

# AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

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December 24, 2012

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## **RE: Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value and Accreditation: Proposed Rule CMS-9980-P**

The American Academy of Child and Adolescent Psychiatry (AACAP) appreciates the opportunity to comment on the proposed rule, *ACA Standards Related to Essential Health Benefits, Actuarial Value and Accreditation of Qualified Health Plans*. AACAP supports the ACA's goal of providing meaningful coverage for children and adolescents. The EHB is a critically important opportunity to address the health needs of Americans with untreated mental illness and provide early intervention and necessary services to those seeking care for their mental illness. We are writing to encourage the use of a robust national medical necessity standard and to ensure that all necessary psychiatric services are covered by Essential Health Benefits (EHB) packages.

AACAP is a medical membership association established by child and adolescent psychiatrists in 1953. Now over 8,000 members strong, AACAP is the leading national medical association dedicated to treating and improving the quality of life for the estimated 7-12 million American youth under 18 years of age who are affected by emotional, behavioral, developmental and mental disorders. AACAP's members actively research, evaluate, diagnose, and treat psychiatric disorders and pride themselves on giving direction to and responding quickly to new developments in addressing the health care needs of children and their families.

AACAP supports a comprehensive essential health benefit package that provides a clear federal minimum standard (or national floor) to ensure coverage that meets the health care needs of diverse populations, including individuals with disabilities and chronic conditions. We recognize that the EHB proposal departs from a national standard and extends wide flexibility to

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states and insurers on providing an EHB package to consumers based on a benchmark plan approach. Without a well-defined medical necessity standard, the stigma toward mental health care and the mentally ill may result in an inadequate level of coverage, which is not in keeping with the spirit of the Mental Health Parity and Addiction Equity Act (MHPAEA) and the principles of non-discrimination and balance in the ACA. We urge you to ensure that the EHB is not narrowly defined by acute treatment outcomes, but rather broad enough to include services that improve, maintain, or prevent deterioration of childhood mental illnesses.

#### **Parity for Mental Health and Substance Use Disorders (§ 155.115 (a) (2))**

We appreciate the Administration's leadership during the health care reform debate to ensure extension of the MHPAEA to the individual market, and the application of parity to mental health and substance use disorder benefits in the context of the EHB. However, we remain concerned that plans may not implement parity appropriately. While the proposed rule is clear that the requirements of MHPAEA apply to the EHB, the rule does not provide sufficient clarity about how these requirements apply and the process to supplement inadequate coverage.

In the final rule, we urge HHS to provide a detailed framework for States, insurance commissioners, health insurance exchanges, consumers, providers, and other stakeholders to detail the process for supplementing plans with deficient MH/SUD coverage to ensure that the EHB meets parity requirements. We also urge HHS to conduct a comprehensive and transparent parity analysis of all EHB packages and release this and other detailed benefit information for the States as soon as possible.

#### **Benchmark plans that do not meet EHB requirements (§ 156.110 (c))**

The proposed rule states that only if a selected benchmark plan does not cover any services in a category must that category be substituted. There is no further discussion of what that means, what benefit or benefits would constitute coverage in each category, or examples of what actual threshold for substitution might be required or allowed. Also, the proposed rule appears to indicate that a plan could cover only a single service within a category and still be in compliance with EHB. The ACA's balance and nondiscrimination requirements suggest that a much stronger minimum set of benefits in each category would be required – yet, there is no guidance within the proposed rule about whether there is a minimum standard of coverage within each category and how to supplement benefits should existing coverage be inadequate. In the final rule, we ask HHS to clarify what benefits would constitute coverage in each category, explain how the Department intends to define and enforce the non-discrimination and balance requirements in this context, and clarify that where two types of services are listed under a category of benefits, both must be covered to an equal degree. Additionally, all plan descriptions and materials should prominently include clear and complete language, intended for consumers and their families, describing the processes for appeal of a denial of coverage.

#### **Benefit Substitutions (§ 156.115 (b))**

The proposed rule allows plans substantial flexibility to substitute benefits within the EHB categories. This approach could undermine coverage for certain enrollees, including those with mental health and substance use needs, if a plan is able to use its substitution flexibility to reduce or eliminate medically necessary components of the continuum of care for these conditions. Should plans be permitted to substitute benefits in this way, it could result in gaps in coverage

and potential issues related to cherry-picking. For example, a plan may be able substitute medically necessary services required by individuals with more complicated conditions or health needs, and enhance benefits used by those with less severe conditions, in hopes of attracting a healthier risk pool. We ask that HHS make it clear that these approaches are unacceptable and provide clarity about allowing substitution flexibility.

**Prescription drug benefits (§ 156.120)**

The proposed rule improves upon the prescription drug approach outlined in the December 2011 Informational Bulletin. We appreciate that the Department has expanded this approach so as to ensure greater coverage of prescription drugs. However, the prescription drug provisions in the proposed rule remain insufficient to adequately meet the needs of individuals who are in need of multiple drugs per class, particularly people with mental illness.

The ACA's requirement that the EHB not discriminate based on age, disability, or expected length of life is meant to ensure that the benefits package meets the needs of individuals with complex health needs as sufficiently as it meets the needs of those without these conditions. However, the proposed rule requires that plans offering EHB coverage meet only a target number of drugs within a specified class, without regard to which drugs are covered. This approach would allow plans to avoid covering specific drugs that may have unique and important therapeutic advantages in terms of efficacy or safety. This approach is particularly problematic for children with mental illness. Antipsychotic medications are not clinically interchangeable, and providers must be able to select the most appropriate and clinically indicated medication for their patients. Physicians may need to change medications over the course of an illness as patients suffer side effects or their illness is less responsive to a particular drug, and patients requiring multiple medications may need access to alternatives to avoid harmful interactions.

AACAP is pleased that the proposed rule requires health plans to have procedures that allow an enrollee to ask a plan for a drug that is not covered. However, the rule does not say what protections people will have from unreasonable plan requirements or harmful delays.

**Out-of-network cost sharing requirement (§ 156.130 (c))**

The rule says that patient cost-sharing, such as deductibles and co-pays, for services outside of a plan's network will not count toward the annual limit on cost-sharing. This will result in people paying more or going without care if their plan does not have an adequate network for the services they need, such as from a psychiatrist. To address this problem, we urge HHS to require that cost-sharing for out-of-network specialty mental health services count toward the annual limit on cost sharing and deductibles.

In conclusion, AACAP urges HHS to maintain a federal role with regard to the EHB to comply with the ACA's nondiscrimination and preventive services requirements (Section 2713), as well as to implement and enforce the MHPAEA. It is also important that patients benefit from having information available to make meaningful decisions concerning their rights and available services. Thus, we recommend that HHS engage in a patient family education campaign that provides informed "navigation" services to individual consumers and their families. We also urge HHS to work with states to ensure consumers and providers have the opportunity to fully participate in the process of determining and updating EHB benefits in the future. Thank you for

considering our recommendations and we look forward to working with you and your staff as you implement the Affordable Care Act.

If you have any questions, please contact Kristin Kroeger Ptakowski ([kkroeger@aacap.org](mailto:kkroeger@aacap.org)), Senior Deputy Executive Director, Director of Government Affairs and Clinical Practice.

Sincerely,

A handwritten signature in cursive script that reads "Martin J. Drell, M.D.".

Martin J. Drell, M.D.  
President