



December 21, 2012

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

RE: Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation

Dear Administrator Tavenner:

Thank you for the opportunity to comment on a proposed rule on Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation.

The Parity Implementation Coalition (the Coalition) is an alliance of addiction and mental health consumer and provider organizations. Its members include the American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Society of Addiction Medicine, Betty Ford Center, Cumberland Heights, Faces and Voices of Recovery, Hazelden, MedPro Billing, Mental Health America, National Alliance on Mental Illness, National Association of Psychiatric Health Systems, TeenScreen at Columbia University, the Watershed Addiction Treatment Programs, Inc., and the Wellstone Barlow Mental Health Initiative. In an effort to end discrimination against individuals and families who seek services for mental health and substance use disorders, these organizations advocated for more than twelve years in support of parity legislation and are committed to the prompt and effective implementation the Mental Health Parity and Addiction Equity Act (MHPAEA).

SUMMARY OF RECOMMENDATIONS

The Parity Implementation Coalition respectfully offers the following comments on the proposed rule and recommendations for inclusion in a final Essential Health Benefit (EHB) rule:

1. **Requirement to include addiction and mental health as part of the EHB and comply with MHPAEA.** We applaud HHS for codifying the requirement under §147.150(a) of this proposed rule that, in 2014, new individual and small group plans – both inside and outside of the state health insurance exchanges – will be required to offer mental and substance use disorder coverage, and to cover it at parity and for clarifying under §147.150(c) that these same requirements apply to child only plans.
2. **HHS should ensure that all EHB-benchmark plans meet federal parity requirements and provide adequate mental health and substance use disorder services for all persons who depend on coverage through state exchanges.** In particular, we request that the Department: (a) include a requirement that all EHB-benchmark plans must meet federal parity standards; (b) clarify that states can supplement insufficient base-benchmark plans that do not meet parity or other

requirements; (c) modify the supplementation methodology to include supplementation for sub-components of EHB categories; and (d) clarify this supplementation is not considered an “additional required benefit” and will not impact state funding requirements.

3. **Benefit Substitution.** The Department should ensure that health plans offering EHB, that choose to substitute benefits cannot do so to avoid higher-risk enrollees or undermine coverage for particular services. Therefore, we urge HHS to (a) include in a final rule regulations to prohibit such type of benefit substitution within EHB categories. With respect to within-category benefit substitution, we urge HHS to: (b) limit substitutions to the sub-components of the EHB categories, rather than allowing substitutions within the entire benefit category; (c) extend the requirement of “balance” to within-category balance in addition to balance across the spectrum of the 10 EHB categories; (d) ensure that all substitutions within each individual EHB category meet the requirements of parity law; and (e) clarify that plans offering EHB may never substitute any state mandated benefits. The Departments should also clarify that the prohibition against substitution across benefits as set forth under EHB, likewise applies with respect to the six classifications of benefits set forth under MHPAEA. Thus, substitution across the six classifications under MHPAEA is similarly impermissible.
4. **Cost-Sharing & Network Adequacy.** The Department should ensure that patients do not become unfairly fiscally burdened when health plans offering EHB do not have adequate provider networks. We urge HHS to: (a) allow certain out-of-network costs to count toward annual cost-sharing and deductible limits; and (b) establish an out-of-pocket maximum for these specified out-of-network costs. Finally, we urge HHS to: (c) finalize its rule on cost-sharing in emergency department settings and extend this requirement to all emergency services.
5. **Prescription Drugs.** Patients should have access to FDA approved medications for the treatment of mental illness and addictive disorders.
6. **Non-discrimination.** HHS should clearly identify a non-discrimination standard, and provide several examples of what would constitute violations; describe a detailed process and timeline for oversight over state implementation of a non-discrimination standard so that consumers can be assured that discriminatory plans will not find their way onto the exchange; and include in the final rule language outlining clear and strong federal enforcement provisions and penalties for violations.
7. **Accreditation of QHP Issuers.** HHS should require that the parity requirements contained in URAC’s Version 7 standards for accreditation of health plans be a mandatory minimum standard applied by all accrediting bodies for accreditation purposes.
8. **Transparency & Consumer Engagement.** Additional guidance is needed to ensure sufficient transparency of information and stakeholder involvement within the EHB process. To achieve these goals, we ask HHS to: (a) make robust information available on every base-benchmark plan; (b) set transparency requirements for plans offering EHB; and (c) provide guidance to ensure ample stakeholder engagement in the EHB process.

9. **Enforcement.** HHS should provide aggressive oversight and enforcement in the area of EHB and MHPAEA compliance.

BACKGROUND

Prevalence of Mental and Addictive Disorders

Addiction and serious mental illnesses are chronic diseases that can be prevented and treated effectively. Unfortunately, in the last year, just over half of the 11.5 million adults with serious mental illnesses received treatment for a mental health condition and only 11% percent of the 19.3 million people suffering from an alcohol and/or drug use disorder received treatment.^{1,2} A robust essential health benefit is essential to remedying this treatment gap and increasing access to addiction and mental health prevention, treatment and recovery support services for millions of American and their families.

Moreover, the Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that up to a third of the 30 million Americans who may gain access to health insurance through the Affordable Care Act will have a mental or substance use disorder. It is critical that individuals have meaningful access the EHB's mental health/substance use disorder (MH/SUD) benefit so the full potential of the law can be realized.

No Health Without Mental Health

Treating mental health and addiction is not only the right thing to do – it is the cost effective thing to do. For example:

- Mental health and substance use disorders cost employers \$17 billion annually in absenteeism and lost productivity³
- Illicit drug use costs America \$193 billion annually - over \$11 billion in health costs, \$61 billion in crime-related costs, and \$120 billion in lost productivity. This exceeds the annual direct and indirect costs of diabetes⁴
- In one study, middle-aged and older adults who received “collaborative care” for depression had significantly reduced healthcare costs compared to those in usual care, with a \$522 initial investment yielding cost savings of \$3,363 per patient⁵

Status of Mental Health and Substance Use Disorder Parity Law: Lack of Federal Guidance and Slow Implementation by Plans

MHPAEA generally prevents large group health plans and health insurance issuers that provide MH/SUD benefits from imposing discriminatory benefit limitations on those benefits than are imposed on medical/surgical coverage. Under the law, if a group health plan includes medical/surgical benefits and MH/SUD benefits, the financial requirements (e.g., deductibles, co-payments, etc.) and treatment limitations (e.g., prior authorization, concurrent review, etc.) that apply to MH/SUD benefits must be no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits.

Unfortunately, MHPAEA's interim final rule leaves many questions unanswered. Four key areas require additional regulatory guidance:

1. Transparency and disclosure
2. Scope of service
3. Nonquantitative treatment limits
4. Medicaid managed care parity

As a result of the lack of guidance regarding final regulations in these key areas, many individuals seeking care for mental health and addictive disorders are unable to access the services they need. Unfortunately, since MHPAEA was signed into law in 2008, health plans are continuing to impose more stringent limits on addiction/mental health benefits than on medical benefits. As a result, patients are unable to fully access vital benefits.

Not only are parity regulations lacking, but plans have just begun to implement parity within their plan designs. While the interim final rule has been applicable since July 1, 2010, we find that many plans are still lacking in parity implementation. Moreover, there has been little oversight to ensure that plans are following their obligations under the law.

Parity Law and Exchanges

In 2014, under the Affordable Care Act, new individual and small group plans – both inside and outside of the state health insurance exchanges – will be required to offer mental and substance use disorder coverage, and to cover it at parity. We applaud HHS for codifying this requirement under §147.150(a) of this proposed rule and for clarifying under §147.150(c) that these same requirements apply to child only plans. We support HHS' efforts to add a specific provision to the proposed regulations to address parity within benefit substitutions (§156.115(a)(2)). However, we caution HHS that because the parity law has not been fully implemented, a cross-reference to parity law does not guarantee that plans will offer MH/SUD benefits at meaningful parity with medical/surgical benefits.

We recognize that the scope of these regulations is not to address gaps in parity regulations, but we think that the Department has an obligation, as part of its Congressional mandate under MHPAEA and the ACA, to implement MH/SUD parity to the fullest extent possible within state exchanges and the EHB.

Strong consumer protections must also be included in the final rule in order to address historical discrimination by health plans against individuals with mental health and addictive disorders. MHPAEA was intended to end this discrimination, but in the absence of full implementation and enforcement of the law, discrimination has still continued. For example, plans continue to medically manage and limit the scope of benefits more stringently for MH/SUD benefits than for medical benefits.

RECOMMENDATIONS

I. **EHB-Benchmark Plan Supplementation**. HHS should ensure that all EHB-benchmark plans meet federal parity requirements and provide adequate mental health and substance use disorder services for all persons who depend on coverage through state exchanges. In particular, we request that the Department: (a) include a requirement that all EHB-benchmark plans must meet federal parity standards; (b) clarify that states can supplement insufficient base-benchmark plans that do not meet parity or other requirements; and (c) modify the supplementation methodology to include supplementation for sub-components of EHB categories.

a. ***EHB-Benchmark Plans: Include Requirement that All EHB-Benchmark Plans Must Meet Federal Parity Standards.*** [§156.110]

The proposed rule references the parity standards set forth in §146.136 (implementing the requirements under the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)) only with respect to health plans offering EHB under §156.115, not with respect to the standards for the EHB-benchmark plan itself. We recognize that many decisions impacting parity in EHB plans will happen at the plan level –therefore we think it is imperative to emphasize parity within §156.115 – we believe it is equally important that the base-benchmark plan itself meet parity standards and that the rule under §156.110 similarly reflect parity requirements.

We urge HHS to include an additional provision under §156.110: *General Requirements. An EHB-benchmark plan must meet the following standards:*

...

(g) *With respect to the mental health and substance use disorder services, including behavioral health treatment services, required under §156.110(a)(5) of this subpart, provide coverage that complies with the requirements of §146.136 of this subchapter.*

We note that the proposed rule requires the base-benchmark plan to meet non-discrimination and balance standards, but these are not the same as meeting parity. An added parity requirement here will ensure that the base-benchmark plan – to which all EHB offerings must be substantially equal – meets all legal requirements of MHPAEA.

b. ***EHB-Benchmark Plan Supplementation: Statement Clarifying that States Can Supplement Insufficient EHB-Benchmark Plans that do not meet Parity or Other Requirements.*** [§156.110(b)-(c)]

The proposed rule states that if an EHB-benchmark plan does not provide any coverage in one or more of the 10 statutory categories, it *must be* supplemented by adding that particular category in its entirety from another base-benchmark plan option. This rule implies that if there is at least *some* coverage under a particular category – even if very weak – then the EHB-benchmark plan could meet the EHB requirements without further supplementation.

We assume that if a base-benchmark plan included only a single item or service in a particular category, then it would not meet the requirements for an EHB benchmark plan; at minimum, the balance standard is not met. However, the proposed rule does not describe how a state could supplement its EHB-benchmark plan to provide a more complete set of services in a category that is significantly lacking and/or that is not in compliance with parity. MHPAEA sets forth six classifications of benefits that, if provided under the medical benefit, must also be provided under the MH/SUD benefit. What power does a state have to supplement their EHB-benchmark plan when state officials are aware of inadequacies that could cause the plan to fail other requirements of the rule? For example, a number of states have indicated their concern that their EHB-benchmark plans do not contain sufficient coverage for mental health or substance use disorder services to satisfy parity and other EHB requirements. The rule is not clear as to whether these states may supplement EHB-benchmark plans in the face of clear knowledge of plans that do not meet parity requirements.

Furthermore, assuming that states may supplement deficient categories when setting their base-benchmark plan, the rules do not make clear whether supplementing categories to bring them into compliance with parity would be considered a “state mandate,” leaving states financially obligated.

We urge HHS to encourage states to supplement their base-benchmark plan to comply with parity, non-discrimination, and the other requirements of the law. In addition, we ask HHS to explicitly clarify that supplementing the state’s EHB for these reasons is not considered “additional required benefits” under §155.170(a) of the rule, and will not impact state funding requirements.

We urge HHS to include additional provisions under §156.110(b) as follows:

- ...
- (4) *Supplementing EHB-Benchmark Plans that do not meet Parity, Non-Discrimination and Balance Requirements:*
- (i) *If the state determines that an EHB-benchmark plan does not meet the requirements of mental health and substance use disorder parity under §146.136 of this subchapter, the state must supplement the base-benchmark plan to meet parity requirements, including the six classifications of benefits rule.*
 - (ii) *If the state determines that an EHB-benchmark plan does not meet the requirements of non-discrimination as defined in §156.125 of this subpart, the state must supplement the base-benchmark plan to meet non-discrimination requirements.*
 - (iii) *If the state determines that an EHB-benchmark plan does not meet the requirement that an EHB have an appropriate balance among the EHB categories, in accordance with Section 1302(b)(4)(A) of the Affordable Care Act, the state must supplement the base-benchmark plan to meet balance requirements.*
 - (iv) *Any benefits supplemented to meet the provisions of §156.110(b)(4)(i)-(iii) of this subpart will not be considered “additional required benefits”*

under §155.170(a) of this subpart. A state is not required to make payments under §155.170(b) of this subpart to defray the cost of any benefits supplemented to meet the provisions of §156.110(b)(4)(i)-(iii) of this subpart.

In addition, we ask that HHS issue a similar requirement for the supplementation for the federal default base-benchmark plan under §156.110(c). The addition of these provisions will encourage states to set a strong base-benchmark plan – to which all EHB offerings must be substantially equal – that meets all legal requirements of MHPAEA and other required provisions of the law.

c. EHB-Benchmark Plan Supplementation: Modify Supplementation Methodology to Include Supplementation for Statutorily-Required Sub-Components of EHB Categories. [§156.110(b)-(c)]

Several of the 10 statutory EHB categories include two or more sub-components. For example, the category of “*maternity and newborn care*” under §156.110(a)(4) includes two components: (1) *maternity care*; and (2) *newborn care*. As Congress was careful to include both of the terms “maternity” and “newborn” under this statutory category, we believe that every EHB benchmark plan must include coverage under both of these sub-components. This also applies to mental health and substance use disorder services including MH/SUD treatment.

The proposed supplementation methodology implies that so long as there is at least *some* coverage under a particular category – even if that coverage is provided in one sub-component of an EHB category but not in other sub-components – then the base-benchmark plan could meet the EHB requirements without further supplementation. States should be required to supplement for each sub-component of an EHB category. We note that all EHB-benchmark plans are ultimately required to meet standards for non-discrimination and balance (we discuss elsewhere in these comments how to strengthen these definitions). However, we are concerned that the subjective concepts of “non-discrimination” and “balance” can only go so far to ensure that the EHB-benchmark plan is adequate to meet the needs of persons who depend on coverage through state exchanges.

What happens when an EHB-benchmark plan design does not raise balance or discrimination concerns, but the benefits in a particular category do not meet all sub-components? For example, if a plan includes robust preventive/wellness services, but no chronic disease management services, is that plan providing coverage sufficient to meet all of the components of the “*preventive and wellness services and chronic disease management*” benefit category of the EHB? By providing robust preventive/wellness services, this plan might be considered in “balance” with other categories” (i.e. “*not unduly weighted toward any category*”), and yet, the plan does not cover an entire sub-component of one of the EHB categories as described by the statute. Assuming the plan otherwise offers benefits in a non-discriminatory fashion, then the proposed rule would not require this plan to supplement from another base-benchmark plan option that includes chronic disease management services. In this scenario, consumers are left with an unsatisfactory benchmark for this category, with their only recourse being the possibility that individual plans will substitute benefits to include these missing services.

This hypothetical concern is very real within the “*mental health and substance use disorder services, including behavioral health treatment*” category. Reportedly, some states have already inquired with HHS whether they must cover both mental health *and* substance use disorder and behavioral health treatment services within their benchmark, or if the provision of mental health services alone is sufficient to meet this category of the EHB.

We believe that a base-benchmark plan cannot meet the statutory definition for an EHB-benchmark plan if it does not provide items and services for *every* sub-component of the statute’s listed categories. We believe supplementation should be required when an EHB-benchmark plan offers only mental health services, but not substance use disorder services, or vice versa. Likewise, if a plan offers newborn care, but not maternity, or rehabilitation without habilitation, supplementation should be required.

Modifying the supplementation methodology to provide for supplementation when sub-categories are insufficient would be easy for states to administer and for HHS to oversee. Furthermore, this interpretation ensures that items and services which may be at risk of being left out of the benchmark – such as substance use disorder services or habilitative services – will be included in base-benchmark plans in accordance with the expressed intent of the statutory language. We urge HHS to add the following language (written below in bold) to the supplementation methodologies in §156.110(b) and (c) to address this issue:

§156.110(b)(1): General supplementation methodology. A base-benchmark plan that does not include items or services within one or more of the categories – or sub-component thereof – described in paragraph (a) of this section must be supplemented by the addition of the entire category – or sub-component thereof – of such benefits offered under any other benchmark plan option...

§156.110(c): Supplementing the default base-benchmark plan. A default base-benchmark plan as defined in §156.100(c) of this subpart that lacks any categories of essential health benefits – or sub-component thereof – will be supplemented by HHS in the following order...

II. Benefit Substitution. The Department should ensure that health plans offering EHB cannot substitute benefits to avoid higher-risk enrollees or undermine coverage for particular services. Therefore, we urge HHS to (a) prevent benefit substitution within EHB categories. However, if the Department continues to allow within-category benefit substitution, we urge HHS to: (b) limit substitutions to the sub-components of the EHB categories, rather than allowing substitutions within the entire benefit category; (c) extend the requirement of “balance” to within-category balance in addition to balance across the spectrum of the 10 EHB categories; (d) ensure that all substitutions within each individual EHB category meet the requirements of parity law; and (e) clarify that plans offering EHB may never substitute any state mandated benefits.

a. HHS Should not Allow Benefit Substitution within EHB Categories [§156.115(b)]

The proposed rule states that the issuer of a plan offering EHB may only substitute benefits *within* EHB categories, not *across* different categories. In general, we applaud the proposed rule's approach to prevent substitution across categories. We believe this approach will help reinforce the goals of parity laws, ensuring that plans may not reduce benefits from the "*mental health and substance use disorder services, including behavioral health treatment*" category and replace them with benefits elsewhere.

However, we do have concerns about substitution *within* categories. In particular, we are deeply concerned that plans could use within-category substitution flexibility to avoid higher-risk enrollees or undermine coverage for particular services. Permitting insurance carriers to deviate from the benchmark benefits chosen by the state, as the rules propose, would significantly weaken the EHB as envisioned by the ACA. The EHB standard is intended to ensure a consistent, minimum level of benefits across all non-grandfathered, fully-insured plans in the individual and small group insurance markets to prevent insurers from adopting benefit designs intended to attract healthier people and deter enrollment by those in poorer health. The proposal for substitution within categories would undermine these goals.

We are concerned that some insurers would exercise this within-category substitution flexibility to impose problematic benefit restrictions – such as restrictions on the number of visits for a particular service – that would shift costs to individuals with significant health care needs. Because the ACA prevents insurers from rejecting high-cost enrollees or charging more for individuals with pre-existing conditions, insurers may be more likely to make benefit substitutions that include significant service limitations or adopt other methods to reduce their exposure to expensive health claims. Although the proposed rule states that benefit substitutions have to be actuarially-equivalent, Coalition members are concerned that discrimination in MH/SUD coverage may persist since that the actuarial value calculation under §156.135 does not take service/visit limitations into account, only dollar amounts.

This year, the Parity Implementation Coalition, joined former Congressmen Patrick Kennedy and Jim Ramstad in hosting a series of field hearings on the implementation of MHPAEA across the country. At the field hearings, patients, physicians and other providers testified that while discriminatory quantitative limits such as higher co-pays and visit limits have been largely eliminated, patients are still finding discriminatory barriers to their addiction and mental health benefits. Just some of these examples include:

- A patient from Virginia testified about his plan requiring that he “fail first” at outpatient treatment before the plan would pay for inpatient addiction treatment. The plan did not have a similar requirement on its medical/surgical benefits.
- A physician from California testified about the barriers he and his colleagues encounter. He stated, “There are a seemingly endless number of obstacles that insurers utilize to evade providing mental health and substance use services. Roadblocks we face include vague medical necessity standards, lengthy approval processes that result in attrition, bureaucratic stonewalling of service requests, appeals processes that require an advanced degree to navigate and so on. I encounter these obstacles every day in my work.”

Finally, HHS' proposed approach creates an added level of uncertainty for consumers. If insurers can substantially vary the details of the benefits they cover from a state's chosen benchmark benefits standard, consumers will have a difficult time making an "apples-to-apples" comparison of plan options to make an informed decision about coverage.

For the above reasons, we urge HHS to establish final regulations that prohibit within-category benefit substitution and require insurers to adhere to the standards of the EHB-benchmark plan set in every state.

b. Benefit Substitution: If Within-Category Benefit Substitution is Allowed, then HHS Must Limit Substitutions to Sub-Components of EHB Categories, Rather than Substitutions Within the Entire Benefit Category [§156.115(b)]

If within-category substitution is to be allowed, we urge HHS to develop careful standards for substitution. We think an appropriate substitution approach should take into account the various sub-components of a given EHB category (similar to our recommendation that the "supplementation" provisions under §156.110 include sub-components of EHB categories). The substitution rule as proposed prevents plans from making substitutions across categories, but it does not prevent plans from making substitutions across *sub-components* of categories. For example, the rules, as proposed, could enable plans to design benefit packages that favor mental health services to the detriment of substance use disorder services without necessarily running afoul of the "balance" and "non-discrimination" requirements. Moreover, some state parity laws cover mental health conditions and exclude substance use disorders. If the largest small employer plan in a state is selected as the benchmark plan, substance use or mental health conditions could be excluded based on state law exclusions.

A final rule must clarify that substitution can only occur within each distinct sub-component of an EHB category, rather than within the entire benefit category. Under this approach, a plan could, for example, make actuarially-equivalent substitutions within the array of mental health services offered by the base-benchmark plan, but it could not remove a substance use disorder item or service found in the benchmark by substituting with a mental health item or service. Likewise, a plan could make substitutions within "maternity care" or within "newborn care" but could not remove a newborn care service and substitute with a maternity care service, as these are distinct components of the "*maternity and newborn care*" statutory category.

Under this approach, insurers still have sufficient flexibility for plan innovation, but consumers are guaranteed to have a meaningful level of coverage within each sub-component of an EHB category. In addition, if all plans have to offer the same distribution of benefits as found in the sub-components of the EHB-benchmark plan, it will be much easier for consumers to compare the features of different plan options and make informed decisions about coverage.

Modifying the substitution methodology in this fashion would be easy for plans to administer and for states to oversee. Furthermore, this interpretation ensures that items and services which may be at risk of being left out of plan offerings – such as substance use disorder services – will be included in accordance with the expressed intent of the statutory language. We urge HHS to

add the following language (written below in bold) to the benefit substitution methodologies in §156.115(b) to address this issue:

§156.115(b)(1)(ii): Benefit substitution is allowed if the issuer of a plan offering EHB...substitutes a benefit that meets the following conditions:

(ii) Is made only within the same essential health benefit category. If the benefit category contains one or more sub-components, benefit substitution is only allowed within that sub-component, not across the entire benefit category.

c. Benefit Substitution: If Within-Category Benefit Substitution is Allowed, then HHS Must Extend the Requirement of “Balance” to Within-Category Balance [§156.110(e)]

The proposed rule codifies the statute, requiring that all EHB plans have “an appropriate balance among the EHB categories to ensure that benefits are not unduly weighted toward any category.” If plans providing EHB are allowed to substitute within EHB categories – which is not contemplated by the statute – then it is appropriate for HHS to extend the “balance” requirement to require balance *within* each category, in addition to balance across the spectrum of the 10 EHB categories. Under this approach, benefits within a category could not be unduly weighted toward one service or condition. A *within-category* balance requirement would provide an important check on insurers who would elect to use substitution in a manner so as to avoid higher-risk enrollees or undermine coverage for particular services. In the context of substance use disorder benefits, for example, plans could not meet the within-category balance requirement if they substitute items and services in favor of certain types of conditions, for example, treatment for alcohol dependency over other forms of addiction.

We urge HHS to modify the requirement of balance under §156.110(e) to extend the balance requirements within EHB benefit categories.

d. Benefit Substitution: If Within-Category Benefit Substitution is Allowed, then HHS Must Ensure All Substitutions Within Categories that Contain Mental Health and Substance Use Disorder Services are Made in Compliance with Federal Parity Law [§156.115(b)]

Although the EHB contains a specific category for “*mental health and substance use disorder services, including behavioral health treatment,*” not every service important to persons with mental health or addiction will be contained within this category. For example, the emergency services, hospitalization, ambulatory patient services, and preventive/wellness services categories may all contain important benefits for the prevention, diagnosis, treatment and management of mental health and substance use disorders. We are concerned that substitutions within these other categories may undermine mental health and addiction treatment in favor of other illnesses. Similar to the treatment of other chronic conditions, individuals with MH/SUD receive services in a variety of settings such as preventive screenings for depression and alcohol and drug use, psychiatric crisis stabilization in an emergency department and medication assisted treatment in ambulatory settings.

We recognize that HHS has tried to mitigate these concerns by including a requirement, under §156.115(a)(2), that plans providing EHB meet the requirements of MHPAEA. The preamble also makes mention of the importance of parity in EHB coverage. However, the rule needs to be stronger to effectively address the goals of parity. We do not believe it is sufficient to do an assessment of parity looking at the overall plan offering. Rather, we think it is appropriate to conduct an assessment of parity within *each individual* benefit category. Not only is this consistent with the goals of federal parity law – MHPAEA and the interim final regulations require parity across classifications of benefits *and within* classifications of benefits – but this requirement would ensure that no matter how items and services important to mental health and addiction are categorized, the benefits are offered with parity.

Therefore, we urge HHS to include a provision under §156.115(b) to require plans offering EHB to assess: (i) whether each individual benefit category meets the requirements of parity; and (ii) whether proposed benefit substitutions will interfere with parity obligations. This requirement would serve to educate and remind plan issuers that parity is not the same as balance: parity is not met by simply having a balanced number of benefits in the “*mental health and substance use disorder services, including behavioral health treatment*” category. Rather, parity is met when the plan provides a similar range of benefits to those provided for medical/surgical benefits within *each* benefit category.

We strongly urge HHS to develop strong parity guidelines for benefit substitutions because we are concerned that, in all likelihood, there will not be adequate development of such guidelines to assess parity within each plan offered on the exchange. Strong parity language here would go great lengths to ensure that plans pay attention to parity with any benefit substitution decisions they make.

e. Benefit Substitution: If Within-Category Benefit Substitution is Allowed, then HHS Must Clarify that EHB Plans May Not Substitute Any State Mandated Benefits [§156.115(b) and §155.170]

The proposed rule outlines the process for inclusion of state mandated benefits within the EHB. Under the rule, states may require QHPs to offer benefits “in addition” to the EHB package. Any state mandate enacted on or before December 31, 2011 will be considered part of EHB, and states will not have to incur additional costs for their coverage. However, for any state-required benefits enacted after December 31, 2011, the state must make payments to defray the cost, either directly to the individual enrollee or to the QHP issuer.

In general we applaud this provision in the proposed rule. Until HHS fully implements the parity law, it is important that current state mandates are kept at the type, level and duration as currently required in the states. As of 2011, there are several types of state mandates in place related to mental health and substance use disorders:

- 34 states mandate coverage for drug abuse treatment, requiring plans to provide for the evaluation, education and treatment of those dependent on both legal and illegal drugs;
- 3 states have passed a residential crisis service mandate, requiring payment for short-term, intensive mental health and support services in a community-based, non-hospital, residential setting rendered by a licensed provider;

- 7 states mandate coverage for a drug abuse counselor that can help patients identify behaviors and problems related to their addiction(s); and
- 10 states have in place a requirement that plans cover anti-psychotic drugs (to treat conditions such as schizophrenia).

This list is illustrative, but not exhaustive, of the types of benefit mandates currently in place to assist persons with mental health and addiction problems. Patients in these states depend on these benefits, and we thank HHS for assuring that these benefits are included within the EHB.

While we assume that all state-mandated benefits are *required* to be part of every EHB plan, and that these benefits cannot be substituted (as they are mandated by state laws), the rule does not explicitly state this requirement. Furthermore, the rules should anticipate that at least some states will augment their state mandated benefits after December 31, 2011. If a state determines a particular benefit is so important that it would elect to defray the cost of that benefit to individual enrollees and/or insurers, then a plan may not override that state decision through substitution.

Therefore, we ask HHS to include a provision under §156.115(b) clarifying that plans offering EHB may not substitute any state mandated benefits, even if the state has required these benefits after December 31, 2011.

III. Cost-Sharing & Network Adequacy. The Department should ensure that patients do not become unfairly fiscally burdened when health plans offering EHB do not have adequate provider networks. We urge HHS to: (a) allow certain out-of-network costs to count toward annual cost-sharing and deductible limits; and (b) establish an out-of-pocket maximum for these specified out-of-network costs. Finally, we urge HHS to: (c) finalize its rule on cost-sharing in emergency department settings and extend this requirement to all emergency services.

a. HHS Should Allow Certain Out-Of-Network Cost-Sharing to Count Toward Annual Cost-Sharing and Deductible Limits [§156.130(c)]

When plan enrollees access services out-of-network, the proposed rule states that any cost-sharing paid in connection to these out-of-network services *does not* count towards annual cost-sharing and deductible limits. We believe this rule unfairly penalizes individuals who have no choice but to seek services from out-of-network providers.

Out-of-network provider utilization is especially prevalent in the context of mental health and addiction services, as many regions simply do not have enough providers to treat these conditions. According to a June 2012 report by the National Center on Addiction and Substance Abuse (CASA) at Columbia University, of the 985,375 practicing physicians in the United States, only about 1,200 are trained in addiction medicine.⁶ There are also significant shortages in providers who are trained to address child and adolescent mental health: there are currently fewer than 7,000 child and adolescent psychiatrists practicing in the whole United States, yet there is a need for almost 30,000.⁷

Due to these serious provider shortages, persons seeking care for mental health and substance use disorder services may not have access to providers who can address their health needs. Here, it is not just a matter of patient preference to seek care out-of-network -- too often, the network just does not have contracts with an adequate level of mental health and addiction providers. The shortage of mental health and addiction providers may be particularly acute in certain states and for certain conditions. Consider the case of Connecticut, where there is not one eating disorder treatment facility in the whole state. As a result, it is unclear whether insurance issuers in Connecticut will have contractual arrangements with any eating disorder facilities; consequently, persons seeking such care will not have a choice but to receive care from non-network providers, and will be obligated to these costs.

We note that HHS has previously issued final regulations establishing minimum criteria for network adequacy in order for plans to be offered on the exchange, requiring that qualified health plans' networks must maintain a sufficient number and type of health professionals, including those specializing in mental health and substance use, "to assure that all services will be available without unreasonable delay." We support strict oversight of this network adequacy requirement.

In conjunction with that requirement, however, we believe it is crucial to include out-of-network costs under cost-sharing and deductible limits when plans are falling short of network adequacy requirements with regard to services that a particular patient needs. In particular, if an EHB network offers poor network coverage for mental health and addiction treatment, consumers will need to seek care out-of-network. **Certain out-of-network cost-sharing paid by, or on behalf of, the patient should count toward the annual limits on cost-sharing (§156.130(a)) and annual limitation on deductibles (§156.130(b)).**

We ask HHS to waive the rule under §156.130(c) under the following circumstances:

- (1) If a patient obtains out-of-network care with their plan's express permission, then these services should be treated as "in-network" expenses for the purposes of §156.130, counting toward annual cost-sharing and deductible limits. This approach is only fair: if the plan has determined its own network to have particular provider or service insufficiencies such that the plan would give permission to an enrollee to seek non-network services, then the enrollee should not be penalized under §156.130.
- (2) The final network adequacy standards set in March 2012 state that networks must maintain a sufficient number and type of health professionals to assure that all services will be "*available*" without unreasonable delay. If a patient must travel more than 50 miles to find in-network services for their treatment needs, then these services should not be considered "available" under the rules. We urge HHS to modify the cost-sharing rules so that plans do not penalize enrollees for seeking non-network care closer to their homes. Accordingly, we propose that HHS modify the rules to waive §156.130(c) when services are not available within 50 miles, and allow cost-sharing related to these services to count toward annual cost-sharing and deductible limits.

(3) Finally, if behavioral health network adequacy is poor relative to medical/surgical network adequacy, then this raises an issue of parity under MHPAEA. If plan networks violate parity law and plan enrollees have to seek services out-of-network, then cost-sharing for these services should not fall under §156.130(c).

b. If HHS will Not Allow Out-Of-Network Cost-Sharing to Count Toward Annual Limits, Then the Final Rule Must Establish a Maximum Out-of-Pocket Expenditure for Persons with Mental Health and Substance Use Disorders [§156.130(c)]

Out of pocket maximum expenditures often range between \$2,000 and \$3,000. Because of the historical lack of access to MH/SUD coverage, we believe HHS should establish a \$2,000 maximum cap if out-of-network cost-sharing will not be counted towards annual limits.

c. HHS Should Finalize its Rule on Cost-Sharing and Emergency Department Services and Extend this Requirement to All Emergency Services [§156.130(h)]

When an enrollee visits an out-of-network emergency department, the proposed rule prohibits plans from imposing any prior authorization or limitations on coverage that are more restrictive than conditions that apply to in-network emergency departments. In addition, if an enrollee seeks emergency department services out-of-network, the proposed rule states that cost-sharing cannot exceed the cost-sharing that would be imposed if the services were provided in-network, in accordance with the limitations under §147.138(b)(3). We applaud this rule generally and ask HHS to finalize this provision.

However, we urge HHS to consider that not all “emergency services” take place in the emergency department. In the context of mental health and substance use disorders, services such as crisis stabilization units at mental health and addiction medically managed residential settings and admission into a psychiatric hospital take place out of the emergency department. Accordingly, we ask HHS to extend this requirement to all emergency services.

IV. Prescription Drugs

The rule requires health plans offering EHB to cover at least the greater of: (1) one drug in every USP therapeutic category and class; or (2) the same number of prescription drugs in each USP category and class in the state’s EHB benchmark plan. Health plans are required to submit the drug list to the Exchange, the state or OPM. The rule requires that a health plan providing essential health benefits have procedures in place that allow an enrollee to request clinically appropriate drugs not covered by the health plan.

The preamble discusses a number of issues related to this requirement:

- a. HHS is considering using the most recent version of the United States Pharmacopeia’s (USP) classification system as a common organizational tool for plans to report drug coverage because it is publicly available, widely used, and comprehensive.

- b. Each EHB plan would be able to cover different drugs than are covered by the EHB-benchmark plan, but those drugs must be presented using the USP classification system. An EHB plan would be able to cover any drugs subject to meeting the minimum number per category and class.
- c. HHS also proposes that drugs listed must be chemically distinct. For example, offering two dosage forms or strengths of the same drug would not be offering drugs that are chemically distinct. Offering a brand name drug and its generic equivalent is another example of drugs that are not chemically distinct.
- d. HHS encourages states to monitor and identify discriminatory benefit designs, or the implementation thereof and to test for such discriminatory prescription drug benefit designs. HHS will use information on complaints and appeals and data on drug lists to refine its review.

Our comments below relate to these issues:

a. HHS Should Include the Medicare Part D Prescription Drug Benefit Protected Classes

The rule proposes that health plans offering EHB cover at least the greater of: (1) one drug in every USP therapeutic category and class; or (2) the same number of prescription drugs in each USP category and class as the state's EHB benchmark plan. We believe the proposed standard is inadequate. The Medicare Part D "all or substantially all" FDA approved prescription medications standard for certain protected classes of drugs should be added to the proposed standard.

The Medicare Part D drug benefit was carefully crafted as part of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). The MMA and subsequent CMS regulation and guidance provide several parameters for the development of the Part D formulary, including: 1) formularies must include drug categories and classes that cover all disease states; 2) each category or class must include at least two drugs (with exceptions); and 3) formularies must include all or substantially all drugs in the immunosuppressant, antidepressant, antipsychotic, anticonvulsant, antiretroviral, and antineoplastic classes. As of 2013, Medicare prescription drug plans (MA-PDs and PDPs) are also required to cover benzodiazepines (including Xanax, Valium and other drugs often used for anxiety and insomnia) and barbiturates, when prescribed for treating epilepsy, cancer or a mental disorder.

We are very concerned that HHS does not intend to include the Part D protected classes of drugs in the EHB. The proposed policy ignores the clinical needs of vulnerable people who will be receiving EHB. Adopting the Part D protected classes of drugs is essential to ensuring that patients will not be placed at risk of inappropriate restrictions or interruptions in therapy. Importantly, the policy is a critical safeguard to prevent discrimination based on health status. These anti-discrimination health principles are a crucial aspect of the Department's statutory responsibilities both under Part D and in defining the EHB. We believe that individuals with serious health conditions who participate in the Exchanges should have the same access and protections as those who participate in Medicare Part D. Replicating the "all or substantially all" policy in the Exchanges for the six classes of clinical conditions will help to manage the

symptoms of patients with serious health conditions and ensure that individuals covered by Exchange plans will have meaningful coverage and appropriate access to available therapies.

b. HHS Should Include all FDA Approved Medications for Addiction

We also recommend the Department ensure individuals have access to the full continuum of FDA-approved addiction pharmacotherapies, at parity with the spectrum of available medical/surgical pharmacotherapies. Like other chronic diseases such as diabetes and hypertension, medical management of opioid, alcohol and tobacco addiction may include medications that are taken for varying periods, including prolonged periods. All FDA-approved medications for the treatment of opioid, alcohol and nicotine dependence and for the treatment of withdrawal should be specifically covered.

Access to medications to treat opioid addiction is particularly important in light of the prescription drug abuse epidemic in the U.S, which the Centers for Disease Control and Prevention (CDC) has called, “the fastest growing drug problem in the United States.” Patients must have access to available pharmacotherapies as part of a robust EHB.

c. The Prescription Drug Policy Should Not Limit the Range of Therapies Available

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. As a result, plans could avoid certain drugs with therapeutic advantages for some patients.

In addition, nothing in the rule would prevent a plan from choosing *only generic* drugs in a class and may greatly limit the range of therapies available to some patients. A generic form of a drug may not work exactly the same as a brand name drug for a particular patient. Patients may react differently to generic drugs than they do to brand name drugs or experience different side effects with each. Sometimes generic substitution may not be appropriate. For example, some available generic versions may not be bioequivalent to the trade-name drug. In cases in which small differences in the amount of drug in the bloodstream can make a very large difference in the drug's effectiveness, generic drugs are often not substituted. In the case of antipsychotic drugs, for example, chlorpromazine tablets in the generic form are not bioequivalent to the brand drug.

The standard for prescription drug coverage should not be about quantity. Instead, a comprehensive standard based on quality should be developed and used.

d. The Prescription Drug Policy Should Allow for Combination Therapies

The proposed policy should make clear that combination therapy will be allowed under the EHB's prescription drug policy. Combination therapy, the simultaneous administration of two or more medications to treat a single disease, plays an important role in some patients' treatment and may not fall into any of the USP categories. Combination therapy may be achieved by giving separate drugs, or, where available, by giving combination drugs, which are dosage forms that contain more than one active ingredient. Combining medications, particularly those with different mechanisms of action, offers the possibility of more effective treatments for patients

who do not respond adequately to individual agents. For example, combination therapy may be particularly useful for persons trying to quit smoking who are still experiencing withdrawal symptoms while using one form of Nicotine Replacement Therapy. These individuals may benefit from using both a nicotine patch and an oral nicotine replacement product, such as gum.

While the proposed rule uses USP for prescription drug coverage, it is unclear how combination therapies will be addressed. We urge HHS to apply the same exception that Medicare does for combination therapies. The Medicare Manual states: *Commercially available combination prescription drug products that contain at least one Part D drug component are Part D drugs when used for a “medically-accepted” indication, unless CMS makes the determination that such product, as a whole, belongs in one of the categories of drugs excluded from coverage under Part D. If CMS has not provided guidance to exclude a specific combination product, such combination product, so long as it contains at least one Part D drug component, should be considered a Part D drug (unless it is excluded from coverage under Part D for another reason).*⁸

e. Clarify that Physician-administered Drugs Will be Covered in EHB

Medicare Part B drugs that are physician-administered are NOT included in USP. As a result, it is unclear whether and how they would be included in the benchmark plans. For example, Vivitrol is a once per month shot administered by a physician. The drug shows promise for weaning some people addicted to heroin and other opiates. Studies show that the drug blocks the effect of opiates on brain cells, reducing relapse and stopping narcotic cravings.⁹ It has been demonstrated to reduce the costs of alcohol-related hospitalizations and other associated medical costs.¹⁰ There is also a new implantable form of buprenorphine, called Probuphine. The implant delivers a constant dose of the drug for six months, eliminating the need for a daily pill that can often be an obstacle in preventing relapse.¹¹ This drug is also physician-administered. These physician-administered drugs and others like them are critical for patients with mental health and substance use disorders.

V. Non-discrimination

The ACA requires the Secretary, under Section 1302(b)(4), 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 mental health and substance use disorders and others with chronic illnesses and disabilities. We appreciate that §156.110(d) of the proposed rule codifies the statute’s requirement, and prevents EHB benchmark plans from including discriminatory benefit designs. Furthermore, we applaud that §156.125 extends non-discrimination requirements to all issuers of EHB.

However, we are deeply troubled by a statement made by the Department in the preamble to this proposed rule: ***“While we believe that it is unlikely that an EHB-benchmark plan will include discriminatory benefit offerings, this section proposes that any EHB-benchmark plan that does include discriminatory benefit designs must be adjusted to eliminate such discrimination in benefit design.”*** The notion that benchmark plans will not include discriminatory benefit

offerings is entirely false. In reality, there is a long, well-documented history of insurance discrimination against those with mental health and substance use disorders. For example, major insurance carriers frequently set the following discriminatory restrictions on plan enrollees:

- Requirement that persons with mental health or addiction have to “fail first” at certain interventions before qualifying for higher level of treatment. “Fail-first policies” may require that a person with mental illness take an older, less effective medication. Only after failing on that drug, which might trigger a serious relapse, may that person be approved for a newer, more expensive – but more effective – medication.
- Requirement of prior authorization for outpatient MH/SUD services. According to a February 2012 report by the RAND Corporation and commissioned by ASPE, requiring prior authorization for mental health and addiction treatment is “*not clinically appropriate, as this may unnecessarily delay clinically appropriate services, and inhibit access to appropriate clinical services.*”¹²
- Limiting coverage for mental health conditions that cannot be “cured.”
- Only covering facilities in the state where the carrier is headquartered.

These types of discriminatory insurance practices were, in part, the impetus for the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008. Federal parity laws are intended to address such discrimination, but in the absence of full MHPAEA implementation and enforcement of the law, discrimination has continued. Even in what little information HHS has provided to consumers about state base-benchmark plans, discrimination is evident. For example, 14 base-benchmark plans *specifically exclude* substance use disorder treatment in residential (non-hospital) inpatient settings despite offering these levels of care for other medical conditions. Residential treatment is indicated primarily for individuals who do not meet clinical criteria for hospitalization but who do not have substance-free social supports to remain abstinent in an ambulatory setting. For these individuals, residential facilities – which offer therapy, medication management, case management, and continuing care services to assist with transition back to the community – provide a safe and substance-free environment in which residents learn skills to help cope with addiction. Residential treatment programs are evidence-based and critically important to recovery, and yet persons in need of these services cannot access these services – even if medically necessary – in 28 percent of state base-benchmark plans.

To help with placement of patients in the right level of care, 29 states require the use of the American Society of Addiction Medicine’s *Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders*. The Coalition believes widespread use of this criteria would help with non-discriminatory access to care for addiction treatment.

Excluding an entire treatment option for persons with substance use disorders is discriminatory when a comparable level of care is offered for other medical/surgical benefits. The 2011 Institute of Medicine report on the essential benefits clarifies that Congress intended “*to ensure that insurers do not make arbitrary and discriminatory decisions based on certain characteristics of people rather than assessing the individuality of each case when making medical necessity decisions and applying clinical policies.*”¹³ Therefore, plans offering EHB must provide coverage for essential benefits without discrimination, ensuring that all individuals have full access to the services under EHB categories, regardless of their diagnosis or condition. If

residential treatment is medically necessary for a particular individual, and if that individual is entitled to EHB coverage (which includes the mental health and substance use disorder services, including MH/SUD treatment category), then that individual must have the opportunity to seek residential treatment. Plans that *exclude* residential treatment even when these services are medically necessary are discriminating against a person with a substance use disorder, in violation of the statute.

Providing non-discriminatory access to services also means that payment rates may not be arbitrarily low for behavioral health providers than other medical providers in a plan's network. The MHPAEA IFR provides that, "standards for provider admission to participate in a network, including reimbursement rates" are a form of a non-quantitative treatment limit that must not be applied more stringently on the behavioral health benefit versus medical providers.

Since HHS has not made available sufficient information on state base-benchmark plans, it is impossible to fully assess discriminatory practices within base-benchmark plans. However, in the limited information provided, we also find discriminatory practices. For example, some plans exclude methadone coverage (opioid addiction treatment) and others place limits and more stringently manage residential mental health and addiction treatment than comparable medical/surgical benefits covered by the plan. We are fearful that the many discriminatory benefits, treatment limitations and cost-sharing practices that are predominant in health plans today will persist in the selected base-benchmark plans, persisting in EHB plan offerings nationwide as a consequence.

These types of discriminatory insurance practices are a significant barrier for many vulnerable individuals in need of mental health and substance use disorder services. We think these EHB regulations are an important opportunity to transparently address discrimination as plans work to design benefits that comply with federal parity laws, and as states devise effective ways to enforce parity regulations.

Given this long history of insurance benefit discrimination in the context of mental health and addiction, we urge HHS to set specific guidelines for discrimination:

- (1) The proposed rule does not identify a standard for plans to follow to determine that their benefit design or implementation is discriminatory. We strongly urge HHS to clearly identify a non-discrimination standard, and provide several examples of what would constitute violations. For example, HHS might set the following standards describing discrimination:
 - Offering limited coverage within an EHB category is discriminatory
 - Making specific coverage exclusions without regard to generally accepted medical necessity is discriminatory
 - Offering a full array medical benefits and limited MH/SUD benefits is discriminatory
 - Requiring qualified health plans to be transparent regarding the terms and conditions of the plan on both medical and behavioral benefits

- (2) There are no guidelines or criteria for plans to establish a process to bring discriminatory benefit design or implementation into compliance with the law. HHS must describe a detailed process and timeline for federal oversight over state implementation of a non-discrimination standard so that consumers can be assured that discriminatory plans will not find their way into the exchange.
- (3) There proposed rule does not describe the process for enforcement of the non-discrimination standard. We strongly urge the Department to include in the final rule language outlining clear and strong federal enforcement provisions and penalties for violations.

VI. Accreditation of QHP Issuers [§156.275]

Section 1311(c)(1)(D)(i) of ACA directs a health plan to “be accredited with respect to local performance on clinical quality measures...by any entity recognized by the Secretary for the accreditation of health insurance issuers or plans (so long as any such entity has transparent and rigorous methodological and scoring criteria.” Qualified health plans must receive accreditation within a period established by an Exchange.

The proposed rule amends current regulations to allow additional accrediting entities (beyond NCQA and URAC) the opportunity to apply and demonstrate how they will meet the conditions for recognition articulated in ACA. The preamble suggests that HHS intends, through future rulemaking, to establish a phase two recognition process which may establish additional criteria for recognized accrediting entities.

We support this proposed expansion of accrediting bodies but urge HHS to require that the parity requirements contained in URAC’s Version 7 standards for accreditation of health plans be a mandatory minimum standard applied by all accrediting bodies for accreditation purposes. These standards incorporate the federal parity law (MHPAEA) and the regulations (IFR) that govern the statute. Importantly, these standards require that:

- *A plan must conduct a detailed internal audit and analysis of each medical management (non-quantitative) intervention applied to behavioral health treatments to assure that these interventions are “comparable to and no more stringent than those applied to medical treatments. These audits must be overseen by the compliance officer and will be reviewed by URAC.*
- *A plan must assure that any mental health or substance use disorder (MH/SUD) services contractor (e.g., a managed behavioral health organization) is in full compliance with MHPAEA.*
- *A plan is required to document that they have disclosed key aspects of the behavioral health benefit to consumers and employers, such as how compliance with parity is achieved and any restrictions or exclusion on the behavioral health benefit.*
- *The standards define utilization management (UM) protocols as “any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative*

treatment limitation to mental health or substance use disorder benefits” not just medical necessity criteria.

- *In the Network standards, a plan must document that it has provided parity between medical and behavioral health treatment services in certain levels and types of care, such as emergency care, pharmacy and inpatient and outpatient treatment.*
- *URAC will review and audit appeals about health plan decisions and a consumer can make a complaint directly to URAC regarding the actions (or lack thereof) surrounding compliance with parity.*

URAC is the only organization to specifically build compliance with the parity law into its standards for accreditation and makes clear that plans must do an analysis of parity compliance and share that analysis. If plans use NCQA or other accrediting bodies for accreditation, those plans may be less likely to comply with parity. We are concerned about HHS’ capacity to oversee all plans for parity compliance. Setting strong accreditation standards for parity is one way to help assure that plans offer appropriate levels of MH/SUD benefits for consumers.

VII. Transparency & Consumer Engagement: Additional guidance is needed to ensure sufficient transparency of information and stakeholder involvement within the EHB process. To achieve these goals, we ask HHS to: (a) make robust information available on every base-benchmark plan; (b) set transparency requirements for plans offering EHB; and (c) provide guidance to ensure ample stakeholder engagement in the EHB process.

a. HHS Should Make Robust Information Available on Every Base-Benchmark Plan

One of the biggest hurdles for consumers and other stakeholders participating in the EHB process today is that HHS has not made available sufficient information on state base-benchmark plans. With regard to mental health and substance use disorder parity, the state base-benchmark plan information released by the Department does not provide *any* discussion of parity compliance. The information does not provide enough detailed plan information to conduct a parity analysis. As a result, we have not been able to help our stakeholder networks understand whether state base-benchmark plans are currently parity compliant, or if significant supplementation will be necessary to achieve compliance with federal parity law.

The released state base-benchmark plan information also fails to include complete information about benefit exclusions, treatment limitations and financial requirements, and the medical necessity criteria the plan uses to determine which services are covered. In addition, where more complete state base-benchmark plans are publically available (through state offices of health reform), we have found that this information is not consistent with the basic plan information posted on the Department’s website. For example, service exclusions reflected in the plan documents for a number of the base-benchmark plans—but not in the HHS-released data—include exclusions for methadone maintenance therapy, residential addiction treatment, and other necessary services.

Given these significant discrepancies, we strongly urge HHS to require release of detailed information regarding exclusions and non-quantitative treatment limitations all base-benchmark options so that consumers can conduct a meaningful analysis of benefits offered, and thoroughly assess plans for parity compliance. Furthermore, HHS must facilitate this process by providing detailed EHB-benchmark plan information on CCIIO's website and other public forums.

b. HHS Must Set Transparency Requirements for Plans Offering EHB

We urge HHS to set transparency requirements for health plans that offer EHB. We note several areas where the proposed rules do not provide sufficient transparency to consumers:

- Under §156.115(b)(2), when a health plan offering EHB makes a substitution to benefits required under the base-benchmark plan, it must provide evidence of actuarial equivalence of substituted benefits to the state, *but not to consumers*.
- Section 156.115(a) states that any limitations on benefits must be substantially equal to the EHB-benchmark plan, but the rule does not require plans to make information about limitations on coverage that differ from the benchmark available to consumers.
- Likewise, under §156.120, a health plan offering EHB has to submit its selected drug list to the Exchange, the state or OPM, *but not to consumers*.

Plans should be required to publically provide information about benefit substitution, limitations on coverage, and lists of covered prescription drugs so that consumers can understand how particular plans differ from the state's chosen benchmark benefit. Consumers require this information *before* making plan selections, not after. HHS must set expectations in the rules that plans offering EHB will make this information publically available, and set up a process for monitoring and enforcing plan transparency.

c. HHS Should Provide Guidance to Ensure Ample Stakeholder Engagement in the EHB Process

We believe that additional guidance is needed to ensure sufficient stakeholder involvement at the state and federal levels. Consumers must have regular opportunities to fully engage in the EHB process, both in determining the EHB base-benchmark option in their state today, and in updating the EHB in 2016.

Currently, there is no meaningful opportunity for consumers to weigh-in on selected benchmarks. As described above, HHS has made very little information about benchmark plans publically available, making it almost impossible for consumers to understand at this stage whether the EHB-benchmark plan in their state is adequate to serve their health care needs. We urge HHS to mandate, through these rules, that states create a stakeholder engagement process to ensure that all interested stakeholders have appropriate opportunities to inform and influence the EHB process in their state.

Finally, HHS 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.

VIII. Enforcement

The preamble states that HHS will use enforcement processes and standards under 45 CFR 150 (i.e., the procedures used to determine that a state has failed to substantially enforce HIPAA requirements, including MHPAEA) to ensure that plans adhere to the required EHB standards. The preamble generally asserts that states will have primary enforcement authority over health insurance issuers, but will allow HHS to take enforcement actions against issuers in a state, if the state has notified HHS that it has not enacted legislation to enforce or that it is not otherwise enforcing 45 CFR 150. HHS can also take enforcement action if HHS determines that a state is not substantially enforcing a provision.

As you know, 45 CFR 150 provides a process whereby an individual, after exhausting all other remedies can make a complaint to CMS that a state is failing to substantially enforce provision of HIPAA. CMS can then make a determination that a reasonable question of enforcement exists and notify a state of the issue. The state has 30 days to respond to CMS, but may request an extension of time to respond. Based upon the state's response, CMS can make a determination whether there has been a failure to enforce provisions of HIPAA and can step in and enforce HIPAA where the state has failed to act. These regulations set forth a complicated process that is time consuming. It can take quite some time to get CMS to act on behalf of the state, leaving patients without recourse until the process has played out.

Post-enactment of MHPAEA, our experience is that states have failed to enforce MHPAEA, often citing that they lack the authority to enforce the law. For example, the State of California believes that need to amend their state constitution in order to have the proper authority to enforce MHPAEA. Likewise, the State of Florida has said that they do not have authority to enforce MHPAEA and have removed themselves from determining questions of compliance of Blue Cross Blue Shield of Florida. Massachusetts has also claimed that they needed to enact legislation to enforce MHPAEA, which they have finally done nearly 4 years after the enactment of the law.

We are very concerned that these same problems will plague issues of state enforcement of EHB and that this process will be inadequate to protect patients covered by [plans]. Instead, HHS should provide aggressive oversight and enforcement in the area of EHB and MHPAEA compliance. For example, HHS should periodically (but no less than annually) sample plans for compliance with EHB requirements—including parity compliance-- and make these results publically available.

We urge HHS to identify how and when the federal government will intervene if a state is not enforcing the law. Of particular concern is how enforcement will be conducted in those states that are not implementing the ACA and not running their own exchanges. We urge HHS to detail how and in what ways it will work with states on enforcement in this particular circumstance. In the case of a state publicly declaring that it cannot or will not enforce federal

law in this area, HHS should amend 45 CFR 150 to allow for an expedited process which would allow CMS to immediately intervene and enforce the law. In addition, HHS should develop and directly enforce reporting requirements and apply appropriate penalties for plan non-compliance. Finally, all enforcement actions should be made public on appropriate federal and state websites and compliance correction plans required and made publicly available as well.

Furthermore, confusion still exists around the appropriate roles of federal and state governments related to the enforcement of parity requirements. It is critical that HHS clarify these roles as quickly as possible. **We encourage 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.**

Thank you for the opportunity to provide comments on the essential health benefit proposed rule. We appreciate your careful consideration of our comments and look forward to working with you further on EHB and parity implementation. Please contact Coalition Co-Chairs Sam Muszynski (IMuszynski@psych.org) or Carol McDaid (cmcdaid@capitoldecisions.com) if you have any questions or if we can be of further assistance.

Sincerely,



Irvin L. Muszynski, JD

Co-Chair, Parity Implementation Coalition



Carol McDaid

Co-Chair, Parity Implementation Coalition

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