MHPAEA exempted the small group and individual health insurance markets from the requirement that mental health and substance use disorder services be provided in a way that is no more restrictive than the medical and surgical services provided by the plan. The ACA expanded the requirements of MHPAEA to small group and individual market plans and required these plans to provide MH and SUD coverage beginning in 2014.

Last year's bulletin and the EHB proposed rule allow States considerable flexibility to define the EHB package that will apply on a State level, based on an existing commercial product that may include a small group plan. The bulletin also gave States the option to include their benefit mandates in their EHB at no cost if they chose a benchmark option that was required to comply with those mandates. Small group plans are more likely to be subject to the State-mandated benefits, making the selection of a small group plan a very attractive option for most States. In addition, the Department has made a small group plan the default benchmark plan for States that do not choose to define their own benchmark under the flexibility they have been given. As a result, the base-benchmarks in the majority of States are small group plans that have not had to comply with MHPAEA. Additionally, base-benchmarks that are based on large group plans may also not be in compliance with MHPAEA for a variety of reasons, including the lack of a final rule on MHPAEA. Therefore, much work will need to be done to supplement many if not most base-benchmark plans to meet the parity requirements of the ACA.

Although the federal government has the responsibility under the ACA to ensure that the EHB meets parity requirements, under the framework established by the Department to define essential health benefits, States also have a role to ensure that the EHB is designed in a way that complies with parity. However, the proposed rule does not provide specific detailed guidance to States on how to supplement the MH and SUD benefits in the base-benchmarks and align treatment limitations and financial requirements to ensure appropriate coverage that complies with the law.

As States seek to design their EHB packages under the flexibility they have been given by HHS in a way that meets the ACA's requirements, we urge the Department to work closely with them to ensure that their EHB packages are supplemented so that MH and SUD benefits are covered in

a manner that is no more restrictive than the other comparable benefits in the EHB. As stated above, our review of available benchmark information has indicated that the continuum of MH/SUD services offered in the base-benchmark plans is significantly more limited than the range of other medical/surgical services covered by the plan. Without the criteria used to determine which MH/SUD and other medical/surgical services to cover, it is impossible to conduct a thorough parity analysis and to determine whether the coverage complies with the law. We urge the Department to conduct a comprehensive parity analysis of all of the base-benchmark plans, and to work with States to ensure compliance.

HHS must also provide States with clear guidance on their responsibilities and flexibility to design a benefits package that complies with the law. We strongly urge the Department to provide explicit language in the final EHB regulations that MH and SUD parity is required, that the base-benchmark plan's scope of services is subject to parity review, and that plans with insufficient MH/SUD coverage must be supplemented to comply with the law. We also urge the Department to define State and federal responsibilities to supplement non-parity compliant base-benchmarks under the approach the Department has put forward.

The proposed rule does not provide clear guidance assuring States that any supplementation of benefits they undertake to bring their EHB into compliance with federal law will not be seen as a benefit mandate that they will be obligated to pay for under the State mandate requirements of the ACA. As a result, States have been reluctant to correct even the most straightforward parity violations in their chosen benchmark plans. Future EHB guidance from HHS should therefore also give States clear assurance that bringing their EHB into compliance with parity and other requirements of federal law will not obligate States to defray any of the associated costs, and such efforts will not be considered State mandated benefits under Section 1311(d)(3)(B) of the ACA.

Finally, when the essential health benefits requirements of the ACA are put into operation beginning in 2014, many States will assume plan management responsibilities for exchange plans and all States will have regulatory oversight over the small group and individual markets operating outside the exchange in their State. It is imperative that States have the complete reassurance from the Department that they can exercise their parity enforcement responsibilities for EHB-subject plans without fear that action by the States to require those plans to supplement deficient benefits may be seen as a State mandate that could leave the State financially responsible for associated costs.

3. **The ACA requires that the EHB be designed in a way that does not discriminate against individuals. 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. We ask the Department to identify a non-discrimination standard, provide examples of what would constitute violations, and provide a framework to ensure compliance.**

The proposed rule rightly references the requirement in Section 1302(b)(4) of the ACA that directs the Secretary to address certain standards in defining the EHB, including elements related to balance, non-discrimination, the needs of diverse segments of the population, and the denial of benefits. Section 1302(b)(4) requires the Secretary to ensure that benefits, payment rates, and incentives built into the EHB do not discriminate based on age, disability, or expected length of life, and that the EHB takes into account the health needs of diverse segments of the population, including women, children, persons with disabilities, and other groups. These protections are critically important to individuals with MH and SUD and others with chronic illnesses and disabilities. We appreciate the acknowledgement in the proposed rule that the EHB must meet these non-discrimination requirements. However, the proposed rule does not identify a standard to determine whether the coverage provided complies with these provisions of the law or establish a process to bring discriminatory benefit design or practice into compliance.

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 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, however in 2009 only 4.3 million of the 23.5 million Americans needing treatment for an illicit drug or alcohol problem received it and only 4.1 million of the 9.8 million Americans who needed treatment for a serious mental illness received it. 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 that does not discriminate against individuals with or at risk for these diseases, and without strong oversight to ensure access to medically necessary MH and SUD care across the continuum, this potential will go largely unfulfilled.

Given the history and often current practice of discriminatory insurance coverage for individuals with MH/SUD, 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 the Department'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.

The preamble of the proposed rule says that the Department believes "that it is unlikely that an EHB-benchmark plan will include discriminatory benefit offerings." We strongly disagree with this assessment, and this has not been our experience as we have analyzed benchmark plan options. For example, we have found language in a number of benchmarks chosen by States that excludes methadone maintenance treatment, a long-established, evidence-based, effective treatment for opioid addiction. We have also found a number of base-benchmark plans that exclude substance use disorder treatment in non-hospital inpatient (residential) settings. Both of these exclusions go against the medical evidence and discriminate against enrollees with substance use disorders. Without effective implementation of the non-discrimination and other consumer protection requirements of the ACA, many individuals needing these SUD services

may not be able to access care due to discrimination based on their medical condition, even though substance use disorder services is a required benefit category under the law.

It is unacceptable for insurance coverage ever to discriminate against individuals based on their mental health or substance use disorder. However, even in many instances when legal protections are in place, those with MH/SUD face access barriers because of their conditions. We therefore strongly urge the Department in the final rule to develop a standard to determine whether EHB coverage or health plan practice discriminates against certain individuals, those with certain illnesses, high-risk individuals, or those with high-cost health needs. The final rule should also give several examples of what would constitute violations of the non-discrimination provisions of the law and implementing regulations. We also ask the Department to include in the final rule language outlining clear and strong federal enforcement provisions and penalties for violations.

The Department should also work closely with States, insurance commissioners, exchange regulators, and other regulatory agencies and officials to design strong non-discrimination enforcement mechanisms on the State level to ensure that benefit design and health plan practice do not discriminate against individuals on the basis of their health or conditions.

4. The Department should clarify what benefits would constitute coverage in each category, and define, with examples, the minimum coverage allowed in each category under the law.

We support the recognition in the proposed rule that the ACA requires benefits in each of the ten categories to be covered, regardless of the flexibility given to States to define the EHB. However, we are concerned that the Department's position seems to be that covering any benefit in a given category—no matter how limited—would meet the EHB requirement. Although the ACA looks to typical employer coverage as a base, the additional parity, balance and non-discrimination provisions of the law were included to ensure that typical coverage that was insufficient would have to be supplemented to comply with the law. The proposed standard that inclusion of only one service in a category would be sufficient coverage does not meet the various EHB consumer protective requirements of the law.

In the event that a base-benchmark plan does not offer coverage in a category, the proposed rule requires that it must be supplemented to include coverage in that category. The rule states that "we propose standards for supplementing a base-benchmark plan that does not provide coverage of one or more of the categories…we propose that if a base-benchmark plan option does not cover any items and services within an EHB category, the base-benchmark plan must be supplemented by adding that particular category in its entirety from another base-benchmark plan option. The resulting plan, which would reflect a base-benchmark that covers all 10 EHB categories, would be required to meet standards for non-discrimination and balance…after meeting all of these requirements, it would be considered an EHB-benchmark plan." There is nothing in the proposed rule that provides greater detail or clarity about the ACA's balance requirement; however it does solicit comment from stakeholders on this issue.

We believe that the Department's position that only providing one benefit in a category is sufficient is incompatible with the requirement in the ACA that the Secretary ensure an appropriate balance among the EHB categories so that benefits are not unduly weighted toward any category. Having a limited EHB category would also violate the ACA's non-discrimination requirement. A much higher threshold must be defined that identifies a minimum set of services in each category necessary to comply with the EHB requirements of the ACA. For complicated illnesses such as MH and SUD this is especially critical.

In developing the EHB, it is important to recognize that people have complex, varied health needs. The EHB should include services that improve functioning and help people achieve rehabilitation and maintain long-term recovery. It should cover services to meet individuals' multiple needs, and should recognize for mental illness and substance use disorders that no single treatment is effective for all individuals. Prevention, treatment and rehabilitation of SUD and mental illness and recovery supports should be covered. Substance use disorders and serious mental illnesses also are often chronic diseases that need to be managed over a lifetime. Like other chronic conditions, there are varying degrees of severity for MH and SUD and a continuum of care exists to ensure that people can receive the appropriate level and type of care, including all evidence-based psychotherapy services, medications, and care coordination as appropriate for MH and SUD.

We strongly urge the Department to define a standard of adequacy that requires the coverage of certain benefits in each category, and if a base-benchmark does not include those benefits in a benefit category, the Department should require that the benefits in that category be supplemented to bring it into compliance. 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. For the mental health and substance use disorder category, all appropriate MH and SUD services, including residential SUD and hospital-based services, outpatient and home-based services, medications, prevention services and recovery support services should be required EHB services.

All States should have adequately robust and detailed essential health benefits packages that ensure full coverage of all medically necessary services across the continuum of care in each of the categories, including the mental health and substance use disorder category, and we continue to urge the Department to work closely with States to ensure that an appropriately comprehensive package of benefits is provided for each of the ten EHB categories. HHS should review State benchmark proposals for adequacy and require States to supplement categories that fall short. We urge the Department to define a minimum standard of coverage with specific benefit examples in the final rule that is consistent with this framework. We also ask the Department to explain how it intends to define and enforce the non-discrimination and balance requirements in this context in the final rule.

5. **The prescription drug provisions in the proposed rule remain insufficient to adequately meet the needs of individuals in need of multiple drugs per class. We urge the Department to adopt a comprehensive standard for the prescription drug EHB category that would require plans to offer all or substantially all prescription medications in each class.**

The proposed rule improves on the prescription drug approach outlined in the EHB Bulletin, which indicated that issuers would only be required to cover at least one drug in each category and class in which the EHB-benchmark plan covered at least one drug. The proposed rule states that the Department received a large volume of comments that raised concerns at the lack of comprehensiveness of this proposed approach, because requiring coverage of only one drug per class or category would result in insufficient access to medications for individuals with certain chronic conditions. We were among the groups that gave comments to this effect, and we appreciate that HHS sought to improve upon the bulletin's approach in the proposed rule, which proposes to require the greater of: (1) one drug in every category and class, or (2) the same number of drugs in each category and class as the EHB-benchmark plan. While we recognize the improvement over the bulletin's proposal, we continue to have concerns that the prescription drug approach outlined in the EHB rule is insufficient, especially for those with complex chronic health conditions.

The proposed rule requires that plans offering EHB coverage meet 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. Not all patients respond to medicines in the same way. 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 prescription drug category must meet an adequacy and quality standard; a quantity standard by itself is insufficient. In addition, allowing plans to exclude more effective therapies from some classes would violate the non-discrimination protection and other consumer protection requirements of the EHB. For example, based on our analysis of base-benchmark plans in a number of States methadone is excluded from coverage as a treatment for opiate addiction. Methadone has a distinct pharmacological profile for which there is no adequate substitute for certain patients, and is recognized as an effective, and cost-effective, medication for opiate addiction. Defining the prescription drug requirements of the EHB in a manner that could potentially exclude methadone maintenance therapy would limit access to evidence-based care and discriminate against a population based on their chronic disease. We also would have the same concern if any other medication for mental or substance use disorders were excluded.

The proposed rule makes clear that the Department 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. We do not believe that reducing short term costs by designing the EHB in a way that denies access to medically necessary services by shifting the full costs of certain medications to insured individuals and families is appropriate. In addition, denying needed medications to save money now may result in sicker, more expensive patients in the longer term, increasing future healthcare costs.

We continue to urge the Department to adopt a more comprehensive standard for the prescription drug category. It should require plans to offer coverage for all or substantially all FDA-approved prescription medications in each class, and would include a robust and timely appeals process for patients who are denied clinically appropriate medications, such as the appeals procedures

outlined in Medicare Part D, which requires an expedited process for appealing a decision. HHS should also adopt standards to guarantee access to medically necessary drugs during the appeals process.

6. **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 MH and SUD needs. We urge the Department to limit this flexibility in the final rule.**

The Department proposes to allow the substitution of benefits in each of the EHB categories, except for the prescription drug category, so long as the sets of benefits the plan is substituting are actuarially equivalent. The proposed rule also would give States the option to enforce a stricter standard on benefit substitution or prohibit it completely.

We are concerned that this approach could undermine the MH and SUD services category, if a plan is able to use its substitution flexibility to reduce or eliminate medically necessary components of the continuum of care for certain conditions, including mental illness and substance use disorders. We believe that this could harm individuals with MH and/or SUD 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 have concerns that under the Department'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 the Department 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. We also ask the Department to clarify how application of the MHPAEA requirements to the MH/SUD benefits would limit substitution flexibility of the benefits in the MH/SUD category, and how the Department would ensure strong parity protections remain in place if substitution flexibility is allowed.

7. **We urge the Department to take a more active role in defining habilitative services, which may include developing a federal definition of scope of coverage for habilitation. We also urge the Department to abandon its intended approach to allow plan issuers to develop their own definitions of habilitative services.**

HHS has noted in the EHB Bulletin and the proposed regulations that habilitative services are not often identified as covered services in health insurance plans, and the Department has struggled to determine how habilitative services are to be defined within the framework the Department has put forward. 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 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 continue to urge the Department to take a stronger role in defining habilitative services. This may include developing a federal definition of the habilitative services category and applying those requirements to all EHB-subject plans. At a minimum, the national standard of habilitation should be either the National Association of Insurance Commissioner's definition or the applicable state Medicaid definition of habilitation. Regardless, the Department should take careful steps to ensure adequate coverage of habilitative services that includes a strong appeals process for enrollees. HHS should also carefully enforce the habilitative services requirements of the EHB to avoid discriminatory practices.

8. **We are concerned that the proposed rule would give States primary enforcement responsibility for the EHB requirements and that the proposed rule does not identify how and when the federal government will intervene when a State is not enforcing the law. Of particular concern is how this enforcement will work in those States that are not moving forward with implementing the ACA and will not be running their own exchanges. We strongly urge HHS to aggressively enforce the MHPAEA compliance requirements on the federal level and work with appropriate State officials to enforce the MHPAEA requirements on the State level to ensure meaningful compliance.**

The proposed rule acknowledges that the ACA generally provides that States have primary enforcement authority over health insurance issuers, but allows HHS to take enforcement actions against issuers if a State is not meeting its enforcement responsibilities. However, the rule does not provide information about when the federal government will intervene. We urge the Department to clarify State and federal enforcement responsibilities in the final rule, and give examples of when the federal government will use its enforcement powers.

As noted previously, while MHPAEA has been in effect for all plans since January 2011, enrollees in large group plans continue to experience discriminatory treatment access, and some States continue to assert that parity enforcement is entirely a federal responsibility. By providing strong enforcement language in the final rule regarding the EHB protections, including the application of parity, the Department can protect consumers from violations of their rights. This includes adding language to regulations that identifies State and federal enforcement roles and responsibilities, as well as penalties for health plans that are found to be in violation of the law. HHS should work closely with State regulators to ensure that they understand their responsibilities and enforce the relevant federal laws in their State. HHS should work especially closely with officials in States that are not actively implementing health reform or even hostile to its implementation, to ensure that consumers are adequately protected. HHS should make clear to States and health plan issuers that it will step in to enforce consumer protection laws that are not being acceptably enforced by the State. Absent a national EHB standard, strong federal enforcement of these provisions is that much more necessary to protect consumers.

HHS should also work with SAMHSA and its other federal partners to educate consumers and providers of their rights under the ACA and provide mechanisms for consumers and providers to report violations to the appropriate authorities.

We urge the Department to develop an appeals process at the federal level that can provide recourse for individuals who have been failed by State review. To ensure that the EHB is comprehensive and meaningful for all enrollees, there must be an appeals review process so that enrollees can access 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 that may suggest common access problems faced by enrollees. The Secretary should also use this data to update essential health benefit package standards.

9. **Additional guidance is needed to ensure sufficient transparency and stakeholder involvement at the State and federal levels. We urge HHS to work with States to ensure consumers have the opportunity to fully participate in the process of determining and updating the EHB that will impact access to care in their State.**

Consumers and providers should have regular opportunities to participate and influence the EHB determination process and its outcomes. Transparency and opportunity for input are critically important, especially considering the far reaches of the decisions being made. Yet in many States, stakeholders have found resistance to participating in the process. For example, documents detailing the benefits and scope of coverage in the chosen or default benchmark plan option are still not available in many of the States, making analysis and meaningful participation in the process extremely difficult. We ask that the Department ensure transparency and guarantee the opportunity for appropriate public input as States and the federal government proceed with the EHB and other health reform implementation processes.

Moving forward, the Department should also work with States to ensure a strong consumer and family education component related to the EHB implementation and ongoing management. Consumers and families should have a basic understanding of how to identify potential violations of their EHB rights and how to take appropriate action to correct violations of their rights and to appeal plan decisions. The federal government should work with State governments to ensure that stakeholders have a voice in updating the EHB, and also in the process leading up to 2016 when the Department has said it will reevaluate its benchmarking approach for the essential health benefits.

10. **We continue to be concerned about the Department's intended approach to define essential health benefits. We don't believe that basing the EHB on existing large or small group plan coverage is what Congress intended or what is in the best interest of the people that we serve, and urge the Department to adopt a comprehensive, federal EHB in 2016. We also urge the Department to explain why the current approach is temporary and to explain the criteria by which the current approach will be evaluated at the end of this two year period.**

When Congress passed the ACA and created the EHB it intended to create a uniform minimum benefit standard that would apply to all States, guarantee small group and individual market health plan enrollees a basic level of protection, and ensure that federal subsidy dollars would be spent on quality coverage. We continue to believe that individuals with MH and/or SUD needs, those with other chronic conditions, and all small group and individual market plan enrollees would be best served by a comprehensive federal EHB that States could go beyond to meet their

specific needs. While we understand the Department's intent to give States a significant amount of flexibility to design their benefits packages, we believe that a national standard is needed that will guarantee strong and specific benefit protections to all covered enrollees and urge the Department to reconsider its intended approach. While we understand that a reconsideration in approach is likely not feasible at this late date, we encourage the Department to adopt a comprehensive national EHB in 2016, when the trial period for the current approach is complete.

Given the negative reaction many States have to the ACA, it is especially critical that any approach giving States additional authority to implement key components of the law be monitored closely by federal officials. Absent a federal floor, strong oversight of States' proposals and enforcement actions is critical to ensure that coverage is comprehensive and robust in all States across the country. We urge HHS to ensure that all EHB plan enrollees can access the full array of MH and SUD services that they need to get and stay well.

Finally, in the next weeks and months we ask the Department to clarify why the current approach is temporary and explain the criteria by which it will be reevaluated at the end of the two year period. These evaluation criteria should include enrollee and provider satisfaction, plan compliance, and other criteria to effectively evaluate the success of the approach and identify any shortcomings. Please use us as a resource in developing these standards to evaluate the success of this approach in meeting the needs of enrollees with mental health and substance use disorder needs.

11. **Inclusion of "Crisis Services" in the "Mental Health and Substance Abuse Services" Category in the Essential Health Benefits Package. As part of the essential health benefits package, we respectfully request that "crisis services" be included in all benefit packages under the banner of MH/SUD benefits offered by qualified health plans and in new Medicaid expansion benefits in each state. Crisis center services are an essential safety net for our communities, due to its 24/7 crisis care, the expertise of center staff in suicide prevention, and the center's access to emergency health care services in the instance of imminent risk. These services are particularly crucial in communities where emergency mental health clinics or mobile health services are unavailable; making crisis centers the core community behavioral health service.**

Crisis center services are an essential level of care for people who chose not to access other behavioral health services. These services help this population avert severe crisis, and can reduce the use of emergency care services. Crisis centers are at the forefront of providing new services that are evidence-based and in accordance with the changing times. People increasingly are accessing health care with mobile and online technologies. Chat and text services and follow-up programs are essential to provide person-centered care and to meet the new needs of behavioral health care consumers. Focusing on crisis centers in the behavioral health system positively impacts the quality of care while also containing costs.

For over 50 years crisis centers have provided invaluable services to callers at risk of suicide. Every month, over 50,000 calls are answered through the Lifeline. Crisis centers play an essential role in providing much needed care 24 hours a day, seven days a week to reduce feelings of hopelessness and suicidal intent.

A SAMHSA-funded evaluation of crisis hotlines published in 2007 reported that seriously suicidal individuals call crisis hotlines; both emotional distress and suicidality decrease in crisis callers during and after calls to hotlines; and nearly 12% of suicidal callers spontaneously reported to the evaluators upon three-week follow-up that the call "kept them from killing or harming themselves" (Gould, Kalafat, Munfakh, & Kleinman, 2007). Findings from this and other ongoing SAMHSA evaluations of crisis call centers participating in the Lifeline network have continued to produce recommendations and standards for service improvements.

There is sufficient evidence of the recurrence of suicidal ideation following discharge from an inpatient facility or emergency department that demonstrates the need for services to target all populations for prevention at this time (Appleby et al., 1999; Qin & Nordentoft, 2005). Recent research indicates that follow-up with hotline callers and people discharged from an emergency department (ED) or inpatient setting has positive results for both consumers and providers of mental health services (Fleischmann, 2008; Vaiva et al., 2006; Zanjani, Miller, Turiano, Ross, & Oslin, 2008).

Follow-up services contribute to continuity of care:

• Follow-up care involves phone calls, home visits, emails, chats or texts that are designed to check in with a hotline caller or a suicide attempt survivor being discharged from an emergency department to motivate them to continue their journey towards recovery.
• Follow-up care aims to ensure that medical support for attempt survivors continues after discharge and is intended to make the process of receiving behavioral health care smooth and uninterrupted.
• Follow-up care can result in less people slipping through the cracks and more people receiving the care and attention they need during a critically vulnerable time.

Crisis centers are uniquely positioned to be a crucial resource for people in need of follow up care, as they have the resources, professionally trained staff, and technological capabilities to provide effective services and appropriate referrals.

Chat and text services allow crisis centers to increase access to care and enhance the capacity to provide a vital service to a significant portion of the population who would otherwise not access possible life saving services.

Chat and text are especially effective in improving access for teens and adolescents:

• Texting and chat have become the preferred method of communication for teens because these modes of communication are immediate, private, and give individuals control over how and with whom they communicate.
• A 2010 report from the Pew Internet and American Life Project indicated that 75 percent of youth 12 to 17 years old own a cell phone; of these, 87 percent use texting and average 40 texts per day.

• Empirical data suggests that texting is a less threatening, less anxiety provoking method of communication for teens and allows for more open, intimate discussions of mental health issues (Haste, 2005).

Crisis services have shown to save lives and save money. We request that these services become part the MH/SUD category within the essential health benefits packages provided in state health insurance exchanges and Medicaid programs.

12. **Inclusion of "Screening and Early Intervention" under the "Preventive and Wellness Services and Chronic Disease Management" Category in the Essential Health Benefits Package. Appropriate screening and early intervention services should be vetted with the U.S. Preventive Services Task Force (USPSTF) so that it becomes part of the standard benefit plan and is available without cost to consumers. Screening services must include, at a minimum, services from the A and B list developed by the USPSTF which includes depression screening and Screening, Brief Intervention and Referral to Treatment (SBIRT) for alcohol use. Services should also include mental and substance use screens available through Early and Periodic Screening Diagnosis and Treatment (EPSDT). Screening may also be used to identify warning signs for suicide to enable early intervention and suicide prevention.**

Individuals and families, across the lifespan, should have coverage in order to receive education and skills training about preventing, treating, and recovering from mental health disorders. In addition, "wellness services" should be covered in regard to consumer and family education on maintaining healthy weight, good nutrition, mental illness prevention, and other aspects of a healthy lifestyle, including wellness. Home visiting programs such as evidence-based home visiting for caregivers, infants and toddlers should be available as well as prevention services including those required by the ACA, and suicide and drug screenings for adults.

Thank you again for the opportunity to provide comments on the essential health benefit proposed rule. We strongly support the goals of the ACA to ensure that all Americans have access to high-quality, affordable health care, including comprehensive care for mental health and substance use disorders. 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 of the ACA. Please contact us if you have any questions or if we can be of further assistance.

Sincerely,

Robert W. Glover, Ph.D.
Executive Director
National Association of State Mental Health Program Directors