Coalition for Whole Health

November 27, 2017

Administrator Seema Verma
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, D.C. 20201

Attn: CMS-9930-P
NPRM Notice of Benefit and Payment Parameters for 2019

Dear Administrator Verma:

The Coalition for Whole Health is a broad coalition of local, State, and national organizations in the mental health and substance use disorder prevention, treatment, and recovery communities. We appreciate the opportunity to comment on the proposed rule detailing standards related to benefits and payment. We thank you for your commitment to making mental health (MH) and substance use disorders (SUD) a top priority and for working to ensure that individuals with MH/SUD needs receive quality care.

On behalf of our constituencies, we offer the following comments and recommendations in response to the proposed rule. Our consideration of these issues is informed by our experiences with private health insurance coverage for MH/SUD. Our comments and recommendations for your consideration are as follows:

STANDARDIZED PLAN OPTIONS

Recommendation: Standardized plan options for consumers should be maintained.

We oppose the proposed changes to eliminate standardized options. Having standardized options assists consumers, including people with MH and SUD care needs, in making informed choices.

When plans share a common benefits structure, including tiering and cost sharing, individuals can make comparisons of plans and benefits. Shopping for health insurance coverage can be an overwhelming experience for many people, including people with MH/SUD care needs, and we believe there is great value in simplified options.

ESSENTIAL HEALTH BENEFITS

Recommendation: Include in the final rule provisions to ensure that Essential Health Benefits (EHB) standards for MH, SUD and other statutorily required benefit categories are robust and comprehensive.

We appreciate the administration's recognition of the opioid crisis as a public health emergency. New data from the Centers for Disease Control and Prevention (CDC) shows that, as of April 2017, 65,669 Americans died of a drug overdose in the previous 12 months. This represents a nearly 18 percent increase in the rate of overdose deaths nationwide as compared to the previous year.

Although the nation's opioid crisis requires a multi-pronged solution, one foundational way to improve access to care is to ensure that there is good insurance coverage of the full continuum of addiction and mental health services and medications as a part of the EHB (Essential Health Benefit) requirements of the Affordable Care Act (ACA). Various provisions of the law, including those that extend the protections of the Mental Health Parity and Addiction Equity Act (the Parity Act) to insurance coverage under the ACA's purview, require coverage of MH and SUD services and medications. The ACA holds tremendous promise for significantly reducing treatment gaps by increasing early identification and treatment coverage and access for MH/SUD, but without a robust EHB that does not discriminate against individuals with or at risk for these diseases, and without strong oversight to ensure access to medically necessary MH and SUD care across the continuum, this potential will go largely unfulfilled.

<u>We are strongly opposed to HHS' proposed changes to the EHB standard which we believe would lower the threshold of covered MH and SUD services and medications and would likely leave many individuals without access to the health care they need to become and remain well</u>.

A long history of insurance discrimination against those with MH/SUD has been a barrier for many individuals with MH/SUD needs to receive services across the continuum, including the preventive services, early interventions, timely diagnoses, treatment, including medications, and recovery services needed to avoid disease and become and remain well. There remains an unacceptably large treatment gap for MH/SUD.

Before the ACA, individuals often did not have health coverage for services that are now covered as EHBs. For example, prior to the ACA, 34% of enrollees in the individual market did not have coverage for substance use disorder treatment, and 18% did not have coverage for mental health services. These services can be a small percentage of the relative benefit costs in commercial market plans, yet scaling back on their coverage would significantly raise out-of-pocket costs for individuals who need them.

We are very concerned that HHS' proposed changes to the EHB benchmark options would jeopardize adequate coverage of the ten EHB categories, including the MH/SUD benefit category. HHS' proposal strongly emphasizes reducing coverage and lowering premiums, which will result in inadequate coverage of benefits and higher out-of-pocket costs for people with MH/SUD care needs. We are concerned that HHS' proposed EHB benchmark options may lead to the selection of rare, outlier benchmarks, with extremely limited coverage of critical services.

A robust EHB standard is essential to individuals receiving effective care. In the preamble of the proposed rule, HHS recognizes that offering less coverage may result in "spillover" effects, including increased use of emergency services and other services provided by safety-net and government-funded providers. This not only affects the individual patient but also impacts our productivity as a nation, and ultimately increases the cost of health care.

The proposed EHB benchmark options put individuals, including those with MH/SUD, in the individual and small group market at risk of increased health care costs, and may also impact an estimated 27 million workers and their dependents who receive coverage through large employers. Annual and lifetime limits on coverage apply to large employer plans as well, and these plans can choose any state's definition of EHBs for purposes of adhering to this prohibition. But these limits only apply to benefits that are considered EHBs. Thus if any state drops its EHB coverage significantly, anyone getting employer-sponsored insurance across the country may once again face annual or lifetime limits as well as higher cost-sharing for benefits that are no longer considered EHBs.

State Selection of Benchmark Plans

- **New Default Benchmark**
  Recommendation: Ensure in the final rule that states have the ability to select the updated version of their current EHB plan.
  HHS proposes that if a state does not make an EHB benchmark selection by the annual selection date for the applicable plan year, then the state's EHB benchmark plan for the prior year will continue to apply. While we appreciate the opportunity for states to keep their current EHB benchmark plan if they so desire, this does not allow states to select the updated version of their current benchmark. The 2017 benchmark plans are based on 2014 plans and many of them are not in compliance with existing EHB requirements or with EHB standards that went into effect in 2016 and 2017 (e.g., prescription drug requirements).

- **New EHB Benchmark Options**
  Recommendation: Exclude from the final rule proposed new EHB benchmark options for the 2019 plan year and beyond.
  We strongly oppose HHS' proposed new EHB benchmark options for plan year 2019 and beyond. We are concerned that the changes that HHS proposes to the EHB benchmark process will reduce the comprehensiveness of coverage for individuals with MH/SUD by allowing states to drop or limit the benefits that are currently covered in their state, give insurers more latitude to deviate from a state's EHB standard, and weaken consumer protections against catastrophic out-of-pocket costs in large employer plans. These changes could disproportionately impact individuals with MH/SUD, those with disabilities and people with other pre-existing medical conditions who could face reduced access to the services they need and higher out-of-pocket costs.

- **Benchmark Option #1: Select another state's 2017 EHB benchmark:** HHS proposes to allow states to select the EHB benchmark plan that another state used for the 2017 plan year. For a number of reasons, we oppose this proposal. HHS indicates that this would increase the number of selection options without requiring extensive analysis since all of the benchmarks are posted on CCIIO's website. However, the documents posted on the CCIIO website are not all up-to-date in terms of ACA requirements. Plan documents posted on the CCIIO website often refer to additional documents for coverage details, such as a benefits schedule, which is not included. To further complicate matters, generally the evidence of coverage or certificate of coverage documents are confusing or incomplete, and many times the documents include multiple amendments which make it difficult to determine covered benefits. In addition, the benefits and limits charts currently provided for each state along with plan documents offer varying level of detail from state to state, with most states simply indicating whether a benefit is covered. There are also significant process concerns. While most states completed an analysis of the ten EHB benchmark plan options and made a transparent decision, some states fell short of this level of transparency. By allowing states to use the benchmarks of other states, HHS' proposal separates the chosen benchmark plan from the state-specific process that created it.

- **Benchmark Option #2: Replace one or more EHB categories with coverage from another state's 2017 EHB benchmark:** HHS proposes to allow states to replace one or more EHB category of benefits in its EHB benchmark plan used for the 2017 plan year with the same category of benefits from another state's EHB benchmark plan used for the 2017 plan year. We oppose this proposal, for the reasons stated above. Moreover, it would be very difficult for states to know what other states cover in each of the EHB categories since the documents that are posted online are not split into EHB categories and the evidence of coverage documents for the benchmark plans are not labeled in that way either. Also, the benefits that fall under the EHB categories are not mutually exclusive, therefore it would be very difficult for a state to identify the services to replace in one or more of the EHB categories.

- **Benchmark Option #3: Select a set of benefits that become the state's EHB benchmark plan:** HHS proposes to allow states to select a set of benefits that would become the state's EHB benchmark plan using a different process from that described above, provided that the selection does not exceed the generosity of the most generous of comparison plans. Per our general comments above, we oppose this proposal and are concerned that it will lead to a race to the bottom by allowing states to provide minimal coverage of EHB categories in 2019 and beyond.

We appreciate that HHS proposes to add into the regulation the ACA requirements that EHBs be defined in a way that ensures appropriate balance among categories, that benefits are not unduly weighted toward any category, and that diverse segments of the population (such as women, children, and people with disabilities) must be taken into account. That section of the ACA also says that benefits cannot be designed in ways that discriminate against individuals because of their age, disability, or expected length of life. This language prohibiting discriminatory benefit design should be added to the regulatory text as well. If states are allowed to select new EHB benchmarks for the 2019 plan year and beyond, states should be required to provide reasonable opportunity for notice and public comment that includes public hearings, a public comment period, and the publication of plan documents and analysis in usable and understandable formats, along with data (such as actuarial certifications and reports) that must be submitted to HHS.

We are very concerned with the level of flexibility in plan benefit design in the proposed rule. As stated in the rule itself, the result of allowing significant state flexibility in benchmark selection, may be that "depending on the selection made by the state in which the consumer lives, consumers with less comprehensive plans may no longer have coverage for certain services." Under HHS' proposal, people who rely on services that are no longer considered EHBs will have to pay out-of-pocket for them or forgo the care they need. In addition, the out-of-pocket maximum and annual and lifetime limit consumer protections will no longer apply to services that are not considered EHBs since these protections only apply to EHBs. This will increase health care costs for many, including people with pre-existing conditions such as MH/SUD, who already pay significantly higher out-of-pocket costs.

Provision of EHB: Substitution of Benefits

Recommendation: Protect against downward flexibility in benefit design to protect individuals with MH/SUD from high out-of-pocket costs and limited covered benefits.

We strongly oppose HHS' proposal to allow benefit substitution both within and between EHB categories. As the Department acknowledges, such a change could make it difficult, if not impossible, for a state to ensure that each of the EHB categories are equally weighted as required by law.

Unless prohibited by state law, issuers offering EHBs are currently permitted to substitute benefits that are 1) actuarially equivalent to benefits replaced and 2) within the same EHB category. As a result, issuers may substitute services that certain populations (e.g., individuals with chronic conditions) need and replace them with actuarially equivalent services, which may be less costly and more likely to attract healthier populations. This will be exacerbated by HHS' proposed policy change that would allow substitution of benefits between EHB categories as well.

The CWH is concerned that allowing substitution between categories could undermine the intent of the ACA and result in reduced access to MH/SUD care that violates the underlying statute. Additionally, as noted above, historical discrimination against MH/SUD makes it

particularly likely that coverage for these benefits would be limited as compared to other medical/surgical benefits.

We are concerned that HHS' proposed change to the substitution of benefits policy will negatively impact coverage of critical services. HHS admits that allowing substitution of benefits within the same EHB category and between EHB categories, as it proposes to do, will increase the burden on individuals with MH/SUD who will have to spend more time and effort comparing benefits offered by different plans in order to "determine what, if any benefits have been substituted, and what plan would best suit their health care and financial needs." In addition, HHS notes that by allowing substitution between EHB categories, "states may encounter difficulties in ensuring that all categories are filled in such a way that amounts to EHBs." This proposed policy change, like the change in benchmark options, serves to negate coverage of the ten EHB categories and will lead to extremely different benefits packages, confused consumers, increased administrative costs to states, and inadequate coverage of critical services. This undermines some of the basic guarantees of the ACA, such as a simple and navigable insurance market for consumers.

Moreover, as the Department notes, "This proposal would increase the burden on consumers who choose between plans offered in the individual and small group markets as they would need to spend more time and effort comparing benefits offered by different plans in order to determine what, if any, benefits have been substituted and what plan would best suit their health care and financial needs."

We believe it is unreasonable to put such a burden on individuals, particularly when health literacy is often low. For example, enrollees often have limited knowledge of their rights and benefits under the parity law. A survey by the American Psychological Association found that only 4% of Americans said they were even aware of the MH/SUD Parity Act. Additionally, even the most educated of consumers may select a plan to then later be caught off guard by a mental health or substance use disorder crisis in his or her family. For these reasons, substitution of the mental health and substance use disorder category with other categories should not be permitted.

In the proposed rule, HHS notes that it considered allowing states to set a range of EHBs and to allow issuers to offer plans within that range. However, HHS determined that this option did not meet statutory requirements. Similarly, allowing issuer substitution of benefits within and between EHB categories does not meet statutory requirements. While states have the option to adopt more stringent standards that limit or prohibit this type of substitution, only a few states have prohibited benefit substitution. We urge HHS to eliminate any provision allowing issuer flexibility to substitute benefits within EHB categories, and not allow substitution of benefits between categories.

In addition, as HHS develops the final rule, we also urge the Department to:

- <u>Create a process for states to address important market coverage gaps by adding new benefits without additional cost to the state</u>. Under the current state benefit mandate policy**,** state benefit mandates enacted after December 31, 2011, other than

for purposes of compliance with federal requirements, will continue to be considered in addition to EHB and states will be required to defray the cost of the mandated benefit. It is important to allow states the flexibility to improve benefit coverage to help meet the health goals of the state. Another consequence of HHS' state mandate policy is that states may refuse to apply state mandates to individual and small group market plans due to costs. We are concerned that this policy in conjunction with the proposed options for selecting EHB benchmark plans will encourage states to select a less comprehensive EHB benchmark plan, resulting in less coverage for individuals. We urge HHS to create a process for states to address important market coverage gaps by allowing states to add new state-required benefits to the EHB without additional cost to the state.

- Include in the final rule a definition of a "typical employer plan" that reflects the findings of the Department of Labor's 2011 report on medical benefits typically covered by employers. The ACA requires that coverage of EHBs in the individual and small group market be equal in scope to the benefits provided under a typical employer plan. The proposed rule would define a typical employer plan as "an employer plan within a product […] with substantial enrollment in the product of at least 5,000 enrollees sold in the small group or large group market, in one or more states, or a self-insured group health plan with substantial enrollment of at least 5,000 enrollees in one or more states." We object to this definition of typical employer plan. The proposed definition fails to take into account the 2011 DOL report, which summarizes some of the benefits that are typically covered by employer plans. It does not reflect the concept of "typicality." The definition merely provides that a typical employer plan is one whose enrollment exceeds 5,000 enrollees in one or more states and is silent as to the scope of coverage typically seen in employer-based plans. In other words, the definition bases typicality on enrollment in a single plan instead of comparability of benefits across multiple employer plans. Adopting the proposed definition of a "typical employer plan" would lower the threshold for minimum coverage of EHBs, opening the door for insurers to offer plans with less robust benefits and weakening the protections that the ACA affords to individuals with MH/SUD, and those with disabilities and other complex medical needs.

- Include in the final rule the requirement that states provide comprehensive, accurate and specific information about covered benefits and limits in their EHB benchmark plan. While we appreciate that HHS has collected and posted plan documents for each of the EHB benchmark plans, and notes that it will continue to do so, many times these documents refer to additional documents for coverage details, such as a benefits schedule, which is not included. We have found that generally the evidence of coverage or certificate of coverage documents are confusing or incomplete, and many times these documents include multiple amendments which make it difficult to determine covered benefits. The charts for EHB benchmarks should provide an accurate picture of covered benefits and, thus,

include specificity about covered benefits and limits. Also, with more detail, the charts could become a helpful tool for state regulators to ensure coverage of EHBs by health plans and issuers.

Recommendation: Fully implement and enforce the Mental Health Parity and Addiction Equity Act.

Individuals with MH/SUD have historically faced discrimination in their insurance coverage, as MH/SUD benefits have typically been weaker and more restrictively managed than other benefits, if they have been covered at all. People with MH/SUD have been discriminated against based on a general classification as having mental health or substance use issues, a specific diagnosis, a type of care or a prescription for a specific medication or any medication at all. Providers of MH/SUD services have also been singled out for discriminatory treatment due to stigma and prejudice against these illnesses. These various forms of discrimination against people with MH/SUD have often been based not any legitimate medical or scientific grounds but on ignorance of and prejudice against these illnesses, the people who suffer from them and the caregivers who treat them.

With passage of the Mental Health Parity and Addiction Equity Act in 2008 (the Parity Act), Congress recognized the long history of widespread discrimination in private insurance coverage of MH and SUD benefits and sought to remedy this inequity. By extending the requirements of Parity Act to the small group and individual health insurance markets under the ACA, Congress has ensured significant improvement in access to these critical services. However, despite considerable recent progress, barriers to accessing MH/SUD services continue across the health care system. Typical problems include lack of insurance coverage of key components of the continuum of MH/SUD care, particularly for those with the most severe illnesses, use of restrictive benefit management techniques that often make it difficult to access appropriate levels of MH/SUD care and appropriate medications, and insufficient numbers of MH/SUD providers in plan networks. Effective implementation, oversight, and enforcement of these EHB and Parity Act protections is critical to ensure that the MH/SUD needs of all enrollees in qualified health plans are appropriately met.

Our past review of EHB state benchmark plans found that most benchmarks do not cover certain MH/SUD services, and that there is inadequate coverage of EHB statutory categories, including harmful treatment limitations and exclusions impacting access to care. A sample review of benchmark plans suggest widespread Parity Act problems, including:

- Coverage exclusions for residential SUD treatment services despite coverage of inpatient services for other illnesses.

- Limited coverage of SUD and MH medications. Violations were sometimes difficult to determine. Certain benchmarks refer to "step therapy," but rarely detail which drugs require step therapy. A number of benchmark plans have coverage exclusions for SUD medication-assisted treatment (MAT) or fail to cover SUD medications on

plan formularies. Some benchmark plans include explicit methadone maintenance therapy exclusions.

- Coverage exclusions in a number of benchmarks for rehabilitative services for certain mental health conditions and residential MH services.

We urge HHS to ensure that all EHB plan enrollees can access the full array of MH and SUD services that they need to become and remain well by ensuring full implementation of the Parity Act. Consistent with the final recommendations of the White House Opioid Commission and our previous comments submitted in response to the August 2017 Parity Act listening session, we urge HHS to:

- Use its enforcement authority over qualified health plans to launch investigations into parity non-compliance. The outcomes of such investigations should be publicized on appropriate federal websites.

- Develop a uniform Parity Act Transparency and Compliance Report tool that carriers and health plan sponsors would be required to submit to state or federal regulators as a condition of approval to offer plans on the commercial market or as an employee benefit.

- Develop model contract provisions that carriers and plan sponsors could use to provide:

    - Uniform descriptions of substance use and mental health benefits
    - Benefit and prescription drug coverage, and medical management standards that fully align with the Parity Act
    - Full disclosure of the Parity Act's non-discrimination standards and tools (compliance officer contact information and document links) that would provide consumers immediate access to plan documents that are needed to assess compliance and pursue complaints.

- Help regulatory agencies enhance the substance use disorder and mental health provider community's capacity to identify potential Parity Act violations and advocate for plan compliance in network adequacy and rate setting standards.

Navigator Program Standards

Recommendation: Maintain the current requirements for navigator entities.

We oppose the proposed changes to reduce the number of required navigator entities in a state from two to one. The requirement to have two entities ensures that a state can have a general entity and one more tailored to specific needs within a state, whether that includes a focus on young adults, limited English proficient individuals, or other targeted populations. Further, removing the requirement that one entity be a community and

consumer-focused non-profit is also troubling. Many of the individuals assisted by navigator entities have complex situations and community and consumer-based entities, including those with expertise in working with people with MH/SUD care needs, are best suited to address their needs. They already have the experience working with these populations on a regular basis.

We also oppose the proposal to remove the requirement that a navigator entity maintain a physical presence in the Exchange service area. Physically present entities remain available after open enrollment to provide assistance if questions arise, can assist in finding providers, can help consumers prepare for re-enrollment. Navigators do much, much more than merely enroll eligible individuals and having the community presence and building the ongoing relationships with consumers is critical to ensure all eligible consumers obtain and maintain health insurance. In particular, individuals with low health literacy (in addition to low literacy in general), low internet proficiency and who live in rural areas may face additional challenges in enrolling and rely on assisters to help complete enrollment. We ask HHS to maintain the requirements that a navigator have a physical presence in the state in which it receives funding to assist consumers.

Establishment of Exchange Network Adequacy Standards

Recommendation: Continue utilizing uniform network adequacy standards for MH, SUD and other medical services.

The CWH opposes HHS's proposal to rely on state regulators to ensure network adequacy, rather than performing its own network adequacy review. HHS proposes to allow state regulators to certify QHP network adequacy so long as HHS determines that the state has the authority to ensure "reasonable access" to providers and the capacity to assess the sufficiency of plans' networks. In states where regulators lack this capacity, HHS proposes to rely on private accreditation of health plans rather than evaluate network adequacy itself. HHS does not propose to change existing network adequacy regulations, but rather, professes an intention to change sub-regulatory policy as to their implementation.

We oppose the proposed standard as it eliminates all efforts to standardize network adequacy requirements across States and QHPs. A review of State network adequacy standards, in effect as of August 2016, compiled by the University of Maryland Carey School of Law, Drug Policy and Public Health Strategies Clinic, found that only twelve (12) states have adopted both quantitative travel time and distance standards to assess network adequacy. Seven (7) states have adopted only distance requirements and two (2) states have only travel time requirements. The remaining twenty-nine (29) states and the District of Columbia do not have quantitative geographic standards that allow for consistent assessment of QHP network adequacy, as contemplated under the 2018 Issuer Letter. For those with quantitative geographic standards, the state-specific standards vary considerably and do not necessarily cover all of the specialties or the minutes/miles criteria that CMS has determined to be necessary to address historical gaps in network adequacy.

The review of State network adequacy standards raises particular concerns for the CWH because only ten (10) states have adopted or require geographic criteria specific to mental health and substance use disorder providers. Reliance on States to assess "reasonable access" based on their existing standards will not ensure that consumers have access to critical behavioral health services, as required under § 156.230(a)(2). Prompt access to behavioral health care is needed now more than ever to respond to our nation's opioid epidemic.

For states that lack the authority or capacity to conduct network adequacy reviews, reliance on the accreditation process is no substitute for objective and uniform standards that apply to all QHPs in the FFE. Consumers do not have ready access to plan accreditation standards, and they cannot enforce those standards.

The elimination of uniform network adequacy standards for MH, SUD and other medical services will also undermine consumer confidence that their plans will provide access to services through network providers. The proposed rule recognizes the need to stabilize the market through increased enrollment of younger individuals. Insurance coverage will be less attractive to individuals of all ages if network adequacy becomes less robust, as they will have no guarantee of access to affordable care at a time of need.

Finally, the proposed retreat from an assessment of uniform quantitative standards is contrary to the recommendations of the National Association of Insurance Commissioners' Health Benefit Plan Network Access and Adequacy Model Act and may discourage States from adopting quantitative network adequacy standards that will help regulators determine whether carriers meet the reasonable access standard. While NAIC's Model Act does not adopt specific network adequacy standards, the drafters emphasize that [s]ome states have developed specific quantitative standards [in law and regulation] to ensure adequacy access that carriers must, at a minimum, satisfy in order to be considered to have a sufficient network." (Model Act, Network Adequacy, Section 5(B) Drafting Note at 74-8). Insurance departments will be hard-pressed to determine network sufficiency, consistent with the Model Act, without quantitative standards. As noted above, the proposed rule will undermine CMS's response to evidence of inadequate network and proposals to develop even more rigorous standards that protect consumers, including those with MH/SUD care needs, and increase confidence in their ability to gain access to care that they need and are paying for.

Essential Community Providers

Recommendation: Maintain existing Essential Community Provider standards.

Essential Community Providers (ECPs) serve a critical role in the health care of lower income individuals with mental health and substance use disorders and other chronic health conditions. Historically, these individuals have received treatment in community-based treatment programs, and they look to these programs for continuity of care and linkages to primary and other health services as they move between the public and private insurance systems.

The requirement that QHP networks must contract with ECPs who provide care to predominately low-income and medically-underserved populations is key to improving health outcomes and reducing health and health care disparities. The CWH opposes HHS's proposals that will reduce ECP participation.

The CWH opposes the proposal to reduce the percentage of ECPs with which a plan is required to contract from 30% of available ECPs in each plan's service area to 20% of available ECPs. The overwhelming majority of plans – 94% - met this standard in 2017, and there is no evidence that plans would have difficulty doing so in 2018. By allowing carriers to contract with far fewer ECPs, many individuals will face the difficult choice of either disrupting their care with a trusted health care provider or, to the extent feasible, paying substantially more to continue care with their non-network provider.

We are also deeply concerned that the proposed rule would severely weaken the ECP standards by no longer requiring state-based exchanges utilizing the federal platform to enforce ECP standards that are used for federally facilitated exchanges. Already, some state-based exchanges that do not use the federal platform have adopted less robust ECP standards. Consumers in these states may have less access to lifesaving MH and SUD care. Robust standards are needed to ensure that plans are providing access to the ECPs on which these communities rely.

The proposed revision to the ECP standard also sends the wrong message to States that are exploring standards that will boost ECP requirements to respond to local needs. For example, community-based substance use treatment programs are not included in the definition of ECP, even though they serve the population served by these providers. We are aware of State Exchanges that have expanded the ECP definition to include community-based substance use treatment programs to address the opioid epidemic. A retreat from the existing federal standard may make it more difficult to retain and expand such standards.

As States battle the escalating opioid and suicide epidemics, we cannot afford to make health care less available for individuals with mental health and substance use disorders. The health care needs of vulnerable individuals certainly outweigh the minimal burden on carriers that would be required to submit a justification of sufficient number and geographic distribution of ECPs.

Qualified Health Plan Certification

Recommendation: HHS should directly monitor and enforce the ACA's non-discrimination provisions.

We recognize that the ACA provides opportunities for state flexibility in some implementation areas. However, that flexibility should not apply to monitoring and enforcing the ACA's non-discrimination provisions.

HHS previously has described a number of plan review and monitoring activities to help determine whether plan benefit designs comply with the ACA non-discrimination

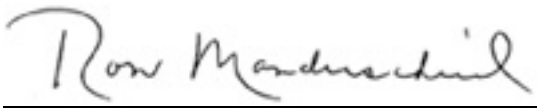
provisions. However, in the proposed rule, HHS states that it wishes to streamline the QHP certification process and further devolve plan review and monitoring to state authorities. We urge HHS to employ a broad, multi-prong approach to non-discrimination compliance monitoring and enforcement that includes effective methodologies and robust national standards to assess plan benefit design. Reliance on state monitoring and enforcement of non-discrimination protections leads to disparate health care access and quality, whereby a plan benefit design may be considered compliant by one state but found non-compliant by another state.

The ACA contains additional protections for individuals by barring discriminatory plan benefit design, establishing that a QHP may "not employ marketing practices or benefit designs that have the effect of discouraging the enrollment in such plan by individuals with significant health needs." A QHP fails to meet the EHB standard if its benefit design discriminates based on an "individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions" and can be decertified from participation in the Exchange. This is reiterated in HHS' regulations. However, despite these robust protections, some QHPs continue to discriminate against individuals with disabilities and those with serious or chronic medical conditions.
In addition to the continued MH/SUD coverage gaps identified above, the National Alliance on Mental Illness (NAMI) also identified adverse tiering for medications used in the treatment of mental illness in its 2015 report: A Long Road Ahead – Achieving True Parity in Mental Health and Substance Use Care. NAMI commissioned a study of formularies for 84 health plans to assess coverage of three classes of psychiatric medications: antipsychotics, antidepressants, and SSRIs/SNRIs used commonly to treat depression. The analysis found that many plans placed these medications on high cost sharing tiers or with restricted access.

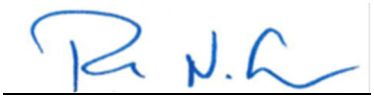
Compliance reviews serve an important role in ensuring that issuers meet EHB and other standards. The CWH strongly supports strengthening the compliance review process and allowing for sanctions on issuers that are non-responsive or uncooperative with the compliance reviews. We also urge HHS to make the results of its compliance reviews publicly available on an ongoing basis rather than posting a year-end summary report. Health care consumers and advocates could greatly benefit from more detailed information revealed by compliance reviews when assessing plan performance, including issuers and plans subject to targeted, expedited reviews when CCIIO has identified potential harm to consumers.

We thank you again for the opportunity to provide comments on the proposed 2017 benefit and payment parameters rule. We strongly support the goals of the ACA to ensure that all Americans have access to high-quality, affordable health care, including comprehensive care for MH and SUD conditions. We appreciate your careful consideration of our comments and look forward to working with you further on the development and implementation of the EHB and related provisions of the ACA. Please contact us if you have any questions or if we can be of further assistance.

Sincerely,



Ron Manderscheid
Co-Chair,
The Coalition for Whole Health



Paul Samuels
Co-Chair,
The Coalition for Whole Health