

PAIN CARE COALITION

A National Coalition for Responsible Pain Care

American Academy of Pain Medicine • American Headache Society • American Pain Society •
American Society of Anesthesiologists

January 31, 2012

Marilyn B. Tavenner
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: **Essential Health Benefits Bulletin**

Dear Acting Administrator Tavenner:

The Pain Care Coalition is pleased to submit these comments on the “Bulletin” of December 16, 2011 setting forth CMS’s proposed approach to defining an Essential Health Benefits (“EHB”) package in implementation of certain provisions of the Affordable Care Act (“ACA”). The member professional societies of the Pain Care Coalition represent tens of thousands of clinicians, educators, and researchers specializing in the diagnosis, treatment, and management of both acute and chronic pain.

BACKGROUND

As recently documented in the ground-breaking Institute of Medicine (“IOM”) report entitled “Relieving Pain in America” (National Academies Press 2011), pain is a public health problem of epidemic proportions in the United States, afflicting all demographic groups and individuals at all stages of life. Pain can be a disease unto itself as with migraine, low back pain, fibromyalgia, and a long list of other conditions affecting the central and peripheral nervous system, or it can be a symptom of other diseases including cancer, heart disease, diabetes, orthopedic and musculoskeletal injuries and other trauma. The IOM estimates that chronic pain alone afflicts over **116 million** Americans and costs the American economy as much as **\$635 billion** in added healthcare costs and lost productivity. Pain affects many more people than cancer, heart disease and diabetes combined. It is also a leading cause of temporary and permanent disability. It imposes untold suffering on individuals and their families.

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Thus, while pain represents a huge burden on the healthcare system, it also represents an enormous opportunity to reduce both human suffering and societal costs if properly assessed, diagnosed, treated and managed across the continuum of healthcare services and settings.

GENERAL COMMENTS AND RECOMMENDATIONS

The Pain Care Coalition appreciates the difficult balancing act the Agency faces in defining a minimum “essential” benefits package for use by diverse insurance arrangements across diverse geographic and demographic areas. A package so comprehensive as to be unaffordable would be a false promise, just as a package limited to token health coverage for those previously uninsured would undermine the very purpose of the ACA. The Pain Care Coalition also generally supports an approach providing reasonable flexibility to the states as opposed to a “one size fits all” approach that might stifle innovation in both delivery and insurance markets. Further, mandating benefits by narrow disease categories, by “body part,” or by provider specialty and setting all have potential disadvantages.

Pain care is particularly complex from a benefit design perspective. Building coverage around discrete conditions, or discrete treatment modalities favored by particular specialties, would not adequately provide for the **diversity** of pain conditions, arising sometimes as symptoms of other diseases, and sometimes as diseases themselves. Nor would that approach adequately provide for the wide **spectrum of complexity** in pain conditions, ranging from much acute pain that is readily managed with monomodal treatment to the most complex chronic pain conditions that require coordinated, comprehensive and interdisciplinary care, often in highly specialized centers, or carefully coordinated across multiple care settings. Good care for these complex chronic pain conditions also often requires long-term pain management that is integrated with the management of other chronic conditions that also cross multiple care settings.

While most pain care falls within one or more of the ACA’s ten mandated coverage categories, a strictly categorical approach to benefit design lacks the coordinating and integrating characteristics that are essential to good pain care for many patients. To take one relatively simple example, even appropriate management of surgical pain requires coordination between acute pain control at the site of surgery, short-term pain relief post surgery which can be in either institutional or ambulatory settings, and for many patients, longer post surgical management on a strictly ambulatory basis. If pain care is viewed solely as being covered within other benefit categories (ambulatory services, hospitalization, prescription drugs, rehabilitative care, and chronic disease management to name the most common), it will be covered in the various “silos” of an EHB package, but not in a comprehensive and integrated fashion.

Given the need for integrated pain management across categorical services and settings, the Pain Care Coalition strongly urges the Agency to adopt a minimum standard for health insurance coverage that speaks to comprehensive pain care across other benefit categories. Simply stated, **one element of an EHB package should be adequate assessment, diagnosis, treatment and management of a patient’s acute or chronic pain.**

It is widely accepted that pain is the most common reason patients access the health care system. Can health insurance that does not cover adequate pain care, be characterized as providing those benefits most “essential” from the patient’s perspective? Would the states argue that covering adequate pain care would be too burdensome on insurers, or too costly for employers? We think not. If the Agency proceeds with its “benchmark” approach, we urge the inclusion of adequate pain management as an essential element of any benchmark, or benchmark equivalent, plan.

ADDITIONAL SPECIFIC COMMENTS

Habilitation and Rehabilitation. The Bulletin discusses terminological distinctions between “creating,” “maintaining,” and “restoring” function. We think the pain patient views these differences as more semantic than real. When pain cannot be “cured,” the management goal becomes sufficient pain relief to permit the patient to function at a reasonable level—at work, at school, and in the family. While for most patients this will fall under “restoring” function in the rehabilitative care model, patients should not be at risk of non-coverage if instead it is simply the ability to maintain a particular functional status over time.

Mental Health Parity. The Bulletin indicates that CMS intends parity to apply in the EHB context to coverage under the mental health, substance use disorder and behavioral health coverage category. The Pain Care Coalition strongly supports this principle. Patients living with chronic pain often suffer from sleep disorders, emotional distress, and even severe depression. Treatment for these conditions makes behavioral health services an integral part of comprehensive, interdisciplinary pain care for some patients. Inferior coverage for these services has historically been a significant impediment to good care for many. Services related to substance use disorders are also important in the pain field as reflected in the growing problem of misuse and abuse of some pain medications.

Service Substitution within EHB Coverage. The Bulletin suggests that the Agency will permit plan issuers to substitute services within coverage categories, and possibly across categories, in determining whether a particular plan is “substantially equal” to the benchmark plan. While this flexibility is appealing, we urge the Agency to proceed cautiously in this area. In the pain field, coverage could well be actuarially equivalent, yet not provide adequate pain relief to individual patients because of individual characteristics (therapies that work in some patients are ineffective, or even contra-indicated for others), or because the setting in which the patient is receiving care falls within the wrong coverage category. This could be particularly problematic in the case of pain medications, where economic equivalence from a premium perspective translates poorly into equal tolerance or effectiveness for the individual patient in need of pain relief.

Evaluation and Updating of EHB. Given the Agency’s general approach to establishing the EHB package, which is “bottom up” and market driven, rather than “top down” and

regulatory, we urge careful evaluation and periodic review of the approach adopted. We suggest that the adequacy of pain care delivered by a plan would be a logical evaluation criterion. As noted above, from the patient's perspective a benefit package that does not provide for adequate pain care can hardly be said to provide the essential ingredients of reasonable health care coverage.

We urge your careful consideration of these concerns, which we believe are fundamental to the provision of quality, humane health care, and of equal importance to those already insured and those who may gain insurance by virtue of implementation of the ACA. The Pain Care Coalition, and the Societies and professionals it represents, would be pleased to assist you and your staff in any way we can as you seek responsible policy solutions.

Respectfully submitted,

A handwritten signature in blue ink, appearing to read "Scott Fishman". The signature is fluid and cursive, with a large initial "S" and "F".

Scott M. Fishman, M.D.
Chairman