CCWH
California Coalition for Whole Health
CiMH ♦ CMHDA ♦ CADPAAC ♦ ADPI ♦ CSAM ♦ CPA

January 25, 2012

Peter Lee, Executive Director
Diana Dooley, Chair
California Health Benefit Exchange
1500 Capitol Avenue
Sacramento, CA 95814

RE: California Coalition for Whole Health Comments to the California Health Benefit Exchange on the Essential Health Benefits Bulletin as released by the Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight on December 16, 2011

Dear Director Lee and Secretary Dooley:

The California Coalition for Whole Health (CCWH) is a diverse group of behavioral health stakeholders concerned with influencing the implementation of the Patient Protection and Affordable Care Act (ACA) to appropriately address mental health and substance use disorder issues. The California Coalition for Whole Health took root in the national Coalition for Whole Health, a group of over a hundred organizations in the mental health and addictions fields from across the nation with shared interest in ensuring appropriate inclusion of behavioral health issues in ACA implementation activities. Members of CCWH have worked alongside our national coalition counterparts to develop the attached recommendations on the *Coverage of Mental Health and Substance Use Disorder Services in the Essential Health Benefit Package*. CCWH strongly urges the California Health Benefit Exchange to review and consider this important set of consensus recommendations to inform California's comments to the Centers for Medicare and Medicaid Services on the Essential Health Benefits Bulletin (released 12-16-11). Additionally, CCWH hopes that these recommendations may serve as an important resource to the California Health Benefit Exchange board and staff as it moves forward in identifying essential health benefits that may not already be part of the benchmark plans.

1) **The California Health Benefit Exchange Board will need to make decisions about mental health and drug and alcohol coverage as part of the Essential Health Benefits.** The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (H.R. 1424) expanded the parity requirements in the Mental Health Parity Act of 1996 to include both quantitative and non-quantitative treatment limitations, new financial requirements, and require out of network covered benefits. Essentially, this important federal law requires an insurer that offers behavioral health benefits to cover them at parity with medical and surgical benefits. The ACA

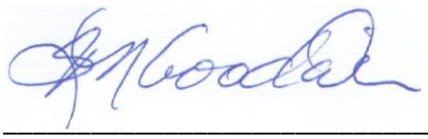
expands the reach of the law to exchange products. The direction for defining Essential Health Benefits outlined by the Centers for Medicare and Medicaid Services in their December 16, 2011 draft bulletin requires states to include mental health and substance use services that comply with 2008 federal Mental Health Parity and Addiction Equity Act requirements, regardless of whether these services are already included or treated at parity in the benchmark plan.

2) **The Business Case[1] for including a full continuum of mental health and drug and alcohol coverage in the Essential Health Benefits is well documented**. In fact, CCWH prefers to think about optimal benefits versus essential health benefits. Optimal benefits achieve a return that far exceeds the investment. There is now abundant evidence that provision of appropriate mental health and substance use services decreases medical costs, improves health outcomes, and enhances the patient experience of care (quality, access, reliability). Mental health and substance use problems will be prevalent in the newly covered population: in 2011, The Kaiser Commission on Medicaid and the Uninsured reported that nearly one-third of adults and one-fifth of children had a diagnosable substance use or mental health problem in the last year. Individuals with severe mental illness and drug and alcohol problems die 25 years sooner than the general population and have higher healthcare costs throughout their lives[2]. Given the necessity under the ACA to link quality outcomes and controlled costs, California's Essential Health Benefits should reflect the latest thinking about effective mental health and drug and alcohol coverage.

The California Coalition for Whole Health strongly urges the California Health Benefit Exchange to look to this group as a valuable resource on these critical issues. Please do not hesitate to contact Dr. Neal Adams or Dr. David Pating at **(916) 379-5354** or to reach out to any of the undersigned representatives to request more information, pose questions, or solicit feedback on mental health or substance use disorder issues.

Sincerely,

Undersigned representatives of the
California Coalition for Whole Health



Sandra Naylor Goodwin, PhD, MSW
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[1] California Institute for Mental Health and the Integrated Behavioral Health Project. The Business Case for Bidirectional Integrated Care: Mental Health and Substance Use Services in Primary Care Settings and Primary Care
[2] Parks J, Svensden D, Singer P, Foti ME. Morbidity and Mortality in People with Serious Mental Illness. Alexandria: National Association of State Mental Health Program Directors, 2006.

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Coalition for Whole Health
Recommendations on Coverage of Mental Health and Substance Use Disorder Services in the Essential Health Benefit Package

In 2010, Congress enacted the Affordable Care Act (ACA), which will substantially expand health insurance coverage for Americans, largely through state health insurance Exchanges for individuals and small businesses, and through an expansion of Medicaid for low-income individuals and families. ACA requires the plans in the Exchanges, as well as Medicaid expansion plans, to cover a set of ~~e~~essential health benefits" that include ~~m~~ental health and substance use disorder [MH/SUD] services, including behavioral health treatment." By including MH/SUD as essential services, Congress recognized that 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.

A well designed Essential Health Benefits package that includes sufficient coverage for mental health and substance use disorders for children, youth and adults is central to efforts to ensure that health reform meets its potential to allow individuals and families to recover from these diseases, improve health, and bend the cost curve. The Coalition for Whole Health, a coalition of national organizations advocating for improved coverage for and access to mental health and substance use disorder prevention, treatment, rehabilitation, and recovery services, recommends full inclusion of mental health and substance use disorder services within the Essential Health Benefits framework. This includes incorporating MH/SUD services in each of the Essential Health Benefits categories, as appropriate, in addition to the *mental health and substance use disorder services* category per se.

The ACA creates broad health care service categories that must be covered by certain health plans. The ACA defines these Essential Health Benefits in ten general categories:

- mental health and substance use disorder services, including behavioral health treatment
- laboratory services
- emergency services
- hospitalization
- prescription drugs
- maternity and newborn care
- pediatric services
- rehabilitative and habilitative services and devices
- preventive and wellness services and chronic disease management
- ambulatory patient services

For an addiction and mental health system to be accessible, accountable, efficient, equitable and of high quality,[i] the Coalition for Whole Health (~~t~~the Coalition") believes that the Essential Health Benefits package covered by both qualified health plans operating in state Exchanges and by Medicaid expansion plans must include, at a minimum, the benefits detailed in this document. These recommendations are based on evidence based practices to sustain addiction and mental health recovery – regardless of the setting. A list of Coalition for Whole Health members who have endorsed this paper is attached.

Overview
Nearly one-third of adults and one-fifth of children had a diagnosable substance use or mental health problem in the last year.[ii] Individuals with severe addiction and co-occurring mental illness, a significant percentage of those with substance use or mental health problems, die prematurely--on average, 37 years sooner than Americans without severe addiction and mental health problems.[iii] A recent study found that people with serious mental illness die 25 years sooner than the general population from common medical conditions such as cancer and heart disease.[iv] Individuals with severe mental health and severe substance use disorders not only have greater mortality rates, but their health care costs throughout their lives are substantially higher, primarily due to preventable emergency department visits and hospital admissions and readmissions. Appropriate mental health and substance use disorder services will decrease costs in the medical system and lengthen the lifespan of millions of Americans with these illnesses. In 2007, the Agency for Healthcare Research and Quality found that nearly 13 percent, or one of every eight emergency department visits are related to a mental health or substance use disorder.[v] Several states have found that providing adequate mental health/addiction treatment

benefits stops the escalation in health care costs and reduces Medicaid spending. For example, Washington State found that one year after providing a full addiction treatment benefit, $398 per member per month savings were achieved in overall Medicaid spending.[vi] However, in 2009, 23.5 million Americans needed treatment for an illicit drug or alcohol problem, but only 4.3 million people received treatment – leaving a gap of 19.2 million Americans who needed treatment for a substance use disorder but did not receive it.[vii] In addition, only 4.1 million of the 9.8 million Americans who needed treatment for a serious mental illness received it.[viii]

The costs associated with untreated mental health/addictive disorders also affect private payers. In 2006, Robinson and Reiter estimated that more than two thirds of primary care visits are related to psycho-social reasons.[ix] Even after controlling for a number of chronic co-morbid diseases, depressed patients covered by private insurance had significantly higher costs than non-depressed patients across 11 chronic co-morbid diseases. The costs associated with alcohol or drug-related hospitals stays are staggering – an estimated $12 billion in 2006 alone. In addition, it has been shown that the children of drug or alcohol addicted people have higher medical expenses than children of non-addicted parents. Depression is one the of costliest health issues for U.S employers, estimated to cost $44 billion annually. Untreated alcohol and drug problems are the number one cause of disability claims and cause significant absenteeism and presenteeism. Total annual economic costs for untreated alcohol and drug abuse total approximately $327 billion.[x] This does not include the increased stress-related or trauma-caused medical costs for family members living with an active alcoholic or drug abusing person.

When substance use and mental health conditions are addressed and treated as the preventable, treatable chronic diseases they are, systems reap substantial cost savings while dramatically improving health. Inclusion of prevention, treatment and recovery of mental illness and substance use disorders through the ACA's Essential Health Benefits package will reduce health costs and ensure that millions of people lead healthier lives, thereby strengthening individuals, families, communities, and our nation as a whole.

The Affordable Care Act, the Mental Health Parity and Addiction Equity Act, and Additional Provisions to Ensure Good Access to Care

With passage in 2008 of the federal "Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act" (MHPAEA), 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 needed to get and stay well. MHPAEA precludes group health plans from providing MH/SUD benefits in a more restrictive way than other medical and surgical benefits. The Affordable Care Act extends MHPAEA's requirements to qualified health plans in the state-based health insurance Exchanges and Medicaid benchmark coverage offered under the Medicaid expansion. Plans may use cost containment techniques but must manage MH/SUD benefits comparably with the way they manage other medical conditions. Final MHPAEA regulations implementing parity in Medicaid managed care plans and clarifying what plans' scope of services are, and what their non-quantitative treatment limitations obligations are, must be fully implemented. To ensure that the MH/SUD provisions of the ACA are implemented well, MHPAEA must first be fully implemented. A fully operationalized MHPAEA must serve as the fundamental building block on which the MH/SUD essential health benefit provisions in the Affordable Care Act are built. Without this non-discriminatory "floor," meaningful access to MH/SUD benefits will not be achieved.

As the Essential Health Benefits package is implemented, the Coalition also believes it must be affirmed that State laws which provide better coverage, rights, methods of access to health care services and consumer protections from the standpoint of the insured are not preempted by the Affordable Care Act. This is consistent with Section 1321(d) in the ACA that makes clear that State laws will not be superseded by the new federal law.

We also support the other consumer protections in the law intended to ensure comprehensive access for covered individuals to all essential services outlined in the Essential Health Benefits package. In particular, we strongly support the requirement in the law that the Secretary shall "ensure that health benefits established as essential not be subject to denial to individuals against their wishes 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."[xi] These protections have very significant implications for individuals with mental health and/or substance use disorders and health and mental health consequences for their family members, and we ask that enforcement of these protections be included among the highest priorities for implementation and ongoing administration of essential health coverage and other health plan requirements.

Proposed Components of Comprehensive Coverage of MH/SUD in the Essential Health Benefits Package

The recommended MH/SUD benefits delineated below are based in part on a review of existing employer plans, because the ACA requires the essential health package to reflect those covered in a ~~-~~typical employer plan." At the same time, however, because final MHPAEA regulations have not been issued, and enforcement of existing regulations has been limited, the parity-based services required under ACA are not yet reflected in the current insurance market. Therefore, this list also draws on evidence-based and best practice approaches to habilitative and rehabilitative services for individuals and families who have MH/SUD as well as employer surveys done by the National Business Group on Health and the Kaiser Family Foundation.[xii.xiii] Like for other chronic illnesses, the Coalition recommends an array of services to meet the needs of plan participants at all stages of the continuum of their MH/SUDs, from mild to severe impairment. Clearly, some services will be necessary for only the severely mentally ill and addicted, while other services will meet the needs of those with mild to moderate MH/SUD.

Under the ACA, MH/SUD treatment must be sufficient to provide medically necessary care. Plans must be required to provide transparent definitions of medical necessity for mental health, substance use disorder and other medical conditions so that parity compliance can be measured. To date, the National Quality Forum has developed the most comprehensive quality standards for treatment of SUD.[xiv] Based on these extensively researched standards and others, the following represents the specific components of comprehensive MH/SUD coverage, which can be delivered in a range of settings, that the Coalition for Whole Health recommends be required as essential health benefits:

Mental Health and Substance Use Disorders, Including Behavioral Health Treatment

Assessment: For those assessed as needing MH/SUD services, individualized assessment tools must drive the quality of care. Targeted MH/SUD services must be included in a distinct treatment plan and the beneficiary must be involved in the treatment planning process. The Coalition for Whole Health supports provisions that require the use of standardized assessment tools under the ACA. Standardized screening and assessment tools, such as the Patient Health Questionnaire for one example, will allow clinicians to identify symptoms and problems and determine the specific interventions that will best treat an individual's presenting symptoms. Standardized assessment tools should include:

- Assessment of health including a comprehensive bio-psychosocial assessment of related mental health and substance use issues, and of needs and strengths that can be used to help individuals attain their treatment, other service and support goals
- Ongoing mental health and substance use disorder assessments using evidence-based assessment tools
- Specialized evaluations including psychological and neurological testing
- Diagnostic assessments of MH/SUD in general medical settings, including education and counseling for mild MH/SUD

Patient Placement Criteria: Today, evidence-based patient placement criteria can help to effectively place individuals into the optimal level of MH/SUD care for the amount of time that is deemed medically necessary. For example, the *Patient Placement Criteria for the Treatment of Substance-Related Disorders-- Second Edition, Revised* (PPC-2R) of the American Society of Addiction Medicine (ASAM) is a widely used tool by which practical and clinical determination of substance use levels of care can be measured; ASAM criteria are currently used in some form in 30 states and have been adopted by a wide range of commercial payers and providers.[xv] Similar mental health patient placement tools exist, such as Locus. In addition, the Substance Abuse and Mental Health Services Administration is working with ASAM to develop the Recovery Support Services Assessment Tool which will be a useful tool in assessing recovery support needs. More work is needed to further develop these tools for operational use. Where available, patient placement criteria should be used for the placement of patients in the appropriate level of care. As a result of MHPAEA and ACA, medically necessary care cannot be subject to annual or lifetime benefit caps, nor can there be arbitrary limits on MH/SUD that are not imposed on other medical conditions. The effects of MH/SUD treatment are optimized when patients receive ongoing recovery supports and information on managing their own illness, and best outcomes occur when individual patients are matched with appropriate levels of care.[xvi]

Outpatient Treatment: As the parity provisions of the ACA require, outpatient treatment services are to be provided as long as medically necessary with no limits on duration or frequency and patients must be allowed to access treatment to manage relapses, as is the case with other chronic conditions. The totality of substantiated interventions that offer promise for treatment resistant cases must also be covered in the essential health benefit package. Outpatient treatment services should include evidence-based:

- Individual, group, and family therapies
- Devices and technology interventions for mental health and addictive disorders
- General and specialized outpatient medical services
- Consultation to caregivers and other involved collateral contacts, such as school teachers, in accordance with confidentiality requirements
- Evidence-based complementary medicine services, comparable to complementary medicine services covered for other health conditions[xvii]
- Monitoring services, comparable to those provided to determine compliance with the treatment regimens for other health conditions

Intensive Outpatient Services: Intensive outpatient and partial hospital programs are ambulatory time-limited treatment programs which offer therapeutically intensive, coordinated, and structured group-oriented clinical services as either a step down or alternative to inpatient acute services for both MH and SUD populations. These services stabilize acute crises and clinical conditions, utilizing recovery principles to help return individuals to less intensive outpatient, case management, peer support, and /or other recovery based services. Coverage of these services is an integral part of most private MH/SUD benefit packages.

Intensive outpatient covered benefits should include:

- Substance use intensive outpatient treatment
- Mental health intensive outpatient treatment
- Partial hospitalization
- Dual-diagnosis partial hospitalization and intensive outpatient services for persons with co-occurring MH and SUD conditions
- Intensive case management for MH/SUD

Residential Services: Residential MH/SUD services are a key component of an optimally-functioning service delivery continuum and help offset the costs associated with emergency department visits, hospital admissions and readmissions.[xviii] In 2008, approximately 2 million adults received inpatient or residential care for mental health problems.[xix] According to SAMHSA's 2009 National Survey of Substance Abuse Treatment Services (N-SSATS), as of 2009, 13,513 substance abuse treatment facilities provided medication, counseling, behavioral therapy, case management, and other types of services to persons with substance use disorders. Of these 13,513 facilities, 4,317 provided inpatient services. Of the 4,317 facilities providing inpatient services, 3,520 or 81.5% were non-hospital residential treatment facilities, and merely 797 or 18.5% were hospital-based treatment providers. The National Survey shows that during 2009, of the 117,515 individuals who obtained inpatient substance abuse treatment, 103,174 or 87.8% received inpatient treatment in a residential, non-hospital facility, and merely 14,341 or 12.2% received inpatient treatment in a hospital setting.[xx]

Coverage of medical residential services is also common in most heath plans. Milliman, Inc found that most health plans have analogous levels of care with MH/SUD residential services including orthopedic, stroke and cardiac rehabilitative services in non-hospital settings.[xxi]

Placement in a residential or inpatient setting—as with placement at all levels of MH and SUD care across the continuum—should be based on the individual needs of the patient. Patients should be regularly assessed to ensure that they are at all times placed within the appropriate treatment setting for the appropriate duration, receiving the appropriate level of care befitting their needs and the severity of their illness. To the greatest extent possible the use of uniform patient placement criteria should drive placement decisions.

Residential treatment is an essential part of this treatment continuum. ASAM and other professional organizations define residential treatment as occurring 24 hours a day, in a live-in setting that is either housed in or affiliated with a permanent facility. While there are several types of residential programs of varying intensity, a defining characteristic of all residential programs is that they serve "individuals who require safe and stable living environments in order to develop their recovery skills." The services provided are organized and staffed by addiction and mental health personnel who provide a planned regimen of care, and generally include medical and social services needed by the patient population. Analogous residential treatment modalities for other medical conditions include stroke rehabilitation, spinal cord injury rehabilitation, traumatic brain injury rehabilitation, and orthopedic rehabilitation.[xxii] Covered benefits should include:

- Residential crisis stabilization
- Detoxification in clinically-managed non-hospital residential treatment facilities for SUD care, including the use of medication-assisted withdrawal management services
- Mental health residential for adults and youth
- Substance use disorder residential, including the use of medication-assisted treatment, for adults and youth[xxiii]
- Dual-diagnosis residential services for adults and youth with co-occurring MH and SUD conditions
- Clinically managed 24-hour care
- Clinically managed medium intensity care
- Inpatient psychiatric hospital
- Inpatient mental health and substance use disorder care
- Inpatient hospital dual-diagnosis care for youth and adults with co-occurring MH and SUD conditions

Laboratory Services

While the use of laboratory tests at all levels of care (hospital, residential, outpatient) is clearly indicated to identify potentially co-occurring general medical conditions, or general medical complications of treatments for MH/SUD conditions, evidence-based medical care for persons with MH/SUD conditions requires the ability to offer integrated general medical and MH/SUD care. The Essential Health Benefit should include coverage for laboratory tests whether offered by MH/SUD specialists, general medical professionals such as primary care providers, or persons in non-behavioral, non-primary care medical/surgical specialties.

- Laboratory services, including drug testing

Emergency Services

- Crisis services in both MH/SUD and medical settings, including 24 hour crisis stabilization and mobile crisis services, including those provided by peers
- 24/7 crisis warm and hotline services
- Hospital-based detoxification services

Prescription Drugs

Pharmacotherapy and Medication-Assisted Treatment: Medications approved for mental illness, alcohol, drug and tobacco treatment are proven to be effective and must be a covered essential health benefit. All FDA approved medications should be covered for SUDs and matched to the assessed individuals' clinical need and personal preference. The full continuum of FDA approved medications for MH/SUD must be covered and parity in access to medications prescribed for the treatment of mental health and substance use disorders must be enforced. Coverage should be continued as long as medically necessary with no limits. Medication services should include:

- Medication management
- Medication administration
- Pharmacotherapy (including medication-assisted treatment)
- Home-based, mobile device or internet-based medication adherence services
- Assessment for medication side effects
- Appropriate wellness regimens for consumers who are experiencing metabolic effects as a result of their medication

Rehabilitative and Habilitative Services and Devices

The history of insurance discrimination in MH/SUD benefits has been a major barrier for individuals to access the type and amount of care they need. Individuals with histories of untreated chronic conditions, including MH/SUD, may have complex and varied health problems that will need to be addressed to help them to get and stay well.

Case management has been identified by both medical and behavioral health authorities as an effective service for improving health outcomes among people with chronic medical, mental health and substance use disorder conditions.[xxiv] Comprehensive case management secures access to and retention in services, promoting compliance with recommended treatment protocols throughout an episode of care. For patients with severe substance use and mental health conditions, multiple co-morbidities and for patients who are resistant to medically necessary treatment, case management services are necessary to promote participation in treatment of sufficient intensity and duration to address underlying illness. Case management also supports successful transitions between more structured care (i.e., residential, partial hospitalization, detoxification services) and less structured care (i.e., outpatient) and addresses practical barriers to participation that impede clinical progress. These effective strategies to improve health outcomes through care management and coordination are consistent with those in the ACA that seek to reduce costs and improve chronic disease care.

Rehabilitative Services: The following rehabilitative services should be covered:

- Psychiatric rehabilitation services
- Behavioral management
- Comprehensive case management in physical health or MH/SUD settings which should include individualized service planning with periodic review to address changing needs, treatment matching, navigation between all needed services, communication between all service providers, enrollment in Medicaid/insurance, and support to maintain continued eligibility
- Assertive Community Treatment (ACT) Teams
- Peer provided telephonic and internet based recovery support services, including those delivered by recovery community centers
- Recovery supports, including those delivered by peer run mental health organizations
- Skills development including supported employment services

Recovery supports: Twenty-three states provide Medicaid reimbursement for peer-delivered mental health and/or addiction recovery support services.[xxv] Ongoing recovery supports for at least one year following an active phase of treatment have treatment has been shown to improve and sustain treatment and health outcomes for individuals with substance use disorders.[xxvi] Recovery supports have also been shown to be an effective engagement tool prior to and during treatment. A June 2008 study of Texas drug court participants who received recovery support services found that ~~-a~~among the specific types of recovery support services, those that were most closely related to the process of recovery such as individual recovery coaching, recovery support group, relapse prevention group and spiritual support group, were more strongly associated with successful outcomes."[xxvii]

For other individuals, recovery supports are their preferred method of self-managing addiction and mental health issues. Recovery support coaching (both clinical and non-clinical) serves as a strengths-based method for individuals to achieve health and wellness goals. Telephonic recovery support services (provided through recovery support centers) have been shown to improve health outcomes and sustain recovery one year following treatment.[xxviii] Certain interactive communication technology devices should be covered if the interactive device aids in sustaining a beneficiary's recovery. Recovery support services should include:

- Peer provided recovery support services for addiction and mental health conditions
- Recovery and wellness coaching
- Recovery community support center services
- Support services for self-directed care
- Community Support Programs and other continuing care for mental health and substance use disorders

Habilitative Services should include**:**

- Personal care services
- Respite care services for caregivers
- Transportation to health services
- Education and counseling on the use of interactive communication technology devices

Preventive and Wellness Services and Chronic Disease Management

According to National Institute of Mental Health research, 50 percent of all lifetime mental health and substance use disorders start by age 14. Yet, because the early signs of a mental health disorder or substance use disorder often are missed, diagnosis regularly occurs 10 years or more after the onset of symptoms and the disease is then allowed to progress. In addition, children who first smoke marijuana under the age of 14 are more than five times as likely to abuse drugs as adults than those who first use marijuana at age 18.3.[xxix] Furthermore, adolescents who begin drinking before the age of 15 are four times more likely to develop alcohol dependence, whereas each additional year of delayed drinking onset reduces the probability of alcohol dependence by 14%.[xxx] It is therefore critical that health-related school, community wide and workplace health promotion initiatives include a specific and discrete emphasis on substance use/abuse prevention and mental health promotion.

The ACA places a mandatory requirement on all group health plans and health insurance issuers offering group or individual health insurance to offer, without cost-sharing, a minimum level of preventive health services, including services that have a rating of A or B by the United States Preventive Services Task Force (USPSTF). These mandatory USPSTF recommendations include depression screening for adults and youth age 12 to 18, alcohol screening and counseling and tobacco screening and cessation interventions for adults. These and other preventive services, such as drug screening and counseling, are a critical component of prevention and should be included in the preventive and wellness services and chronic disease management Essential Health Benefit because approximately four million Americans have both a serious mental illness and a substance use disorder.[xxxi] Health promotion is also a significant part of comprehensive prevention and wellness plans and should be included in the preventive and wellness services and chronic disease management Essential Health Benefit. Services identified in the Preventive, Wellness and Chronic Disease Management Essential Health Benefits category should include:

- Screening (including screening for depression, alcohol, drugs, and tobacco), brief interventions (including motivational interviewing) and facilitated referrals to treatment
- General health screenings, tests and immunizations
- Appropriate MH/SUD related educational programs for consumers, families and caretakers, including programs related to tobacco cessation, the impact of alcohol and drug problems, depression and anxiety symptoms and management, and stress management and reduction, and referral for counseling or support as needed

- Caretaker education and support services, including non-clinical peer-based services, that engage, educate and offer support to individuals, their family members, and caregivers to gain access to needed services and navigate the system
- Health coaching, including peer specialist services, provided in person or through telehealth, e-mail, telephonic, or other appropriate communication methods
- Health promotion, including substance use prevention and services that impact well-being and health-related quality of life
- Wellness programming for youth, including student assistance programming
- Services for children, including therapeutic foster care
- Interventions aimed at facilitating compliance with treatment and improving management of physical health conditions
- Care coordination (including linkages to other systems, recovery check-ups, linkages to peer specialists, recovery coaches, or support services based on self-directed care)
- Relapse prevention, including non-clinical peer-based services, to prevent future symptoms of and promote recovery strategies for mental and substance use disorders.

For these preventive services to have the greatest impact on community health and health care cost efficiencies, beneficiaries should receive substance use and mental health screenings free of cost sharing; even if they visit a health professional for another service. Under interim final ACA regulations, beneficiaries must make an appointment specifically for preventive care in order for the screenings to be free of cost sharing. However, with SUD and MH screenings in particular, it is critically important that no-cost screenings be allowed during visits for other primary care services, since individuals most in need of mental health and addiction screenings are unlikely to seek them out on their own.

Screening, Brief Intervention, and Referral to Treatment, or SBIRT, is a preventive intervention that has been shown to be very effective in hospitals, health clinics and primary care settings in reducing MH/SUD prevalence and future emergency room visits.[xxxii] SBIRT targets people who are just beginning to be symptomatic with mental health or substance use disorders (including tobacco). Medical benefits must support and encourage SBIRT through full reimbursement in emergency rooms and primary care settings. Laws and policies that create barriers to screening, including state Uniform Policy Provision Laws (UPPL) that permit insurers to deny reimbursement for any injury that occurs while a patient is under the influence of alcohol or other drugs, must be repealed or preempted.[xxxiii]

Coverage for Youth

While most services mentioned above apply to youth, there are additional MH and SUD services that are only appropriate for youth and families. These services are listed below in the appropriate corresponding Essential Health Benefits categories.

The Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit should serve as a model for coverage for children and youth up to age 21 who are insured through the state Exchanges and Medicaid expansion plans.[xxxiv] These comprehensive benefits are essential to ensure the early identification, treatment and recovery of youth diagnosed with a mental illness or substance use disorder. Specific attention should also be paid to ensure that the needs of transition age youth are well met.

Maternal and Newborn Services

- Pre-natal and peri-natal screening and brief interventions for maternal depression and substance use disorders and referral to treatment
- Health education
- Targeted case management

- Maternal, infant, and early childhood home visiting programs

Pediatric Services

- Screening for substance use, suicide, and other mental health problems using tools such as the CAGE questions, the Alcohol Use Disorders Identification Test (AUDIT) instrument and other rapid identification tools[xxxv,xxxvi]
- Early intervention services
- Service planning
- Caretaker coaching on children's social/emotional development and support
- Therapeutic mentoring
- Skill building
- Intensive home-based treatment
- Targeted case management

Conclusion

The Affordable Care Act holds tremendous promise for the millions of Americans with, at risk for, or in recovery from mental health and substance use disorders. Providing the full range of MH and SUD prevention, treatment, recovery and rehabilitation across the lifespan will save lives, improve health, and reduce health costs. We appreciate your consideration of the above recommendations and ask that you use us as a resource moving forward.

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[i] Substance Abuse and Mental Health Services Administration. Draft Description of Good and Modern Addictions and Mental Health Service System. (2011) Retrieved from: http://www.samhsa.gov/healthreform/docs/good_and_modern_4_18_2011_508.pdf

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ESSENTIAL HEALTH BENEFITS BULLETIN

Center for Consumer Information and Insurance Oversight

December 16, 2011

Contents

ESSENTIAL HEALTH BENEFITS BULLETIN

Purpose

The purpose of this bulletin is to provide information and solicit comments on the regulatory approach that the Department of Health and Human Services (HHS) plans to propose to define essential health benefits (EHB) under section 1302 of the Affordable Care Act. This bulletin begins with an overview of the relevant statutory provisions and other background information, reviews research on health care services covered by employers today, and then describes the approach HHS plans to propose. This bulletin only relates to covered services. Plan cost sharing and the calculation of actuarial value are not addressed in this bulletin. We plan to release guidance on calculating actuarial value and the provision of minimum value by employer-sponsored coverage in the near future. In addition, we plan to issue future guidance on essential health benefit implementation in the Medicaid program.

The intended regulatory approach utilizes a reference plan based on employer-sponsored coverage in the marketplace today, supplemented as necessary to ensure that plans cover each of the 10 statutory categories of EHB. In developing this intended approach, HHS sought to balance comprehensiveness, affordability, and State flexibility and to reflect public input received to date.

Public input is welcome on this intended approach. Please send comments on the bulletin by January 31, 2012 to: EssentialHealthBenefits@cms.hhs.gov.

Defining Essential Health Benefits

A. Introduction and Background

Statutory Provisions

Section 1302(b) of the Affordable Care Act directs the Secretary of Health and Human Services (the Secretary) to define essential health benefits (EHB). Non-grandfathered plans in the individual and small group markets both inside and outside of the Exchanges, Medicaid benchmark and benchmark-equivalent, and Basic Health Programs must cover the EHB beginning in 2014.[1] Section 1302(b)(1) provides that EHB include items and services within the following 10 benefit categories: (1) ambulatory patient services, (2) emergency services (3) hospitalization, (4) maternity and newborn care, (5) mental health and substance use disorder services, including behavioral health treatment, (6) prescription drugs, (7) rehabilitative and habilitative services and devices, (8) laboratory services, (9) preventive and wellness services and chronic disease management, and (10) pediatric services, including oral and vision care.

[1] Self-insured group health plans, health insurance coverage offered in the large group market, and grandfathered health plans are not required to cover the essential health benefits.

Section 1302(b)(2) of the Affordable Care Act instructs the Secretary that the scope of EHB shall equal the scope of benefits provided under a typical employer plan. In defining EHB, section 1302(b)(4) directs the Secretary to establish an appropriate balance among the benefit categories. Further, under this provision, the Secretary must not make coverage decisions, determine reimbursement rates, or establish incentive programs. Benefits must not be designed in ways that discriminate based on age, disability, or expected length of life, but must consider the health care needs of diverse segments of the population. The Secretary must submit a report to the appropriate committees of Congress along with a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that the scope of the EHB is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary.

In addition, section 1311(d)(3) of the Affordable Care Act requires States to defray the cost of any benefits required by State law to be covered by qualified health plans beyond the EHB.

The statute distinguishes between a plan's covered services and the plan's cost-sharing features, such as deductibles, copayments, and coinsurance. The cost-sharing features will determine the level of actuarial value of the plan, expressed as a "metal level" as specified in statute: bronze at 60 percent actuarial value, silver at 70 percent actuarial value, gold at 80 percent actuarial value, and platinum at 90 percent actuarial value.[2]

Public and Other Input

To inform the Department's understanding of the benefits provided by employer plans, HHS has considered a report on employer plans submitted by the Department of Labor (DOL), recommendations on the process for defining and updating EHB from the Institute of Medicine (IOM), and input from the public and other interested stakeholders during a series of public listening sessions detailed below.

Section 1302(b)(2)(A) requires the Secretary of Labor to inform the determination of EHB with a survey of employer-sponsored plans. On April 15, 2011, the DOL issued its report, in satisfaction of section 1302(b)(2)(A) of the Affordable Care Act, providing results on the scope of benefits offered under employer-sponsored insurance to HHS.[3] The DOL survey provided a broad overview of benefits available to employees enrolled in employer sponsored plans. The report drew on data from the 2008 and 2009 National Compensation Survey (which includes large and small employers), as well as DOL's supplemental review of health plan Summary Plan Documents, and provided information on the extent to which employees have coverage for approximately 25 services within the 10 categories of EHB outlined in the Affordable Care Act (e.g., a certain percentage of plan participants have coverage for a certain benefit).

In order to receive independent guidance, HHS also commissioned the IOM to recommend a process that would help HHS define the benefits that should be included in the EHB and update the benefits to take into account advances in science, gaps in access,

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[2] As noted, these will be the subject of forthcoming guidance.

[3] Available at http://www.bls.gov/ncs/ebs/sp/selmedbensreport.pdf

and the effect of any benefit changes on cost. The IOM submitted its consensus recommendations in a report entitled "Essential Health Benefits: Balancing Coverage and Cost" on October 7, 2011.[4] In order to balance the cost and comprehensiveness of EHB, the IOM recommended that EHB reflect plans in the small employer market and that the establishment of an EHB package should be guided by a national premium target. The IOM also recommended the development of a framework for updating EHB that would take into account new evidence about effective interventions and changes in provider and consumer preferences while ensuring that the cost of the revised package of benefits remains within predetermined limits as the benefit standards become more specific. The IOM recommended flexibility across States and suggested that States operating their own Exchanges be allowed to substitute a plan that is actuarially equivalent to the national EHB package. The IOM also recommended continued public input throughout the process.

Following the release of the IOM's recommendations, HHS held a series of sessions with stakeholders, including consumers, providers, employers, plans, and State representatives, in both Washington, D.C. and around the nation to gather public input. Several key themes emerged. Consumer groups and some provider groups expressed concern at the IOM's emphasis on cost over the comprehensiveness of benefits. Some consumer groups expressed a belief that small group plans may not represent the typical employer plan envisioned by the statute, while employers and health insurance issuers generally supported the IOM conclusion that EHB should be based on small employer plans. Consumer and provider groups commented that specific benefits should be spelled out by the Secretary, while health insurance issuers and employers commented that they prefer more general guidance, allowing for greater flexibility. Both provider and consumer groups expressed concern about discrimination against individuals with particular conditions. Employers and health insurance issuers stressed concern about resources and urged the Secretary to adopt a more moderate benefit package. Consumers generally favored a uniform benefits package, and many consumers requested that State mandates be included in the benefits package. Some requested a uniform benefit package so that consumer choice of plan could focus on other plan features such as premium, provider network, and quality improvement. Some employer, health insurance issuer, and State representatives focused on the need for flexibility across the country to reflect local preferences and practices. States, health insurance issuers, and employers emphasized the need for timely guidance in preparing for implementation around EHB.

B. Summary of Research on Employer Sponsored Plan Benefits and State Benefit Mandates

While the Affordable Care Act directs the Secretary to define the scope of EHB as being equal to a typical employer plan, the statute does not provide a definition of "typical." Therefore, HHS gathered benefit information on large employer plans (which account for

[4] Available at http://www.iom.edu/Reports/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost.aspx

the majority of employer plan enrollees), small employer products (which account for the majority of employer plans), and plans offered to public employees.[5]

There is not yet a national standard for plan reporting of benefits.[6] While the DOL collects information on benefits offered by employer plans, no single data set includes comprehensive data on coverage of each of the 10 statutory essential health benefit categories. Consequently, to supplement information available from the DOL, Mercer,[7] and Kaiser Family Foundation/Health Research & Educational Trust (KFF/HRET)[8] surveys of employer plans, HHS gathered information on employer plan benefits from the IOM's survey of three small group issuers and supplemented this information with an internal analysis of publicly available information on State employee plans and Federal employee plans,[9] and information on benefits submitted to HealthCare.gov by small group health insurance issuers. To inform our understanding of the category of pediatric oral and vision care, HHS staff also analyzed dental and vision plans in the Federal Employees Dental/Vision Insurance Program (FEDVIP).[10] The FEDVIP program is a standalone vision and dental program where eligible Federal enrollees pay the full cost of their coverage.

Similarities and Differences in Benefit Coverage Across Markets

Generally, according to this analysis, products in the small group market, State employee plans, and the Federal Employees Health Benefits Program (FEHBP) Blue Cross Blue Shield (BCBS) Standard Option and Government Employees Health Association (GEHA) plans do not differ significantly in the range of services they cover. They differ mainly in cost-sharing provisions, but cost-sharing is not taken into account in determining EHB. Similarly, these plans and products and the small group issuers surveyed by the IOM appear to generally cover health care services in virtually all of the 10 statutory categories.

For example, across the markets and plans examined, it appears that the following benefits are consistently covered: physician and specialist office visits, inpatient and

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[5] Nomenclature used in HealthCare.gov describes "products" as the services covered as a package by an issuer, which may have several cost-sharing options and riders as options. A "plan" refers to the specific benefits and cost-sharing provisions available to an enrolled consumer. For example, multiple plans with different cost-sharing structures and rider options may derive from a single product.

[6] Section 2715 of the Public Health Service Act (PHS Act) requires group health plans and health insurance issuers in the group and individual markets to provide a Summary of Benefits and Coverage in a uniform format to consumers. HHS, DOL, and the Department of the Treasury issued proposed rules for PHS Act section 2715 at 76 FR 52442 (August 22, 2011). Further information is available at http://www.gpo.gov/fdsys/pkg/FR-2011-08-22/pdf/2011-21193.pdf and http://www.dol.gov/ebsa/faqs/faq-aca7.html.

[7] Available at http://www.mercer.com/survey-reports/2009-US-national-health-plan-survey

[8] Available at http://ehbs.kff.org

[9] HHS staff analyzed the Federal Employees Health Benefits Program (FEHBP) Blue Cross Blue Shield (BCBS) Standard Option and Government Employees Health Association Benefit plan booklets.

[10] Further information is available at https://www.benefeds.com/Portal/jsp/LoginPage.jsp

outpatient surgery, hospitalization, organ transplants, emergency services, maternity care, inpatient and outpatient mental health and substance use disorder services, generic and brand prescription drugs, physical, occupational and speech therapy, durable medical equipment, prosthetics and orthotics, laboratory and imaging services, preventive care and nutritional counseling services for patients with diabetes, and well child and pediatric services such as immunizations. As noted in a previous HHS analysis, variation appears to be much greater for cost-sharing than for covered services.[11]

While the plans and products in all the markets studied appear to cover a similar general scope of services, there was some variation in coverage of a few specific services among markets and among plans and products within markets, although there is no systematic difference noted in the breadth of services among these markets. For example, the FEHBP BCBS Standard Option plan covers preventive and basic dental care, acupuncture, bariatric surgery, hearing aids, and smoking cessation programs and medications. These benefits are not all consistently covered by small employer health plans. Coverage of these benefits in State employee plans varies between States. However, in some cases, small group products cover some benefits that are not included in the FEHBP plans examined and may not be included in State employee plans, especially in States for which benefits such as in-vitro fertilization or applied behavior analysis (ABA) for children with autism are mandated by State law.[12] Finally, there is a subset of benefits including mental health and substance use disorder services, pediatric oral and vision services, and habilitative services – where there is variation in coverage among plans, products, and markets. These service categories are examined in more detail below.

Mental Health and Substance Use Disorder Services

In general, the plans and products studied appear to cover inpatient and outpatient mental health and substance use disorder services; however, coverage in the small group market often has limits. As discussed later in this document, coverage will have to be consistent with the Mental Health Parity and Addiction Equity Act (MHPAEA).[13]

The extent to which plans and products cover behavioral health treatment, a component of the mental health and substance use disorder EHB category, is unclear. In general, plans do not mention behavioral health treatment as a category of services in summary

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[11] ASPE Research Brief, "Actuarial Value and Employer Sponsored Insurance," November 2011. Available at: http://aspe.hhs.gov/health/reports/2011/AV-ESI/rb.pdf.

[12] In addition to mandated benefits, it appears that the small group issuers the IOM surveyed also generally cover residential treatment centers, which the FEHBP BCBS Standard Option plan excludes. However, as this analysis compares three small group issuers to one FEHBP plan, it is unclear if this finding can be generalized to other plans.

[13] See Affordable Care Act § 1311(j); see also PHS Act § 2726, ERISA § 712, Internal Revenue Code § 9812. See also interim final regulations at 75 FR 5410 (February 2, 2010) and guidance published on June 30, 2010 (http://www.dol.gov/ebsa/faqs/faq-mhpaea.html), December 22, 2010 (http://www.dol.gov/ebsa/faqs/faq-aca5.html), and November 17, 2011 (http://www.dol.gov/ebsa/faqs/faq-aca7.html).

plan documents. The exception is behavioral treatment for autism, which small group issuers in the IOM survey indicated is usually covered only when mandated by States.

Pediatric Oral and Vision Care

Coverage of dental and vision care services are provided through a mix of comprehensive health coverage plans and stand-alone coverage separate from the major medical coverage, which may be excepted benefits under PHS Act section 2722.[14] The FEDVIP vision plan with the highest enrollment in 2010 covers routine eye examinations with refraction, corrective lenses and contact lenses, and the FEDVIP dental plan covers preventive and basic dental services such as cleanings and fillings, as well as advanced dental services such as root canals, crowns and medically necessary orthodontia. In some cases, dental or vision services may be covered by a medical plan. For example, the FEHBP BCBS Standard Option plan covers basic and preventive dental services.

Habilitative Services

There is no generally accepted definition of habilitative services among health plans, and in general, health insurance plans do not identify habilitative services as a distinct group of services. However, many States, consumer groups, and other organizations have suggested definitions of habilitative services which focus on: learning new skills or functions – as distinguished from rehabilitation which focuses on relearning existing skills or functions, or defining "habilitative services" as the term is used in the Medicaid program.[15,16,17] An example of habilitative services is speech therapy for a child who is not talking at the expected age .

Two of the three small group issuers surveyed by the IOM indicated that they do not cover habilitative services. However, data submitted by small group issuers for display on HealthCare.gov indicates that about 70 percent of small group products offer at least limited coverage of habilitative services.[18] Physical therapy (PT), occupational therapy (OT), and speech therapy (ST) for habilitative purposes may be covered under the rehabilitation benefit of health insurance plans, which often includes visit limits. All three issuers reporting to the IOM covered PT, OT, and ST, though one issuer did not cover these services for patients with an autism diagnosis. The FEHBP BCBS Standard Option plan also covers PT, OT, and ST. State employee plans examined appear to generally cover PT, OT, and ST.

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[14] When dental or vision coverage is provided in plan that is separate from or otherwise not an integral part of a major medical plan, that separate coverage is not subject to the insurance market reforms in title XXVII of the PHS Act. See PHS Act §§ 2722(c)(1), 2791(c)(2).

[15] For State definitions, see Md. Code Ins. § 15-835(a)(3); D.C. Code § 31-3271(3); 215 Ill. Comp. Stat. 5/356z.14(i).

[16] See 76 Fed. Reg. 52,442 and 76 Fed. Reg. 52,475.

[17] For Medicaid definition, see Social Security Act, § 1915(c)(5)(A).

[18] Data submitted in October 2011.

Comparison to Other Employer Plan Surveys

These findings are generally consistent with other surveys of employer sponsored health coverage conducted by DOL, Mercer, and KFF/HRET. The Department of Labor survey found that employees had widespread coverage for medical services such as inpatient hospital services, hospital room and board, emergency room visits, ambulance service, maternity, durable medical equipment, and physical therapy. Similarly, Mercer found employers provided widespread coverage for medical services such as durable medical equipment, outpatient facility charges, and physical, occupational, and speech therapy. The KFF/HRET survey also found widespread coverage of prescription drugs among employees with employer-sponsored coverage.

State Benefit Mandates

State laws regarding required coverage of benefits vary widely in number, scope, and topic, so that generalizing about mandates and their impact on typical employer plans is difficult. All States have adopted at least one health insurance mandate, and there are more than 1,600 specific service and provider coverage requirements across the 50 States and the District of Columbia.[19]

Almost all State mandated services are typically included in benefit packages in States without the mandate – such as immunizations and emergency services. In order to better understand the variation in State mandates, their impact on the benefits covered by plans, and their cost, HHS analyzed 150 categories of benefit and provider mandates across all 50 States and the District of Columbia. The FEHBP BCBS Standard and Basic Options are not subject to any State mandates, but our analysis indicates that they cover nearly all of the benefit and provider mandate categories required under State mandates. The FEHBP BCBS Standard Option is not subject to any State mandates, but our analysis indicates that it covers about 95 percent of the benefit and provider mandate categories required under State mandates. The primary exceptions are mandates requiring coverage of in-vitro fertilization and ABA therapy for autism, which are not covered by the FEHBP BCBS Standard Option plan but are required in 8 and 29 States, respectively.

These two mandates commonly permit annual dollar limits, annual lifetime or frequency limits, and/or age limits. Research by States with these two mandates indicates that the cost of covering in-vitro fertilization benefits raises average premiums by about one percent[20,21] and the cost of covering ABA therapy for autism raises average premiums by approximately 0.3 percent.[22] Approximately 10 percent of people covered by small

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[19] Of these 1,600 mandates, about 1,150 are benefit mandates and 450 are provider mandates.

[20] Maryland Health Care Commission. Study of Mandated Health Insurance Services: A Comparative Evaluation. January 1, 2008. Available at: http://mhcc.maryland.gov/health_insurance/mandated_1207.pdf

[21] University of Connecticut Center for Public Health and Health Policy. Connecticut Mandated Health Insurance Benefit Reviews. January, 2011. Available at: http://www.ct.gov/cid/lib/cid/2010_CT_Mandated_Health_Insurance_Benefits_Reviews_-_General_Overview.pdf

[22] California Health Benefits Review Program. Analysis of Senate Bill TBD 1: Autism. March 20, 2011. Available at: http://www.chbrp.org/docs/index.php?action=read&bill_id=113&doc_type=3.

group policies live in a State requiring coverage of in-vitro fertilization, and approximately 50 percent live in a State requiring coverage of ABA.

The small group issuers surveyed by the IOM indicated they cover ABA only when required by State benefit mandates. The FEHBP BCBS Standard Option does not cover ABA. The extent to which these services are covered by State employee plans is unclear, as there is variation between States in whether benefit mandates apply (either by statute or voluntarily) to State employee plans.

C. Intended Regulatory Approach

As noted in the introduction, the Affordable Care Act authorizes the Secretary to define EHB. In response to the research and recommendations described above, as a general matter, our goal is to pursue an approach that will:

- Encompass the 10 categories of services identified in the statute;
- Reflect typical employer health benefit plans;
- Reflect balance among the categories;
- Account for diverse health needs across many populations;
- Ensure there are no incentives for coverage decisions, cost sharing or reimbursement rates to discriminate impermissibly against individuals because of their age, disability, or expected length of life;
- Ensure compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA);
- Provide States a role in defining EHB; and
- Balance comprehensiveness and affordability for those purchasing coverage.

As recommended by the IOM, HHS aims to balance comprehensiveness, affordability, and State flexibility while taking into account public input throughout the process of establishing and implementing EHB.[23] Our intended approach to EHB incorporates plans typically offered by small employers and benefits that are covered across the current employer marketplace.

We intend to propose that EHB be defined by a benchmark plan selected by each State. The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a "typical employer plan" in that State as required by section 1302(b)(2)(A) of the Affordable Care Act. This approach is based on the approach established by Congress for the Children's Health Insurance Program (CHIP), created in 1997, and for certain Medicaid populations.[24,25] A major advantage of the benchmark approach is that it recognizes that issuers make a holistic decision in constructing a package of benefits and adopt packages they believe balance consumers' needs for comprehensiveness and affordability. As described below, health insurance

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[23] Available at http://www.iom.edu/Reports/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost.aspx.

[24] Balanced Budget Act of 1997; Public Law 105-33

[25] Section 42 CFR 457.410 and 457.420

issuers could adopt the scope of services and limits of the State benchmark, or vary it within the parameters described below.

Four Benchmark Plan Types

Our analysis of offerings that exist today suggests that the following four benchmark plan types for 2014 and 2015 best reflect the statutory standards for EHB in the Affordable Care Act:

(1) the largest plan by enrollment in any of the three largest small group insurance products in the State's small group market;[26]
(2) any of the largest three State employee health benefit plans by enrollment;
(3) any of the largest three national FEHBP plan options by enrollment; or
(4) the largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the State.

HHS intends to assess the benchmark process for the year 2016 and beyond based on evaluation and feedback.

To reflect the State flexibility recommended by the IOM, under our intended approach, States are permitted to select a single benchmark to serve as the standard for qualified health plans inside the Exchange operating in their State and plans offered in the individual and small group markets in their State. To determine enrollment in plans for specifying the benchmark options, we intend to propose to use enrollment data from the first quarter two years prior to the coverage year and that States select a benchmark in the third quarter two years prior to the coverage year. For example, enrollment data from HealthCare.gov for the first quarter of calendar year 2012 could be used to determine which plans would be potential benchmarks for State selection and the benchmark plan specified during the third quarter of 2012 for coverage year 2014. If a State does not exercise the option to select a benchmark health plan, we intend to propose that the default benchmark plan for that State would be the largest plan by enrollment in the largest product in the State's small group market.

Defraying the Cost of Additional Benefits

Section 1311(d)(3)(B) of the Affordable Care Act requires States to defray the costs of State-mandated benefits in excess of EHB for individuals enrolled in any qualified health plan either in the individual market or in the small group market. Similar to other Exchange decisions, the State may select the benchmark plan. The approach for 2014 and 2015 would provide a transition period for States to coordinate their benefit mandates while minimizing the likelihood the State would be required to defray the costs of these mandates in excess of EHB. In the transitional years of 2014 and 2015, if a State chooses a benchmark subject to State mandates – such as a small group market plan – that benchmark would include those mandates in the State EHB package. Alternatively,

[26] Nomenclature used in HealthCare.gov describes "products" as the services covered as a package by an issuer, which may have several cost-sharing options and riders as options. A "plan" refers to the specific benefits and cost-sharing provisions available to an enrolled consumer. For example, multiple plans with different cost-sharing structures and rider options may derive from a single product.

under our intended approach a State could also select a benchmark such as an FEHBP plan that may not include some or all of the State's benefit mandates, and therefore under Section 1311(d)(3)(B), the State would be required to cover the cost of those mandates outside the State EHB package. HHS intends to evaluate the benchmark approach for the calendar year 2016 and will develop an approach that may exclude some State benefit mandates from inclusion in the State EHB package.

Benchmark Plan Approach and the 10 Benefit Categories

One of the challenges with the described benchmark plan approach to defining EHB is meeting both the test of a "typical employer plan" and ensuring coverage of all 10 categories of services set forth in section 1302(b)(1) of the Affordable Care Act. Not every benchmark plan includes coverage of all 10 categories of benefits identified in the Affordable Care Act (e.g., some of the benchmark plans do not routinely cover habilitative services or pediatric oral or vision services). The Affordable Care Act requires all issuers subject to the EHB standard in section 1302(a) to cover each of the 10 benefit categories.[27] If a category is missing in the benchmark plan, it must nevertheless be covered by health plans required to offer EHB. In selecting a benchmark plan, a State may need to supplement the benchmark plan to cover each of the 10 categories. We are considering policy options for how a State supplements its benchmark benefits if the selected benchmark is missing a category of benefits. The most commonly non-covered categories of benefits among typical employer plans are habilitative services, pediatric oral services, and pediatric vision services.

Below, we discuss several specific options for habilitative services, pediatric oral care and pediatric vision care. Generally, we intend to propose that if a benchmark is missing other categories of benefits, the State must supplement the missing categories using the benefits from any other benchmark option. In a State with a default benchmark with missing categories, the benchmark plan would be supplemented using the largest plan in the benchmark type (e.g. small group plans or State employee plans or FEHBP) by enrollment offering the benefit. If none of the benchmark options in that benchmark type offer the benefit, the benefit will be supplemented using the FEHBP plan with the largest enrollment. For example, 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. If none of the three small group market benchmark options offer prescription drug benefits, that category would be based on the largest plan offering prescription drug benefits in FEHBP. We are continuing to consider options for supplementing missing categories such as habilitative care, pediatric oral care and pediatric vision care if States do not select one of the options discussed below.

[27] A qualified health plan may choose to not offer coverage for pediatric oral services provided that a standalone dental benefit plan which covers pediatric oral services as defined by EHB is offered through the same Exchange.

Habilitation

Because habilitative services are a less well defined area of care, there is uncertainty on what is included in it. The NAIC has proposed a definition of habilitation in materials transmitted to the Department as required under Section 2715 of the PHSA, and Medicaid has also adopted a definition of habilitative services.[28,29] These definitions include the concept of "keeping" or "maintaining" function, but this concept is virtually unknown in commercial insurance, which focuses on creating skills and functions (in habilitation) or restoring skills and function (for rehabilitation). Private insurance and Medicare may use different definitions when relating to coverage of these services.[30] We seek comment on the advantages and disadvantages of including maintenance of function as part of the definition of habilitative services. We are considering two options if a benchmark plan does not include coverage for habilitative services:

1) Habilitative services would be offered at parity with rehabilitative services -- a plan covering services such as PT, OT, and ST for rehabilitation must also cover those services in similar scope, amount, and duration for habilitation; or
2) As a transitional approach, plans would decide which habilitative services to cover, and would report on that coverage to HHS. HHS would evaluate those decisions, and further define habilitative services in the future.

Pediatric Oral and Vision

For pediatric oral services, we are considering two options for supplementing benchmarks that do not include these categories. The State may select supplemental benefits from either:

1) The Federal Employees Dental and Vision Insurance Program (FEDVIP) dental plan with the largest national enrollment; or
2) The State's separate CHIP program.[31]

We intend to propose the EHB definition would not include non-medically necessary orthodontic benefits.

For pediatric vision services we intend to propose the plan must supplement with the benefits covered by the FEDVIP vision plan with the largest enrollment. The rationale for a different treatment of this category is that CHIP does not require vision services. As with habilitative services, we also seek comment on an approach that lets plans define the pediatric oral and vision services with required reporting as a transition policy.

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[28] See 76Fed. Reg. 52,442 and 76 Fed. Reg. 52,475.

[29] For Medicaid definition, see Social Security Act, Section 1915(c)(5)(A).

[30] See section 220.2(c) and (d) in the Medicare Benefits Policy Manual available here: http://www.cms.gov/manuals/Downloads/bp102c15.pdf

[31] If a State does not have a separate CHIP program, it may establish a benchmark that is consistent with the applicable CHIP standards. http://www.cms.gov/SMDL/downloads/CHIPRA%20Dental%20SHO%20Final%20100709revised.pdf

Mental Health and Substance Use Disorder Services and Parity

The MHPAEA expanded on previous Federal parity legislation addressing the potential for discrimination in mental health and substance use disorder benefits to occur by generally requiring that the financial requirements or treatment limitations for mental health and substance use disorder benefits be no more restrictive than those for medical and surgical benefits. However, although parity was applied for covered mental health and substance use disorder benefits, there was no requirement to offer such a benefit in the first instance. Also, prior to the Affordable Care Act, MHPAEA parity requirements did not apply to the individual market or group health coverage sponsored by employers with 50 or fewer employees.

The Affordable Care Act identifies coverage of mental health and substance use disorder benefits as one of the 10 categories and therefore as an EHB in both the individual and small group markets. The Affordable Care Act also specifically extends MHPAEA to the individual market. Because the Affordable Care Act requires any issuer that must meet the coverage standard set in section 1302(a) to cover each of the 10 categories, all such plans must include coverage for mental health and substance use disorder services, including behavioral health treatment. Consistent with Congressional intent, we intend to propose that parity applies in the context of EHB.

Benefit Design Flexibility

To meet the EHB coverage standard, HHS intends to require that a health plan offer benefits that are "substantially equal" to the benefits of the benchmark plan selected by the State and modified as necessary to reflect the 10 coverage categories. This is the same equivalency standard that applies to plans under CHIP.[32] Similar to CHIP, we intend to propose that a health insurance issuer have some flexibility to adjust benefits, including both the specific services covered and any quantitative limits provided they continue to offer coverage for all 10 statutory EHB categories. Any flexibility provided would be subject to a baseline set of relevant benefits, reflected in the benchmark plan as modified. Permitting flexibility would provide greater choice to consumers, promoting plan innovation through coverage and design options, while ensuring that plans providing EHB offer a certain level of benefits. We are considering permitting substitutions that may occur only within each of the 10 categories specified by the Affordable Care Act. However, we are also considering whether to allow substitution across the benefit categories. If such flexibility is permitted, we seek input on whether substitution across categories should be subject to a higher level of scrutiny in order to mitigate the potential for eliminating important services or benefits in particular categories. In addition, we intend to require that the substitution be actuarially equivalent, using the same measures defined in CHIP.[33]

To ensure competition within pharmacy benefits, we intend to propose a standard that reflects the flexibility permitted in Medicare Part D in which plans must cover the

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[32] 42 CFR 457.420.

[33] 42 CFR 457.431

categories and classes set forth in the benchmark, but may choose the specific drugs that are covered within categories and classes.[34] 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.

The Affordable Care Act also directs the Secretary to consider balance in defining benefits and to ensure that health insurance issuers do not discriminate against enrollees or applicants with health conditions. Providing guidelines for substitution will ensure that health insurance issuers meet these standards.

Updating Essential Health Benefits

Section 1302(b)(4)(G) and (H) direct the Secretary to periodically review and update EHB. As required by the Affordable Care Act, we will assess whether enrollees have difficulties with access for reasons of coverage or cost, changes in medical evidence or scientific advancement, market changes not reflected in the benchmarks and the affordability of coverage as it relates to EHB. We invite comment on approaches to gathering information and making this assessment. Under the benchmark framework, we note that the provision of a "substantially equal" standard would allow health insurance issuers to update their benefits on an annual basis and they would be expected on an ongoing basis to reflect improvements in the quality and practice of medicine. We also intend to propose a process to evaluate the benchmark approach.

[34] Drug category and class lists would be provided by the U.S. Pharmacopoeia, AHMS, or through a similar standard. Note: we do not intend to adopt the protected class of drug policy in Part D.

Busting the Silos: How Integrated Mental Health, Substance Use, and Primary Services Care Can Save Money and Lives

What's the Problem?

- **Depression and other mental health and substance use issues cost everyone money.** Depression is one of the top 10 conditions driving medical costs, ranking 7th in a national survey of employers. It is the greatest cause of productivity loss among workers.[1] People diagnosed with depression have nearly twice the annual health care costs of those without depression.[2] The cost burden to employers for workers with depression is estimated at $6,000 per depressed worker per year.[3]
- **Over half of the people receiving Medicaid and Medicare have psychiatric illness.** 49% of Medicaid beneficiaries with disabilities have a psychiatric illness. 52% of those who have both Medicare and Medicaid have a psychiatric illness.[4]
- **On the state level, spending is almost four times greater for those with mental illness.** 11% of Californians in the fee for service Medi-Cal system have a serious mental illness. Healthcare spending for these individuals is 3.7 times greater than it is for all Medi-Cal fee-for-service enrollees—$14,365 per person per year compared with $3,914.[5] Studies in other states have arrived at similar conclusions.

What's the Solution?

- **Integrate medical, mental health and substance use services.** If a 10% reduction can be made in the excess healthcare costs of patients with comorbid psychiatric disorders via an effective integrated medical-behavioral healthcare program, $5.4 million of healthcare savings could be achieved for each group of 100,000 insured members…the cost of doing nothing may exceed $300 billion per year in the United States."[6]

Prove it.

- **Help diabetes, help depression. Help depression, help diabetes.** People with type 2 diabetes have nearly double the risk of depression. Studies have shown depression in diabetic patients is associated with poor glycemic control, increased risk for complications, functional disability and overall higher healthcare costs. There are treatment protocols can double the effectiveness of depression care resulting in improved physical functioning and decreased pain.[7]
- **Take care of your head, heal your heart.** Care management focused on the health status of people with serious mental illnesses has been shown to significantly improve risk scores for cardiovascular disease.[8]

Busting the Silos: How Integrated Mental Health, Substance Use, and Primary Services Care Can Save Money and Lives, Prepared by Dale Jarvis and Associates, LLC, Seattle Washington, April 2011

- **Substance use hurts (and costs) everyone.** In the Kaiser Northern California system, family members of patients with SU disorders had greater healthcare costs and were more likely to be diagnosed with a number of medical conditions than family members of similar persons without a SU condition. In follow up studies, if the family member with a SU condition was abstinent at one year after treatment, the healthcare costs of family members went down to the level of the control group.[9]

Better prevention. Better access. Bigger savings.

- **Substance use and depression screening saves money.** A ranking (based on clinically preventable burden and cost effectiveness) of 25 preventive services found that alcohol screening and intervention rated at the same level as colorectal cancer screening/treatment and hypertension screening/treatment. Depression screening/intervention rated at the same level as osteoporosis screening and cholesterol screening/treatment.[10]
- **Access=prevention.** Adding attention to the healthcare needs of persons served in MH settings resulted in significantly improved access to routine preventive services (e.g. immunizations, hypertension screening and cholesterol screening).[11, 8]
- **Save big by addressing depression in the safety net population.** Depression care management for Medicaid enrollees can reduce overall healthcare costs by $2,040 per year with impressive reductions in emergency department visits and hospital days.[12]
- **Save big by addressing substance use.** A Kaiser Northern California study showed that those who received SU treatment had a 35% reduction in inpatient cost, 39% reduction in ER cost, and a 26% reduction in total medical cost, compared with a matched control group.[9]

The full text of the "The Business Case for Bidirectional Integrated Care" can be found online at: http://www.cimh.org/Initiatives/Primary-Care-BH-Integration.aspx .

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