

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

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

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

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

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

With passage in 2008 of the federal “Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act,” (MHPAEA) Congress recognized the long history of mental health and addiction benefits being targeted for more stringent review than other medical and surgical benefits and the corresponding unacceptably large treatment services gap. By extending the requirements of the MHPAEA to all qualified health

plans under the Affordable Care Act, Congress reiterated its intent to eliminate discrimination in health coverage for mental health and substance use disorders.

In addition to stigma being a major factor contributing to disparate insurance coverage of mental health and substance use disorder benefits, plans have often sought to manage mental health and substance use disorder benefits through an acute, not chronic disease, care lens despite clear scientific research that serious mental illnesses and substance use disorders are preventable, treatable chronic health conditions that should be managed over the lifetime. The MHPAEA and its implementing regulations seek to eliminate this systemic discrimination in insurance coverage of mental health and substance use disorder benefits and to ensure that people with mental health and/or substance use disorder treatment needs receive the clinically appropriate type, level and amount of care needed to get and stay well. Congress's decision to extend the MHPAEA requirements to plans offering the substance use disorder and mental health benefits in the Affordable Care Act's essential benefit package demonstrates the understanding that these benefits must be provided in a way that ensures good access to these critically important services.

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

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

Plans should use process and outcome measures that focus on whether the patient's quality of life and ability to function well are both improving. Plans should consider the individual treatment needs of the patient and the availability of evidence-based practices to treat the disorder as part of making medical necessity determinations. Medical necessity determinations about who needs what services, levels of care, and lengths of stay should be driven by decisions made by qualified treatment professionals, and medical management tools including utilization review, criteria for review and approval of evidence-based treatment services, preferred provider networks and preauthorization should not be used to deny care that is determined necessary by a treating professional.

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

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

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

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

In managing their benefits, insurers should focus on the quality of mental health and substance use disorder care and create incentives for implementation of evidence-based practices, including matching the patient to the appropriate type and level of care, and use of medications when appropriate, to produce the best possible outcome for each patient. The latest patient matching tools must be used to place the patient in the appropriate level of care as early in the process as possible. All treatment must be based upon the latest and best available evidence-based or consensus-based practice to create the best possible outcome for each patient. Insurers should acknowledge that remaining in substance use disorder treatment for an adequate period of time is critical for treatment effectiveness.

Research on evidence-based practices to prevent and treat mental illness and substance use disorders, and to help individuals sustain their long-term recovery from these chronic diseases, should be considered. These include: the Comprehensive Community Mental Health Services Program for Children and Families and the Community Support Program (CSP); the National Quality Forum's "National Voluntary Consensus Standards of Care for Treatment of Substance Use Disorders: Evidence-Based Treatment Practices," the American Society of Addiction Medicine(ASAM) Patient Placement Criteria (PPC 2R), various Institute of Medicine (IOM) reports," the U.S. Preventive Services Task Force (USPSTF) and Health Resources Services Administration's Bright Futures guidelines; and several Surgeon General Reports, including "Mental Health: A Report of the Surgeon

General,” “Mental Health: Culture, Race and Ethnicity,” and the Surgeon General’s “Call to Action To Prevent and Reduce Underage Drinking.” These reports and tools, as well as others, continue to document the effectiveness of treatment for and prevention of mental health and substance use disorders.

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

Although requiring Affordable Care Act-plans to comply with the MHPAEA will ensure that mental health and substance use disorders benefits are not covered in a more restrictive way than other medical and surgical benefits, if there are significant barriers to access to medical and surgical benefits people will be unable to meaningfully have any of their physical and mental health needs adequately met.

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

In crafting the essential benefits package, the Secretary of HHS should ensure that the mental health and substance use disorders benefit is broad and robust, representing the full continuum of care. This includes the full range of prevention, treatment, rehabilitation, and recovery support care. Care should be available to individuals and their family members that responds to their health needs over their lifetimes. The essential benefits should reflect the chronicity of serious mental illness and substance use disorders and should provide coverage for the full continuum of care to ensure that people get the clinically appropriate level of care.

Since passage of the Affordable Care Act, the Substance Abuse and Mental Health Services Administration (SAMHSA) has led a process with stakeholders to identify the services, interventions and strategies that people with mental health and substance use disorders need to get and stay well and which should be provided in a good and modern addictions and mental health system. The Secretary of HHS should use SAMHSA’s “Description of a Modern Addictions and Mental Health Service System” paper to help determine which services should comprise the mental health and substance use disorder benefit.

We ask that the Department make clear to health insurance plans that the ACA requires a robust benefits package for mental health and substance use disorders that includes the full range of mental health and substance use disorder prevention, substance use and depression screenings, early intervention, treatment, rehabilitative and recovery support services, and that these benefits must be provided in no more restrictive a way than other medical and surgical benefits offered by the plan. Plans should be informed that they

must adhere to all of the requirements of the Wellstone/Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and that law's corresponding regulations.

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

The Secretary should also establish regular working groups, which include representatives from the mental health and substance use disorder communities, to advise about benefit design, get feedback on benefit packages and share information with consumers. The Secretary should also regularly meet with members of state organizations, non-profit associations, advocates, providers and other important stakeholders who are devoted to furthering the rights of those populations in order to inform the process and determine those issues. Advice should be solicited from providers of services as to "best practices."

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

Limits on specific or total benefits could have the effect of undermining existing restrictions on lifetime and annual benefit limits and could be particularly harmful to people with chronic illnesses, including those individuals with substance use disorder and mental health treatment needs.

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

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

and wellness services and chronic disease management; pediatric services, including oral and vision care.

As Congress recognized through the passage of the Paul Wellstone and Pete Domenici Mental Health and Addiction Equity Act, people with mental health and substance use disorders have faced systemic discrimination in accessing health insurance benefits. In developing the essential benefits package HHS should recognize that people have complex, varied health needs and should require that each participating plan provides a robust set of benefits in each of the identified categories of care. Plans that fail to provide a robust set of services in each of the benefit categories should be required to expand access to those benefits.

HHS should also recognize that people with substance use disorders and mental illnesses will not only need a robust benefit representing the full continuum of care in the “mental health and substance use disorders services, including behavioral health treatment” benefit category, but will also will need good coverage under a number of the other categories. To become and stay healthy, people need to have good coverage and access to full the range of services over their lifetime. The following additional benefit categories are particularly important to meet the prevention, treatment, rehabilitation and recovery support needs of people with mental illness and/substance use disorders: hospitalization; maternity and newborn care; prescription drugs; rehabilitative and habilitative services and devices; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Comprehensive health care reform should fully incorporate the prevention, treatment and rehabilitation of substance use disorders and mental illness as both primary disabling conditions and co-occurring conditions with other chronic diseases. Designing a robust essential benefit on preventive and wellness services and chronic disease management is particularly important for people with mental illness and substance use disorder prevention needs. The wellness benefit should recognize that individuals with histories of serious mental illness and/or untreated substance use disorders often suffer from other chronic health conditions and that providing care for the primary mental illness and substance use disorder will help reduce the occurrence of other chronic diseases such as obesity, heart disease, pulmonary disorders, and hypertension in individuals and, as research has shown, their family members. Research has also shown that stressful or traumatic childhood experiences can lead to social, emotional, and cognitive impairments that can increase the likelihood of unhealthy behavior, disease, disability and premature death. The wellness benefit should recognize that coverage for substance use disorder and mental illness prevention efforts (including depression screenings) is critical to preventing these adverse childhood experiences and the subsequent costs to the healthcare system over the lifetime of those individuals.

The wellness benefit should also promote effective mental health check-ups, screening for substance use disorders and mental illness, and early intervention for mental health and substance use disorders across the lifespan, recognizing that half of all lifetime cases of mental illness begin by age 14 and adolescents who use alcohol and other drugs are

much more likely to misuse drugs and alcohol as adults. Pre-natal and peri-natal screening for maternal depression and substance use disorders should be reimbursed and encouraged, as well as referral into treatment for those who need care.

The rehabilitative and habilitative essential benefit is also critically important to the mental health and substance abuse community. This benefit should include coverage for services that are effective in helping people with mental health and/or substance use disorders get and stay well. For example, individuals with serious mental illness or substance use disorders who have habilitative needs have experienced limited or no stability, often lack basic life skills and education, have limited or no social supports, and often lack safe and stable housing. To get and stay well, these individuals generally need more services focused on building basic life skills and job training. The essential rehabilitative and habilitative benefit must be responsive to the needs of these individuals.

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

In designing the essential benefit package, we urge the Secretary of HHS to consider the needs of people with and at risk for mental health and substance use disorders in each of the relevant essential benefit categories.

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

Prohibiting denial of benefits based on age, expected length of life, present or predicted disability, degree of medical dependency or quality of life is extremely important to ensure that people with chronic diseases, including serious mental illness and substance use disorders, have all of their complex health needs met.

HHS and the appropriate state agencies must oversee a strong enforcement effort to ensure that health plans are compliant. This oversight system must be designed to include the input of providers and consumers and a consumer-/provider-friendly appeals

process. This information will be critical to determining whether plans are complying with the Affordable Care Act.

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

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

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

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

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

Strategies aimed at ensuring that individuals in special populations have good access to the full range of services they need should be employed. Intensive outreach, limited or no co-payments, and enhanced services should be recognized as important components of chronic care management that will be particularly helpful for individuals with barriers,

including those with mental illnesses and substance use disorders. In addition, as the Affordable Care Act is implemented, there must be specific work to ensure that vulnerable individuals with barriers to getting care, such as those transitioning from the criminal justice system back to the community, have good access to the healthcare they need, including the full range of mental health and substance use disorder services.

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

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

Given the complex nature of the healthcare system in this country, it is important that policymakers build on the strengths of both federal and state governance and oversight authority to implement healthcare reform in a way that guarantees the greatest potential for success. Traditionally, states have led the movement to reduce costs, expand access, protect consumers, and improve quality while the federal government has set a legal and regulatory framework and provided the financial foundation for the healthcare system. While the Affordable Care Act represents a welcome expansion of the federal role in the healthcare system, many of the key components of the law, including the Medicaid expansion and the establishment of state-based health insurance exchanges, serve to reinforce the fundamental nature of our health system as a federal-state partnership. In their role as insurance regulators, states have developed an extensive body of law related to the insurance industry. Many of these laws represent hard-earned victories that improve health care by requiring coverage for specific benefits and services, and function to correct market flaws that would otherwise limit coverage. These mandate laws serve to remedy coverage determinations and other practices that reflect bad health policy, such as arbitrary determinations of medical necessity, denials based on artificial distinctions between habilitation and rehabilitation, faulty judgments that specific treatments are experimental, and other practices that can entirely shut out vulnerable populations from access to health care. For these reasons, as implementation moves forward it is critically important that the necessary steps are taken to ensure that state laws which provide better coverage, rights, methods of access to treatment and consumer protections, from the standpoint of the insured, remain in effect and are not preempted.

10. What criteria and method(s) should HHS use in updating the essential package? How should these criteria be applied? How might these criteria and method(s) be tailored to assess whether: (1) enrollees are facing difficulty in accessing needed services for reasons of cost or coverage, (2) advances in medical evidence or

scientific advancement are being covered, (3) changes in public priorities identified through public input and/or policy changes at the state or national level?

Updates to the essential benefit package are important to ensure that newer services or promising practices are covered. There should be a regular process through which new services are considered. Consumers and services providers should have a clearly defined role to provide input in this process.

There are several steps the HHS Secretary can take to continually monitor and improve the essential health benefits package. Two important initial steps include: (1) ensuring a robust appeals process for enrollees seeking to access essential benefits; and (2) continuing to monitor implementation of the federal mental health and addiction parity law to ensure that equity in benefits is achieved.

1. Ensuring a Robust Appeals Process: Under the Affordable Care Act (Section 1001) all new group health plans and health insurers offering group or individual health insurance coverage must implement an effective internal appeals process for coverage determinations and claims. Additionally, these plans and insurers must comply with state external review laws. If the state has not established an external appeals process or if the health plan is self-insured, the plan must implement an external review process that meets minimum standards required by the HHS Secretary. Many of the state external review laws provide an appeals procedure that permits reviewers to reject an insurer's medical necessity definition, providing some recourse for patients denied coverage. Although nearly all states have external review laws, these laws can be inconsistent, and state processes for appeals can be lengthy.

We urge the HHS Secretary to develop an appeals process at the federal level that can provide recourse to individuals who have been failed by state review. If the essential benefit standard is to be robust and meaningful for enrollees, then the appeals review process needs to be equally robust and meaningful so that enrollees can realize the benefits to which they are entitled. A quick and strong benefit appeals program at the federal level will be especially important to individuals in need of mental health and substance use disorder treatment because these individuals are prone to denial of benefits due to stringent and out-dated medical necessity definitions that do not recognize the range of treatment approaches needed to help individuals reach recovery.

Furthermore, we urge the Secretary to review data from this appeals process to uncover patterns of benefit denial which may suggest common access problems faced by enrollees. The Secretary can use this data to update essential benefit package standards.

2. Continuing to Monitor Parity Law Implementation. The Affordable Care Act (Section 1302) mandates that the scope of essential health benefits offered by qualified health plans through the state Exchanges be equal to the scope of benefits under a "typical" employer plan. The notion of a "typical" employer plan relative to mental health and substance use disorder benefits is currently in changing as a result of implementation of

the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

MHPAEA requires employer-sponsored group health plans to cover treatment for mental illness and substance use disorder benefits on the same terms and conditions as all other medical conditions. Final regulations implementing the provisions of MHPAEA became effective for plan years beginning on or after July 1, 2010. As many plan years are set to begin January 1, 2011, the positive effects of the full implementation of parity law are in development. What results from full implementation of parity law will impact what the scope of mental health and substance use disorder benefits looks like under the “typical” employer plan. This in turn could impact the scope of essential health benefits offered through the state Exchanges.

We urge the HHS Secretary to continue to monitor implementation of parity law and review what typical employer coverage looks like after full implementation. The Secretary should solicit input from the community about how parity laws have changed access to mental health and substance use disorder treatments and services. Lessons learned from parity law implementation should inform the discussion about how to update mental health and substance use disorder benefits in essential health benefits package.