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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 National Association of State Alcohol and Drug Abuse Directors (NASADAD) appreciates the opportunity to comment on the Essential Health Benefits (EHB) Bulletin released by the Department of Health and Human Services' (DHHS) Center for Consumer Information and Insurance Oversight (CCIIO) on December 16. NASADAD represents State substance abuse agency directors in all 50 States, seven territories and the District of Columbia who oversee and implement efficient prevention, treatment and recovery systems.

We appreciate the guidance's specific focus on SUD services and acknowledgment that coverage in the small group market is often limited for these services. We are also pleased with the focus on the requirement that SUD coverage be consistent with the Mental Health Parity and Addiction Equity Act (MHPAEA) both inside and outside an Exchange. According to the latest National Survey on Drug Use and Health in 2010, 23.1 million persons aged 12 or older needed treatment for a drug or alcohol use problem. During the same year, only 2.6 million persons received treatment in a specialty facility. Among those individuals who made an effort to receive treatment, two of the most often cited barriers were lack of health insurance and not being able to afford the cost of services.

The implementation of EHB and the Medicaid expansion holds great potential in addressing the high number of individuals with SUD who are uninsured or underinsured. However, we also know from a NASADAD Study (*Effects of State Health Care Reform on Substance Abuse Services in Maine, Massachusetts and Vermont)* that even with expansion in coverage, the uninsured rate among those with SUD remained high in the three studied States. To help States achieve compliance with both PPACA and MHPAEA and ensure consumers have access to necessary SUD services, we offer the following comments:

1) Release guidance for cost sharing and the Medicaid Expansion in a timely manner
2) Work with the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide technical assistance to States, including State substance abuse agencies to ensure substance use disorder benefits are included as required by the PPACA

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3) Work with Federal partners and State substance abuse agencies to implement and enforce parity as required by the Mental Health Parity and Addiction Equity Act (MHPAEA) and PPACA
4) Make benefit and enrollment data for benchmark plans publicly available as soon as possible
5) Work with State substance abuse agencies and State Health Insurance Exchanges to ensure substance use disorder providers are eligible for reimbursement in Exchange plans
6) Define standards for medical necessity

Below is a more detailed explanation of NASADAD's recommendations.

1) Release guidance for cost sharing and the Medicaid expansion in a timely manner

As noted above, the cost of substance use disorder services is a main barrier for individuals with a SUD to access treatment. Without a State substance abuse agency being able to identify cost sharing requirements for Exchange plans, it is difficult to fully assess how accessible plans will be to individuals with SUD or at risk of a SUD. For example, in Massachusetts the co pay for Methadone maintenance (dosing, counseling, and screening) was identified as a disincentive for individuals needing services for opiate addiction. In response, co pays for methadone have been prohibited for plans in the Massachusetts Health Connector, which is essentially the State's Exchange. As you develop regulations on cost sharing we urge you to consider barriers to individuals receiving necessary treatment once they are enrolled in an Exchange.

Further, we urge you to release guidance for the Medicaid benchmark plan. Under the PPACA, an estimated 6-9 million individuals with a substance use or mental health disorder will be eligible for Medicaid. States need guidance in order to adequately plan for the changes to take place in 2014.

2) Work with the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide technical assistance to States, including State substance abuse agencies to ensure substance use disorder benefits are included as required by the PPACA

The Affordable Care Act specifies ten categories that must be included in the essential health benefit package. Congress explicitly intended these categories be considered essential health benefits in order to ensure consumers have access to important coverage. Categories, including Mental Health and Substance Use Disorders, Rehabilitative and Habilitative Care, are examples of conditions or service categories that are specifically included within Section 1302 of the PPACA to correct longstanding gaps in coverage that consumers face in the individual and small group markets.

We recommend working with SAMHSA to provide technical assistance to States (including State substance abuse agencies) to ensure SUD services are included as required by the law, particularly in instances where a State's benchmark plan must be supplemented to include appropriate SUD benefits.

3) Work with Federal partners (including SAMHSA) and State substance abuse agencies to implement and enforce parity as required by the Mental Health Parity and Addiction Equity Act (MHPAEA) and PPACA

We noted the acknowledgment in the EHB Bulletin that the PPACA requires the EHB to include SUD benefits in a manner consistent with the requirements of the MHPAEA. We ask the Department to work with its federal partners, State substance abuse agencies and other relevant State agencies (insurance departments) to develop States' capacity to ensure compliance with MHPAEA. This includes ensuring plans are not able to include financial requirement or treatment limitation, either quantitative or

nonquantitative, to MH/SUD benefits in any classification, that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification. Such plans also may not apply separate cost sharing requirements or treatment limitations that are applicable only with respect to MH/SUD benefits. These parity requirements are to apply to treatment limitations on the scope and range of services and settings covered within any benefit classification.

4) **Make benefit and enrollment data for benchmark plans publicly available as soon as possible**

The design of the EHB will directly impact the scope of health benefits and the well-being of over 70 million Americans, including all enrollees in non-grandfathered plans in the individual and small group markets, the health insurance exchanges, the Medicaid benchmark, and the Basic Health Program. In short, these benefit sets will have far reaching implications for our entire health system; including the over 25 million Americans with untreated mental illness and/or substance use disorders.

In the bulletin and its supporting documents, HHS discusses the information it collected and analyzed to draw conclusions about what a "typical employer plan" covers. The bulletin explains that, in general, products in the small group market, State employee plans, and the Federal Employee Health Benefits Program (FEHBP) Blue Cross Blue Shield Standard Option, and Government Employees Health Association plans do not differ significantly in the range of services they cover. We ask that HHS identify and provide benefit data from the specific plans that would be eligible at this point in time to serve as benchmarks in a State.

Specifically, we request that HHS make publicly available the benefit data from 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 additionally request the most current enrollment data in each of the plans identified as well as the plan contracts.
If HHS is unable to publicize the data, we ask that HHS work with States or other entities (such as the Office of Personnel Management, in the case of FEHBP plans) to provide this information.

5) **Work with State substance abuse agencies and State Health Insurance Exchanges to ensure substance use disorder providers are eligible for reimbursement in Exchange plans**

The EHB should incorporate State funded, certified and/or licensed addiction providers and facilities as part of the provider network to ensure effective, qualified SUD services are provided. Given the increase in the number of individuals anticipated to access SUD services through Medicaid and Exchanges, providers with SUD expertise will be essential. Research has shown that chronic physical illnesses very often co-occur with mental health and/or substance use disorders. For example, one recent study of Medicaid beneficiaries found that approximately two-thirds of those with common chronic physical conditions also had at least one MH or SUD condition, and those beneficiaries with co-occurring chronic physical illnesses and a mental health or substance use disorder had associated healthcare costs that were 60 to 75 percent higher than those with only physical chronic illnesses.[1] SUD service providers have a long history of meeting the health needs of these hard-to-serve populations.

6) Define 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 where a patient can show that a clinical recommendation is consistent with professional clinical guidelines, their insurer may reject a prescribed treatment if it is inconsistent with other definitional elements such as relative cost, efficiency and effectiveness.

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."

Thank you again for the opportunity to provide comments on this important issue. As your work continues on the EHB, please feel free to use NASADAD as a resource.

Sincerely,

Rob Morrison
Executive Director

Cc: Mark Stringer, President

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[1] Cynthia Boyd, Bruce Leff, Carlos Weiss, Jennifer Wolff, Allison Hamblin and Lorie Martin (2010). "Clarifying Multimorbidity Patterns to Improve Targeting and Delivery of Clinical Services for Medicaid Populations." Center for Health Care Strategies, pgs. 4-5. Available at: http://www.chcs.org/usr_doc/clarifying_multimorbidity_patterns.pdf. The common chronic physical conditions were asthma/chronic obstructive pulmonary disease, congestive heart failure, coronary heart disease, diabetes and hypertension.