



STATEMENT TO THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES LISTENING SESSION ON THE INSTITUTE OF MEDICINE RECOMMENDATIONS ON ESSENTIAL HEALTH BENEFITS UNDER THE AFFORDABLE CARE ACT

October 20, 2011

On behalf of the National Alliance on Mental Illness (NAMI), I pleased to offer the following comments on the recommendations from the Institute of Medicine (IOM) to the Secretary on the Essential Health Benefits (EHB) requirement in the Affordable Care Act (ACA).

NAMI is the nation's largest organization representing people living with serious mental illness and their families. Through our 1,100 affiliates in the all 50 states, NAMI is engaged in education, support and advocacy aimed at improving the lives of people living with disorders such as schizophrenia, bipolar disorder, schizoaffective disorder, borderline personality disorder, major depression and severe anxiety disorders such as PTSD. NAMI supported enactment of the ACA when it passed Congress in 2010 and has supported the efforts of the Department to ensure its full and effective implementation. Development of a strong EHB is critical to making sure that expanded coverage options meet the needs of people living with serious mental illness.

Before responding to the specific questions presented as part of this Listening Session, NAMI would like to express disappointment that the IOM report appears to have fallen short of its goal of providing the Secretary with needed clarity on the specific contours and boundaries in each of the 10 benefit categories listed in the ACA. At the same time, the report also appears to have gone beyond its original scope in setting forth a rigid standard for measuring overall EHB (the "typical" employer plan in the small group market) and an inflexible formula for updating the EHB in the future (imposing an arbitrary cap on growth). As these comments discuss below, NAMI believes that these recommendations have enormous potential to push the EHB beyond statutory boundaries.

In keeping with the title of the Institute of Medicine report "Essential Health Benefits—Balancing Coverage and Cost", how can the Department best meet the dual goals of balancing the comprehensiveness of coverage included in essential health benefits and affordability?

NAMI fully recognizes the need for the Secretary to balance affordability and comprehensiveness with in each of the 10 benefit categories set forth in the EHB requirements in the ACA. At the same time, NAMI does not believe that it was the intent of Congress for "typical employer coverage" to be limited to the small group market. In fact, there is nothing in the statute itself, or the legislative history, that should have driven the IOM to the conclusion that the EHB should be tied to this standard.

This limitation set forth by the IOM report is particularly troubling to NAMI as health coverage in the small group market has a long tradition of either excluding categories of treatment and benefits for mental illness, or (more commonly) imposing arbitrary limits or conditions (durational limits on inpatient days, outpatient visits, higher cost sharing, separate deductibles, etc.) that apply only mental health benefits. Adopting the small group market with its history of discriminatory coverage as the benchmark for the EHB creates enormous risk for mental health coverage.

NAMI would also note that the current small group market is largely exempt from the requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (P.L. 110-343). This law requires group health plans to cover mental health and addiction treatment on the same terms and conditions as medical-surgical benefits. It is the case that group health plans sponsored by employers with 50 or fewer workers are exempt from the federal parity law. Likewise, a majority of the state mental health parity laws have similar small employer exemptions. This is troubling to NAMI in that the IOM is recommending to the Secretary that the standard for the EHB is being tied to a market largely out of compliance mental health parity. This is particularly disturbing given that Congress specifically directed, in Section 1311 of the ACA, that all plans offered through the Exchanges comply with the Wellstone-Domenici law.

NAMI would further note that this decision by the IOM to recommend the typical employer plan in the small group market as the standard for the EHB runs contrary to the very design of the Exchanges, i.e. to aggregate risks, create economies of scale, and spread costs across the larger markets and avoid the inefficiencies, adverse risk selection and high costs of the small group market.

In fact, the legislative history of the ACA is replete with findings and provisions that Congress intended for the Exchanges to operate as a large group market, with risk spread across a large universe and more efficient and transparent pricing for individuals and small businesses. NAMI would therefore urge the Secretary to reject this recommendation from the IOM and instead adopt a standard for the EHB based on the large market that is more fully compliant with the Wellstone-Domenici law, where coverage for mental illness is more durable and comprehensive.

How might the Department ensure that essential health benefits reflect an appropriate balance among the categories so that they are not unduly weighted toward any category?

NAMI believes that the consideration of balance must be understood in the context of health reform's parity requirements. As noted above, Section 1311 of the ACA mandates the application of existing mental illness parity requirements to all qualified health plans in state Exchanges and to Medicaid expansion plans. In addition, inclusion of mental health and substance use disorder services is a required category of essential health benefits. Therefore, Exchange plans and Medicaid expansion plans *must* offer such services and therefore *must* offer them on terms of parity.

It is important to note that broad national parity requirements have only been phased in over the past two years, and numerous questions about implementation remain. Therefore, as noted above using the typical employer plan in the small group market runs contrary to the statutory requirements for the EHB set forth in the ACA. Clearly, Congress did not intend for the EHB to perpetuate the inadequate coverage that an assessment of historical employer coverage patterns reflect. A meaningful consideration of “balance” with regard to mental illness treatment must incorporate this understanding.

NAMI would also like to go on record against the recommendation in the IOM report for each benefit component, item or service in the EHB to meet a requirement to be not only medically effective, but also “demonstrate meaningful improvement in outcomes over current effective services/treatments.” Such a standard would almost certainly exclude from coverage many current treatments and interventions that patients and their families rely on. We know that many new treatments and services enter clinical use before this level of evidence has been developed in randomized controlled trials or observational studies.

Likewise, we know that even the most rigorous standard of evidence or well designed comparative study often fails to take into account heterogeneous patient populations and can fail to demonstrate clinical superiority beyond the “average” patient. This is certainly the case with available treatments for serious mental illness where there is significant diversity in how individual patients respond to particular interventions. Imposing a rigid superiority standard as the IOM recommends would inevitably lead to significant access restrictions for people living with serious mental illness.

What criteria should be used to update essential health benefits over time and what should the process be for their modification?

NAMI would urge the Secretary undertake a process for updating the EHB by employing standards to ensure that patients have access to medically appropriate care and not set national standards for whether individual items and services are either included or excluded. NAMI is concerned about recommendations from the IOM that would have the Secretary make decisions on inclusion/exclusion for specific tests, treatment or procedures based on an individual basis. When updating the EHB, the Secretary should instead allow for some flexibility to ensure that new therapies and treatments become available. In NAMI’s view, the process for updating the EHB should not turned into a national coverage determination process.

NAMI would like to go on record in opposition to the IOM recommendation to impose a ceiling in the process for updating the EHB. NAMI can find no provision in the ACA that would give the IOM license to recommend a requirement that all update to the EHB package be cost neutral. Such a requirement would lead directly to significant barriers to patient access to care and result in a highly contentious annual update process for the Secretary to undertake. There is no such requirement in the ACA and imposing one is beyond what Congress set forth in allowing the Secretary to define the EHB. Finally,

such a requirement would serve as a rigid and inflexible cost control tool that ultimately undermines the critical goal of quality of care.

Finally, NAMI would like to call attention to the recommendations in the IOM report that appear to expand and shift the mission of the Patient Centered Research Outcomes Research Institute (PCORI) toward a central role in updating the EHB. In the ACA, Congress went to great lengths to ensure that the PCORI Board is independent from the Secretary's role in establishing and updating the EHB. In fact, PCORI's role is specifically limited to development, oversight and dissemination of patient-centered comparative effectiveness research.

The statute specifically bars PCORI and the research it produces and disseminates from being used for national coverage decisions. NAMI is troubled that the IOM appears to be trying to refocus PCORI and its work toward making coverage decisions, rather than generation of high quality comparative research to assist patient and providers in real world treatment settings. NAMI urges the Secretary to help PCORI focused on this critical goal.

Respectfully Submitted,

A handwritten signature in black ink, appearing to read "Andrew Sperling". The signature is fluid and cursive, with a long horizontal stroke at the end.

Andrew Sperling
Director of Legislative Advocacy
National Alliance on Mental Illness