COMMUNITY CATALYST

# Essential Health Benefits:
# Mental Health and Substance Use Disorders Advocacy

*Updated October 2012*

The Affordable Care Act (ACA) will not only bring health coverage to 30 million Americans, it will require most new insurance policies to contain a minimum set of core benefits. These Essential Health Benefits (EHB) are required in private plans sold through new health insurance markets (the Exchanges) that will be established in each state. EHB are also required for all new individual and small group plans sold outside the Exchanges, as well as in new Medicaid coverage. The ACA requires core benefits in 10 categories, designed to mirror the benefits provided under a typical employer-sponsored health plan.

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| **1. Ambulatory services (e.g. doctor's visits, outpatient services)** | **6. Prescription drugs** |
| **2. Emergency services** | **7. Rehabilitative and habilitative services and devices** |
| **3. Hospitalization** | **8. Laboratory services** |
| **4. Maternity and newborn care** | **9. Preventive and wellness services and chronic disease management** |
| **5. Mental health and substance use disorder services, including behavioral health treatment** | **10. Pediatric services, including oral and vision care** |

The inclusion of mental health and substance use disorders services is integral to improving and maintaining Americans' overall health and reducing the enormous health care costs[1] that result when these illnesses are not treated. The annual cost to society of substance use disorders alone is approximately $200 billion, yet only a fraction ($15 billion) is spent on treatment. Treatment is effective[2] in reducing substance use, which brings savings to the health care and criminal justice systems, and increases job productivity.

As of September 30, each state had to choose or default to a "benchmark" plan on which to model their EHB for the state's individual and small group markets that will apply both inside and outside of the Exchange. In the near future, states will also have to choose one for the

Medicaid expansion population; regulations are forthcoming. State officials can choose the same benchmark plan for both the Exchange and Medicaid expansion population; or states could follow a 2005 law that allows for "benchmark equivalent" benefits in lieu of choosing a Medicaid benchmark. States choose the benchmarks from among the three largest federal employee plans, the three largest state employee plans, the three largest small group plans, or the largest non-Medicaid HMO. The benchmarks will determine the specific services and volume of services to be included in the 10 EHB categories. For more information on EHB, please see Health Insurance 101.[3] The largest small group plan will automatically become the private insurance benchmark for states that did not choose their own benchmarks by September 30.

With some benchmarks, the mental health and substance use disorders benefits might fall short of complying with either the intent of the ACA to require comprehensive benefits in each category, or a separate federal law requiring parity of mental health and physical treatment – that is requiring that benefit limits are no stricter for behavioral health than they are for physical health. In this case, the federal government has stated[4] that the benchmark must be augmented. (The parity law requires cost sharing that is no stricter as well; this cannot be assessed until health plans start offering insurance products to consumers.)

## What Advocates Can Do After September 30, 2012

**Assess mental health and substance use disorders coverage, including parity adequacy.** Advocates should examine the chosen benchmark plans to investigate whether benefit limits need to be altered to comply with parity. For example, Oregon's benchmark[5] limits residential treatment for mental health and substance use disorders to 45 days annually. It is likely this limitation violates the parity provisions required by the ACA. In guidance documents,[6] the federal government has said the mental health and substance use disorders services in small group plans are often not at parity with other benefits because those plans are usually not subject to state or federal parity laws. States (or the federal government) must alter the benchmarks to comply with parity laws. (See section below for more - "What Benefits Do Consumers Need?")

**Build a coalition to support expanded benefits.** There is an opportunity to build a broad coalition to advocate for these benefits, including with strange bedfellows. The cost savings associated with treatment have garnered support from conservatives for initiatives such as drug courts, which steer drug law offenders to mandatory treatment as an alternative to incarceration. Additionally, drugs such as crystal meth have ravaged rural communities traditionally represented by conservative legislators, leading to more bipartisan work on the substance use disorders issue. Substance use disorders coalitions exist in many states comprising people in recovery and providers. In many states these coalitions are not linked to other consumer health care advocates.

**Submit comments on the supplemental benefits.** After September 30, states or the federal government will "supplement and adjust" each state's benchmark so that it complies with the requirements of the ACA. Mental health and substance use disorders parity is predicted to fall short. The federal government will seek public comment on the plan for supplementing the benchmark, giving advocates an opportunity to weigh-in. The final decision on the benchmark's make-up will be made by the U.S. Department of Health and Human Services.

**Advocate for transparency**. Transparency[7] must be a priority, so that the benefits offered can be monitored and to ensure categories have the breadth of benefits intended by the ACA. Advocates cannot work on behalf of consumers if they have poor knowledge of the benefit package.

**Identify the EHB decision-makers in your state and meet with them.** The EHB decision makers vary from state to state, but could include the state insurance commissioner, secretary of health, Governor's office, legislature, or ad hoc advisory body. This is an opportunity to learn whether your state officials understand mental health and substance use disorders. Many officials are sympathetic to these issues, but because they have not worked directly in these areas they are often unfamiliar with the unique obstacles faced by people with these conditions. For more, see the Community Catalyst document titled "How to Build and Maintain Relationships with State Officials."[8]

**More resources are available.** Community Catalyst published a document on EHB advocacy[9] and relevant blog content[10]. State Refor(u)m, a resource for state officials implementing the ACA, has a matrix[11] that tracks state progress on EHB.

## What Benefits Do Consumers Need?

No "gold standard" exists for mental health and substance use disorders, but the Coalition for Whole Health, a broad group of advocates, commissioned a paper[12] by the actuarial consulting firm Milliman that described typical mental health and substance use disorders benefits covered by large group plans.

The Coalition also developed a detailed list[13] of recommended benefits and recently released a detailed checklist[14] to help assess benchmark plans. These fall under five of the ten EHB categories, which are Mental Health and Substance Use Disorder Services; Prescription Drugs; Rehabilitative and Habilitative Services and Devices; Pediatric Services; and Preventive, Wellness, and Chronic Disease Management Services.

Community Catalyst has developed a short summary of services[15] needed to treat mental health and substance use disorders.

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[1] http://www.soros.org/reports/unforeseen-benefits-addiction-treatment-reduces-health-care-costs
[2] http://www.drugabuse.gov/publications/principles-drug-abuse-treatment-criminal-justice-populations/providing-drug-abuse-treatment-to-offenders-worth-f
[3] http://101.communitycatalyst.org/aca_provisions/essential_benefit_package
[4] http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf
[5] http://www.oregon.gov/OHA/OHPR/EHB/docs/ehb-plan-comparison.pdf
[6] http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf

[7] http://www.communitycatalyst.org/doc_store/publications/Transparency_EHB_final_July_2012.pdf
[8] http://www.communitycatalyst.org/doc_store/publications/Relationships_with_State_Officials.pdf
[9] http://www.communitycatalyst.org/doc_store/publications/Principles_EHB_Advocacy.pdf
[10] http://blog.communitycatalyst.org/index.php/tag/essential-health-benefits/
[11] http://www.statereforum.org/state-progress-on-essential-health-benefits
[12] http://www.coalitionforwholehealth.org/2012/02/milliman-report-on-essential-behavioral-health-benefits-2/
[13] http://www.coalitionforwholehealth.org/2012/01/ehb-consensus-principles-and-service-recommendations/
[14] http://www.coalitionforwholehealth.org/wp-content/uploads/2012/03/Essential-Health-Benefit-tool-for-MH-and-SUD-coverage.pdf
[15] http://www.communitycatalyst.org/doc_store/publications/EHB_SUD_list-July2012.pdf