COALITION FOR WHOLE HEALTH

January 31, 2012

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

Dear Mr. Larsen:

The Coalition for Whole Health is a broad coalition of local, State, and national organizations in the mental health and substance use disorder prevention, treatment, and recovery communities, and we appreciate the opportunity to comment on the Essential Health Benefits Bulletin ("the Bulletin") released by the Center for Consumer Information and Insurance Oversight on December 16, 2011. We thank you for your strong commitment to making mental health (MH) and substance use disorder (SUD) care a top priority and for working to ensure that individuals with MH/SUD needs receive quality care.

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

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

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

- Allowing States the ability to require compliance with State benefits mandates without financial penalty from the federal government. The Department should work closely with all States to ensure they have accurate estimates of their potential financial obligations to the federal government if they choose a benchmark plan that is not subject to any or all of the benefit mandates in the State.

- Reemphasizing that each of the ten EHB categories is covered and providing guidance to States about how to supplement coverage if a category is not covered in the particular benchmark plan option chosen by the State.
- Limiting benefit design flexibility beyond the benchmark flexibility for States and health insurance issuers to the same standards and measures applied to CHIP. As you know, both the CHIP flexibility standards and the application of the MHPAEA preclude downward actuarial adjustments to MH and SUD benefits. As discussed in more detail below, we also ask the Department to include language in further EHB guidance explicitly affirming this prohibition.

Thank you, too, for your close and continued work with SAMHSA on the EHB and your work with the MH/SUD fields. We look forward to continuing to work closely with the Department to ensure that the EHB effectively addresses the MH/SUD needs of impacted enrollees.

On behalf of our constituencies, we offer the below recommendations to the Department in response to the EHB Bulletin. Our consideration of these issues is informed by our experiences with health insurance coverage for MH/SUD, which has historically been provided at extremely low levels, if at all. The following is a summary of our recommendations for final EHB guidance, followed by more detailed comments, for your consideration. We urge the Department to:

1. Develop a detailed, comprehensive essential health benefits package that would serve as a "federal floor." We continue to believe that a comprehensive federal EHB that States could go beyond to meet their specific needs is the preferred approach, and ask the Department to develop a comprehensive federal minimum package. However, if the Department continues to allow States to define their EHBs absent a federal floor, we ask the Department to provide strong oversight and ensure that each of the ten categories of benefits is comprehensive and robust in all States. HHS should also aggressively enforce the consumer protections outlined in §1302(b)(4)(A-D) of the ACA.

2. Aggressively enforce the MHPAEA on the federal level and work with the appropriate State officials to enforce the MHPAEA on the State level to ensure meaningful protection.

3. More closely align EHB benchmark flexibility to that allowed under the CHIP and Medicaid programs by limiting States' choices to those available in CHIP and for certain Medicaid populations. If the Department continues to allow States to benchmark to a small group plan—which may be the weakest and most variable option—we urge the Department to change the default plan to one of the large group plans or another comprehensive benefits package defined by HHS.

4. Ensure comprehensive, appropriate coverage within the EHB by: (a) Requiring that each of the ten EHB categories be comprehensive in the benchmark plan, and if a category is not comprehensive in the benchmark plan, the Department should require the State to supplement the category using a benchmark option that does provide comprehensive benefits in that category; (b) including language in the final EHB guidance and the forthcoming actuarial value guidance clearly stating that both the MHPAEA and CHIP flexibility standards preclude downward actuarial adjustment to MH and SUD benefits; (c) developing a federal definition of medical necessity; and (d) ensuring robust prescription drug coverage, including medications for MH/SUD.

5. Annually review and update the EHB in all States to ensure that plan enrollees are being well served, and take appropriate action when plans fail to provide a comprehensive EHB package consistent with the requirements of the ACA. The Department should also provide annual guidance to States

requiring that they update their EHBs to reflect the latest medical evidence and scientific advancement.

6. Work with States to ensure consumers and providers have opportunities to participate in the process of determining the EHB on the federal and State levels. As the Department continues implement the EHB and related provisions in the ACA, there should be a strong consumer and family education campaign to ensure MH and SUD service consumers will be able to access the care they need, understand their coverage, and identify potential violations of their EHB rights.

1. **The Department should ensure that all EHB plan enrollees can access a comprehensive EHB package by: (a) reconsidering the benchmark approach and developing a detailed, comprehensive federal EHB floor. However, if the Department continues to allow States to define their EHB packages absent a federal floor, the Department must (b) provide particularly strong oversight to ensure adequate coverage of each of the ten EHB categories in all States. The Department should also (c) aggressively enforce the consumer protections outlined in §1302(b)(4)(A-D) of the ACA.**

a. Develop a federal floor for the essential health benefit.

When Congress passed the ACA and created the EHB they intended to create a uniform minimum benefit standard that would apply to all States, guarantee small group and individual market health plan enrollees a basic level of protection, and ensure that federal subsidy dollars would be well spent. While we understand the Department's intent to give States a significant amount of flexibility to design their benefits packages, we continue to believe that a national standard is needed that will guarantee strong and specific benefit protections to all covered enrollees and urge the Department to reconsider this approach. We believe that an approach to EHBs that draws on the success of proven federal frameworks that promote State flexibility within the context of a defined federal standard, such as HIPAA and traditional Medicaid models, would offer significant benefits to consumers by establishing a minimum floor for essential health benefits that is uniform across the States. Under such a model, States would be permitted to identify essential health benefits above the federal floor, preserving state autonomy and flexibility to adapt to local health care preferences. As you are well aware, States differ widely on their support for the ACA and their commitment to effectively implement and enforce the law. In the absence of a federal floor of benefits, we believe there is a significant risk that these diseases will not be adequately covered in many States.

b. In the absence of a federal floor, strong federal oversight of State benchmark proposals is critical to ensure coverage is comprehensive and robust in all States.

We believe that the Department should work closely with States to ensure that a robust package of benefits across the full continuum of care is provided for each of the ten EHB categories. Strong federal oversight of State-defined EHBs will be particularly important for MH/SUD.

A long history of insurance discrimination against those with MH/SUD has been a barrier for many individuals in need of MH/SUD services across the continuum, including the preventive services, early interventions, timely diagnoses, treatment, and recovery services needed to avoid disease, and to get and stay well. There is also an unacceptably large treatment gap for MH/SUD. Nearly one-third of adults and one-fifth of children have a diagnosable substance use or mental health problem[1], however in 2009, only 4.3 million of the 23.5

[1] Garfield, RL. *Mental health financing in the United States: A primer.* Kaiser Commission on Medicaid and the Uninsured. May 2011.

million Americans needing treatment for an illicit drug or alcohol problem received it[2], and only 4.1 million of the 9.8 million Americans who needed treatment for a serious mental illness received it.[3] The ACA holds tremendous promise for significantly reducing treatment gaps by increasing early identification and treatment coverage and access for MH/SUD , but without a robust EHB and strong oversight to ensure access to medically necessary MH and SUD care across the continuum this potential will go largely unfulfilled.

We encourage the Department to define and clearly indicate limits on State flexibility to reduce any of the ten EHB categories—and to clearly indicate to States the additional prohibition provided by the MHPAEA against limiting the MH/SUD benefit category—and to enforce these limits. HHS should annually review State benchmark proposals for comprehensiveness of each of the ten EHB categories and require States to supplement categories that fall short. In the case that a State chooses to benchmark to a plan that does not provide full and specific details about some or all of the benefits it offers, the Department should require States to develop specific benefit details, and work with them to do so. As a result, all States should have comprehensive and detailed State benefits packages that ensure full coverage of all medically necessary services across the continuum of care in each of the categories. In addition to working closely with States, we ask the Department to develop strong enforcement mechanisms and provide strong federal oversight to ensure that all health plans subject to the EHB will be in compliance with the essential health benefits and MH/SUD parity requirements of the law.

We recognize that the Department intends to assess the benchmark process for the year 2016 and beyond based on evaluation and feedback. Assuming the Department continues to allow States to choose among benchmark options absent a federal benefits floor at least through 2016, we strongly urge you to exercise an assertive oversight role to ensure appropriate protections for plan enrollees.

c. Transparent decision-making at the State level.

The Coalition urges the Department to ensure transparency and guarantee the opportunity for appropriate public input as States implement the EHB. To ensure meaningful transparency, the Department should identify and make publically available benefit data from each benchmark option for each state, so that HHS, States, consumers, providers and advocates can effectively work together to analyze options.

The Coalition for Whole Health recently sent a letter to Secretary Sebelius encouraging the release of this plan data. Specifically, we asked HHS to make publicly available the three largest national Federal Employee Health Benefits Program plan options by enrollment, and, for each state, the three largest plans by enrollment in the small-group market, the three largest state employee health benefit plans by enrollment and the largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the state. We reiterate this request, as this information is critical for providing input into the EHB implementation.

d. Enforcement of strong EHB consumer protections.

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

- Ensure that the essential health benefits reflect an appropriate balance within and among the categories so that benefits are not unduly weighted toward any category;

[2] Substance Abuse and Mental Health Services Administration. (2010). *Results from the 2009 National Survey on Drug Use and Health: Volume I. Summary of National Findings* (Office of Applied Studies, NSDUH Series H-38A, HHS Publication No. SMA 10-4856). Rockville, MD.
[3] Substance Abuse and Mental Health Services Administration. (2009). *Results from the 2008 National Survey on Drug Use and Health: National Findings* (Office of Applied Studies, NSDUH Series H-36, HHS Publication No. 09-4434). Rockville, MD.

- Not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life;
- Take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups;
- Ensure that health benefits established as essential not be subject to denial on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life.

The final EHB regulations should integrate these protections into the Department's criteria for approving State benchmark proposals.

Again, absent a strong federal benefits floor, we ask the Department to provide strong oversight of States and all necessary technical assistance to ensure comprehensive coverage of each of the ten categories in the EHB. To assist you, the Coalition for Whole Health has developed specific recommendations on coverage of mental health and substance use disorder services in the EHB that we have attached to these comments. These recommendations are based on evidence-based practices to sustain addiction and mental health recovery, and we believe that all EHB packages must include, at a minimum, the benefits outlined in this document for an addiction and mental health system to be accessible, accountable, efficient, equitable, and of high quality.

2. Strong MHPAEA enforcement on both the federal and State levels is needed to ensure meaningful protections for those in need of MH and/or SUD coverage.

We believe that the ACA and the federal parity law hold tremendous promise to improve access to care for people with MH/SUD service needs, and were extremely pleased with their passage. As stated above, we strongly support the acknowledgment by the Department in the Bulletin that the ACA requires the EHB to include MH and SUD benefits in a manner consistent with the requirements of MHPAEA. We urge the Department to clearly state in final EHB guidance that all plans subject to the EHB must comply with the requirements of the MHPAEA. These parity requirements must apply to all financial requirements and treatment limitations on the scope and range of services and settings covered within any benefit classification, regardless of any flexibility given to States to define their EHB.

With the passage of the MHPAEA in 2008, Congress sought to end the long history of insurance discrimination against those with MH/SUD that has prevented so many individuals from receiving the clinically appropriate type, level, and amount of care they needed to get and stay well. However, there are still significant problems in implementation and enforcement of the federal parity law which require special consideration from the Department as it works to define and implement the EHB.

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

In addition, lack of clarity in the regulations in four key areas has prevented equitable access to MH/SUD care. These include: disclosure of medical criteria, a standard for implementing parity in medical management, scope

of services, and Medicaid managed care parity. Patients and providers are also often unclear about how parity is being applied by plans, and plans are often refusing to disclose the MH/SUD medical necessity criteria and/or the medical/surgical criteria used by the plan to make benefit determinations. HHS should require full disclosure of benefit and medical management criteria from States and plans to ensure MHPAEA compliance. Without additional regulatory guidance in these areas, the parity law will not provide the critically needed federal protection from health insurance discrimination for the millions of Americans with substance use disorders and mental illness. Moving forward, final MHPAEA regulations implementing parity in Medicaid managed care plans and clarifying what plans' scopes of services are, and what their non-quantitative treatment limitation obligations are, must be fully implemented expeditiously. We look forward to working with you to ensure that these measures are well understood and widely implemented.

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

3. **Benchmark flexibility should be more closely aligned with the flexibility allowed under the CHIP and Medicaid programs, and the Department should limit States' choices to the benchmark options available under CHIP and for certain Medicaid populations. If the Department continues to allow States to benchmark to a small group plan, it should change the default plan to a large group plan or a comprehensive, federally defined minimum EHB.**

    a. ***Benchmark choices should reflect the benchmark flexibility allowed under the CHIP program and for certain Medicaid populations.***

The Bulletin notes that the approach put forth by the Department is based on the approach taken by CHIP and allowed for certain Medicaid populations. However, the Bulletin proposes to allow States to benchmark their EHBs to additional options beyond the flexibility allowed by CHIP and Medicaid; in particular it proposes to allow States to benchmark to one of the three largest small group insurance plans in the State.

We are concerned that small group plans may not offer adequate benefit packages, particularly related to MH and SUD. As noted in the Bulletin, during the HHS listening sessions following the release of the IOM report on EHB, a number of consumer groups expressed concern that small group plans may not represent the "typical employer plan" as envisioned by the statute. The Coalition for Whole Health was among the groups that expressed this concern.

While the Bulletin states that small group plans and other potential benchmark options do not differ significantly in the range of services they cover, the Bulletin also acknowledges that, for MH/SUD, "coverage in the small group market often has limits." We again encourage the release of this data to allow for independent analysis. Absent the data we cannot be certain that MH/SUD benefits are adequately covered in these plans.

While the application of the requirements of the MHPAEA to all EHB coverage is important to help ensure adequate coverage for MH/SUD, we continue to have serious concerns that coverage based on the benefits offered in the small group market may be insufficient. Since small employers (those under 50 employees) have been exempt from the federal parity law, a benchmark in the small group market is unlikely to offer adequate coverage of MH/SUD services. While the ACA's parity requirements should—and legally must—mitigate this problem for MH/SUD services, we remain concerned that basing the EHB on a small employer plan would

likely result in weaker MH/SUD coverage, especially in the short term. In addition to generally providing better MH/SUD benefits than the small group plans, the large group plans have already been subject to the requirements of the MHPAEA, and we believe the benefits offered today in the large group market better reflect the coverage that Congress intends to be available in the small group and individual markets beginning in 2014.

We therefore urge the Department to limit States' flexibility to benchmark their EHB packages to only large group plans. We believe this would be best met by aligning State EHB benchmark flexibility with the benchmarking options allowed by CHIP and Medicaid, in §2103 and §1937 of the Social Security Act, respectively. More closely aligning EHB benchmark flexibility to the flexibility allowed by CHIP and for certain Medicaid populations would serve to better protect enrollees by generally providing better coverage, and would limit benefit variation across States.

We believe that all benchmark proposals should be carefully analyzed to ensure adequate coverage for each of the ten EHB categories, including MH/SUD, and benchmarks that fall short must be supplemented. The MH/SUD benefits should also be carefully analyzed for compliance with the MHPAEA. Regardless of the benchmarks chosen, the EHB should provide comprehensive coverage of the full continuum of mental health and substance use disorder services. This includes, at a minimum, the benefits outlined in the attached document.

b. The default plan should not be a small group plan

Similarly, we have serious concerns that the Bulletin is proposing to use a small employer plan as the default benchmark plan for States that do not exercise the option to select a benchmark health plan. The largest small employer plan in a State may well be the weakest and most variable of the ten options. We are again particularly concerned about MH and SUD coverage in the small employer market since small employers have been exempt from complying with the federal parity law and small group coverage is generally more limited than what is offered by large group plans. Instead, we urge the Department to identify a large market plan or an HHS defined comprehensive essential health benefits package as the default benchmark plan, to provide a comprehensive federal standard in at least a number of States.

4. The Department should require *comprehensive* coverage of each EHB category by (a) requiring States to supplement missing or inadequately covered categories using other benchmark options to provide comprehensive benefits in that category; (b) clearly stating that EHB benefit flexibility standards preclude downward actuarial adjustment of MH and SUD benefits; (c) developing a federal definition of medical necessity; and (d) ensuring robust prescription drug coverage, including robust coverage for MH/SUD medications.

a. Require* comprehensive *benefits in each of the ten EHB categories.

As stated above, we strongly support the acknowledgment in the Bulletin that all issuers subject to the EHB standard must cover each of the ten benefit categories, regardless of the benchmarking flexibility given to States. This requirement is consistent with §1302 of the ACA. We are concerned, however that the Bulletin seems to suggest that providing any benefits in a category would meet the EHB standard.

In the event that a State chooses a benchmark plan that is "missing categories," the Bulletin proposes to require the State to "supplement the missing categories using the benefits from any other benchmark option." The Bulletin also provides a similar process for determining benefits in a State with a default benchmark that is

"missing categories." An example provided explains that "in a State where the default benchmark is in place but that default plan did not offer prescription drug benefits, the benchmark would be supplemented using the prescription drug benefits offered in the largest small group benchmark plan option with coverage for prescription drugs." We are concerned that requiring only the provision of any benefit in a category to meet EHB compliance would be far too weak a threshold, violating §1302(b)(4) of the ACA's instruction to the Secretary to ensure that the EHB reflects "an appropriate balance among the categories."

We strongly urge the Department to require that the *benefits* in each category be *comprehensive*. If the benchmark does not include comprehensive benefits in a benefit category, the Department should require that the benefits in that category be supplemented with the benefits in other benchmark options to make it comprehensive. As previously mentioned, we have attached specific recommendations developed by the Coalition for Whole Health to ensure comprehensive coverage of mental health and substance use disorder services in each of the ten EHB categories. We believe that all EHB packages should, at a minimum, include the benefits outlined in this document.

b. Provide clear guidance that the MHPAEA and benefit flexibility standards preclude downward actuarial adjustment of MH and SUD benefits.

The Bulletin makes clear that the Department will permit actuarial adjustment and allow plans to offer benefits that are "substantially equal" using the same actuarial equivalency standard that applies to plans under CHIP. As you know, CHIP reauthorization amended §2103 of the Social Security Act to ensure compliance with the requirements of the MHPAEA in the case of a State child health plan that provides both medical and surgical benefits and mental health or substance use disorder benefits, and protected MH and SUD services from actuarial adjustment. Similarly, the ACA amended §1937 to extend the MHPAEA requirements to Medicaid benchmark plans and protect MH/SUD services from actuarial adjustment in Medicaid benchmark or benchmark equivalent benefits packages. We ask that the Department include language in the final EHB guidance, as well as the upcoming actuarial value guidance, explicitly stating the MHPAEA and CHIP flexibility standards both preclude downward actuarial adjustment to MH and SUD benefits in the EHB.

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

c. Define federal standards for medical necessity.

While the Bulletin does not address medical necessity standards within the context of EHBs, the degree to which Americans enjoy full access to covered services within the ten EHB categories will depend, to a large degree, on the medical necessity standards that plans use to determine whether a service within these categories is covered.

Few regulations address the definition of medical necessity: there is no federal definition, and only about one-third of States have any regulatory standards for medical necessity. Consequently, the definition of "medical necessity" is most commonly found in individual insurance contracts that are defined by the insurer. As a result, the standard of medical necessity is most often controlled by the insurer, not the treating professional.

Even with an unambiguous requirement under the parity law for plans to provide medical necessity criteria, plans have been slow and resistant to providing the criteria. The medical necessity definitions utilized by insurers today have an especially strong impact for MH/SUD, where treatments often vary widely in cost. For example, a course of treatment that emphasizes prescribed medications and brief therapy may have radically different costs from one that is long-term. We therefore strongly encourage the Department to define federal standards for medical necessity under the EHB. Given that medical necessity definitions commonly used by insurers today often impede access to appropriate MH/SUD treatment, federal medical necessity standards for this category of the EHB are critically important.

Our recommendations for a federally defined medical necessity standard are consistent with the Institute of Medicine's Report *Essential Health Benefits: Balancing Coverage and Cost,* released October 7, 2011, which discusses a framework for HHS to address medical necessity within the essential health benefit, stating: "The committee believes that the concepts of individualizing care, ensuring value, and having medical necessity decisions strongly rooted in evidence should be reemphasized in any guidance on medical necessity. Inflexibility in the application of medical necessity, clinical policies, medical management, and limits without consideration of the circumstances of an individual case is undesirable and potentially discriminatory."

Similarly, each health plan should be required to make public on the internet their particular and complete medical necessity guidelines and list the names and titles of the clinical/medical committee who made medical necessity decisions. We urge the Department to monitor these medical necessity standards and to take appropriate action where they are inconsistent with established clinical standards.

d. Ensure appropriate prescription drug coverage.

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

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

5. The EHBs should be reviewed and updated annually in all States to ensure that plan enrollees are being well served and that EHBs reflect the latest medical and scientific advancements.

The Bulletin asks for input on how the Secretary should meet the requirement to periodically review and update the EHB. We believe that HHS should annually review and update the EHB in each State to ensure that the EHB is effectively meeting the needs of plan enrollees, and take appropriate action if States or plans fail to provide a comprehensive EHB package consistent with the requirements of the ACA. We also believe that the Government Accountability Office and other independent federal agencies should periodically review EHB compliance and effectiveness.

HHS should provide annual guidance to States requiring that they update their EHBs to reflect changes in medical evidence and scientific achievement. As with many other diseases, there is currently much scientific progress being made in the prevention and treatment of MH and SUD. NIDA, NIAAA, NIMH, NIH, and other public and private sector institutions are conducting cutting edge research on MH and SUD, and new evidence, research, and medical innovations will need to be adopted by the healthcare system as they are developed and proven.

Finally, HHS must ensure that States maintain a quality, modern EHB that reflects the latest innovations and provides comprehensive benefits regardless of whether the plan they benchmark to updates or cuts back its benefits package. Plans should not be able to take advantage of the benchmark flexibility to make harmful coverage determinations that could impact all enrollees in a State's qualified health plans.

6. Consumers and providers should have regular opportunities to participate and influence the EHB determination process and its outcomes. The Department should also implement a strong consumer and family education campaign to ensure consumers understand their coverage and rights.

a. Health care consumers and providers should have regular opportunities to provide input and influence the EHB determination process and its outcomes.

It is critically important that HHS works with States to ensure consumers and providers have the opportunity to fully participate in the process of determining and updating EHB benefits on the State and federal levels. Transparency and opportunity for input are critically important, especially considering the far reaches of the decisions being made. We ask that the Department ensures transparency and guarantees the opportunity for appropriate public input as States work through this process.

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

b. Moving forward with implementation of the EHB and related provisions of the ACA, the Department should promote a strong consumer and family education campaign about the EHB and other consumer rights.

The Department should work with States to ensure a strong consumer and family education component related to EHB implementation and ongoing management. The Department should also continue to work with States to implement the important related components of the ACA, including the health insurance exchanges and the Navigator program, to encourage enrollment in appropriate coverage and maintenance of eligibility. Consumers and their families should have a basic understanding of how to get enrolled and maintain enrollment in health coverage, the benefits available, how to identify potential violations of their EHB rights, and how to take appropriate action to correct violations of their rights and to appeal plan decisions. We urge the Department to develop an appeals process at the federal level that can provide recourse to individuals who have been failed by State review. To ensure that the EHB is comprehensive and meaningful for enrollees, there must be an appeals review process that is equally meaningful so that enrollees can realize the benefits to which they are entitled. A quick and strong benefit appeals program at the federal level will be especially important to individuals in need of MH and SUD treatment. Furthermore, we urge the Secretary to review data from this appeals process to uncover patterns of benefit denial which may suggest common access problems faced by enrollees. The Secretary can use this data to update essential benefit package standards.

HHS and States should also work closely with community organizations and with health care providers to ensure patients are able to access the care they need. The Department should solicit input from the community about how the federal parity law and the ACA have changed access to MH and SUD treatments and services. Lessons learned from parity law implementation should help to inform the discussion about how to update MH/SUD benefits in the EHB.

Thank you again for the opportunity to provide feedback on the essential health benefits Bulletin. We strongly support the goals of the ACA to ensure that all Americans have access to high-quality, affordable health care, including comprehensive care for MH and SUD. We appreciate your careful consideration of our comments and look forward to working with you further on the development and implementation of the EHB and related provisions. Please contact us if you have any questions or if we can be of further assistance.

Sincerely,

NATIONAL SIGN-ONS:

AIDS United
American Association for the Treatment of Opioid Dependence
American Association of Pastoral Counselors
American Association on Health and Disability
American Foundation for Suicide Prevention/SPAN USA
American Psychiatric Association
American Society of Addiction Medicine
Anxiety Disorders Association of America
Bazelon Center for Mental Health Law
Carter Center Mental Health Program
Center for Clinical Social Work/ABE
Clinical Social Work Association
Coalition of Behavioral Health Agencies, Inc.
Community Anti-Drug Coalitions of America
Community Catalyst
Dale Jarvis and Associates, LLC
Disciples Justice Action Network
Eating Disorders Coalition
Hazelden
HIV Medicine Association
International Certification and Reciprocity Consortium
International Society of Psychiatric-Mental Health Nurses (ISPN)
Legal Action Center
Mental Health America
Mental Health Corporation of America
NAADAC, the Association for Addiction Professionals
National Alliance on Mental Illness
National Association for Children of Alcoholics (NACoA)
National Association of Addiction Treatment Providers, NAATP
National Association of Alcoholism and Drug Abuse Counselors - NAADAC
National Association of County Behavioral Health & Developmental Disability Directors
National Association of Psychiatric Health Systems

National Association of Social Workers
National Association of State Mental Health Program Directors
National Council for Community Behavioral Healthcare
National Council on Alcoholism and Drug Dependence, Inc.
National Foundation for Mental Health
National TASC
No Health Without Mental Health
Psychiatric Special Interest Group of the American Academy of Nursing
State Associations of Addiction Services
TeenScreen National Center for Mental Health
The Partnership at Drugfree.org
Treatment Communities of America
Treatment Research Institute
United Church of Christ
United Methodist Church-General Board of Church and Society
US Psychiatric Rehabilitation Association (USPRA)

STATE & LOCAL SIGN-ONS:

Addiction Treatment Providers Association of New York
Alcohol and Substance Abuse Council of Jefferson County
Alcoholism and Substance Abuse Providers of New York State, Inc.
Aquila Recovery
Association for Behavioral Healthcare of Massachusetts
Association of Substance Abuse Programs of Texas
Burke Council on Alcoholism & Chemical Dependency, Inc. of Morganton, NC
California Association of Addiction Recovery Resources
California Association of Alcohol and Drug Abuse Counselors
California Association of Alcohol and Drug Program Executives
California Committee for Whole Health
California Council of Community Mental Health Agencies
California Institute for Mental Health
California Mental Health Directors Association
California Mental Health Planning Council
California Society of Addiction Medicine
Center for Life Management
Chautauqua Alcoholism & Substance Abuse Council, Inc.
Community Mental Health and Substance Abuse Services of St. Joseph County
Council on Addictions of New York State
County Alcohol & Drug Program Administrators Association of California
Criterion Health, Inc.
Day One, Portland, Maine
Drug and Alcohol Treatment Association of Rhode Island (DATA)
Drug Policy and Public Health Strategies Clinic, University of Maryland Francis King Carey School of Law
Family Training and Advocacy Center of Philadelphia, PA
Focus on Community
Gateway Foundation
Illinois Alcoholism and Drug Dependence Association

Indiana Addictions Issues Coalition
Iowa Behavioral Health Association
Join Together, Northern Nevada
Maine Association of Substance Abuse Programs
Maryland Addictions Directors Council
Maryland Association of Core Services Agencies
Maryland Psychological Association
Massachusetts Association for Mental Health, Inc.
Mental Health America of Los Angeles
Mental Health Association in California
Mental Health Association of Maryland
Michigan Association of Community Mental Health Boards
NAMI Maryland
National Association of Social Workers - Indiana Chapter
National Council on Alcoholism and Drug Dependence - Maryland
Nebraska Association of Behavioral Health Organizations
New Jersey Association of Mental Health and Addiction Agencies, Inc.
Ohio Association of County Behavioral Health Authorities
PAR-People Advocating Recovery
Partners In Recovery, LLC of Mesa
Partners In Recovery, LLC of Peoria
Partners In Recovery, LLC of Phoenix
Partners In Recovery, LLC of Wickenburg, Arizona
Peer Assistance Services, Inc.
Provider Alliance of the Michigan Association of Community Mental Health Boards
Recovery Resources, Cleveland, OH
Regional Addiction Prevention
SAARA of Virginia, Inc. & the SAARA Center for Recovery
Sacred Heart Rehabilitation Center, Inc.
Seaway Valley Council for Alcohol/Substance Abuse Prevention, Inc.
Seven Counties Services Inc.
Silver Hill Hospital
Tarzana Treatment Centers Inc.
Texas Health Institute
Tri-County Services
Virginia Association of Community Services Boards
Washington Association of Alcoholism and Addiction Programs (AAP)
Watershed Treatment Programs, Inc.