

Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

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Delivered via electronic submission to: EssentialHealthBenefits@cms.hhs.gov

January 31, 2012

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Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8010
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RE: Comments on HHS Essential Health Benefits Bulletin

I write on behalf of the Tribal Technical Advisory Group (TTAG) to the Centers for Medicare and Medicaid Services (CMS) regarding the "Essential Health Benefits Bulletin" prepared by the Centers for Medicare and Medicaid Services (CMS), Center for Consumer Information and Insurance Oversight (CCIIO), dated December 16, 2011, (CCIIO EHB Bulletin) and released by the Department of Health and Human Services (HHS).

The TTAG advises CMS on Indian health policy issues involving Medicare, Medicaid, the Children's Health Insurance Program, and any other health care program funded (in whole or part) by CMS.¹ In particular, the TTAG focuses on providing policy advice to CMS regarding improving the availability of health care services to American Indians and Alaska Natives (AI/AN) under these Federal health care programs, including through providers operating under the health programs of the Indian Health Service, Indian Tribes, tribal organizations and urban Indian organizations (I/T/U).²

The CCIIO EHB Bulletin is designed to announce a proposal that HHS intends to pursue later in rulemaking to define essential health benefits (EHB) under section 1302 of the Patient

¹ Sec. 5006(e) of the American Recovery and Reinvestment Act codifies in statute, at sections 1902(a)(73) and 2107(e)(1)(C) of the Social Security Act, the requirement for the Secretary of Health and Human Services to maintain a Tribal Technical Advisory Group within CMS and the requirement that States seek advice from Tribes on a regular and ongoing basis where one or more Indian health program or urban Indian organization furnishes health care services.

² The abbreviation "I/T/U" means the Indian Health Service (IHS), an Indian Tribe, tribal organization or urban Indian organization, and is sometimes referred to collectively as "Indian Health Care Providers". The term "Indian Health Service" means the agency of that name within the U.S. Department of Health and Human Services established by Sec. 601 of the Indian Health Care Improvement Act (IHCIA), 25 USC §1661. The term "Indian Tribe" has the meaning given that term in Sec. 4 of the IHCIA, 25 USC §1603. The term "tribal organization" has the meaning given that term in Sec. 4 of the IHCIA, 25 USC §1603. The term "urban Indian organization" has the meaning given that term in Sec. 4 of the "IHCIA", 25 USC §1603.

Protection and Affordable Care Act.³

We appreciate the opportunity to provide preliminary comments on the Bulletin. Although the CCIIO EHB Bulletin itself does not make specific mention of American Indians and Alaska Natives (AI/ANs), or of Indian Tribes, the ultimate design of the EHB package will have a profound impact on the ability of AI/AN to access affordable health insurance coverage and to secure needed health care services from their providers of choice, particularly Indian Health Care Providers.

The following provides a review of issues of concern regarding the proposal contained in the CCIIO EHB Bulletin.

Selection of the Benchmark Plan

In the proposal, a State is afforded the opportunity to select a benchmark plan for use in defining the EHB package that will be available in the individual and small group markets inside and outside in a State's health insurance exchange (Exchange). A State is to use relative enrollment figures in narrowing the potential benchmark plans from which to choose. For example, one option is for a State to choose "the largest plan by enrollment in any of the three largest small group insurance products in the State's small group market."⁴

The TTAG recommends that States be given the option, in addition to being able to choose by relative enrollment, to apply a criterion of customer satisfaction when selecting the benchmark plan. As such, a State would be able to establish as a criterion for selection of a benchmark plan a plan in one of the four benchmark plan types that has the highest customer satisfaction among plan enrollees. Criteria would also need to be applied that ensure that the selected plan has a substantial market share in the State and the methodology used to measure customer satisfaction was sufficient rigorous and valid.

Default Benchmark Plan

In the CCIIO EHB Bulletin, the following is proposed for selection of a benchmark plan in a State if a State does not proactively select the benchmark plan.

If a State does not exercise the option to select a benchmark health plan, we intend to propose that the default benchmark plan for that State would be the largest plan by enrollment in the largest product in the State's small group market.⁵

³ Refers collectively to the Patient Protection and Affordable Care Act (Pub. L. 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), and referred to herein as the Affordable Care Act or ACA. Section 36B, contained in section 1401 of the ACA, was subsequently amended by the Medicare and Medicaid Extenders Act of 2010 (Pub. L. 111-309), the Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011 (Pub. L. 112-9), and the Department of Defense and Full-Year Continuing Appropriations Act, 2011 (Pub. L. 112-10).

⁴ CCIIO EHB Bulletin page 9.

⁵ CCIIO EHB Bulletin page 9.

In order to provide greater uniformity across the United States, at the same time continuing to allow States to exercise the option of selecting the benchmark plan, the TTAG recommends that HHS should select as the benchmark plan in a State (when a State fails to select the benchmark plan in that State) from the third benchmark plan type listed (i.e., national Federal Employees Health Benefits Program (FEHBP) plan options) rather than from the first category (i.e., small group insurance). When selecting from this benchmark plan type, HHS could incorporate the relative customer satisfaction of plan enrollees in addition to relative plan enrollment. But given that enrollees under the FEHB program are able to choose the plan they are to enroll in on an individual basis (rather than to be offered a single plan by an employer), the relative enrollment figures inherently include a measure of customer satisfaction under the FEHB program.

Comprehensive Benefits

On page 8 of the CCIIO EHB Bulletin, it reads: “We intend to propose that EHB be defined by a benchmark plan selected by each State. The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a ‘typical employer plan’ in that State...”⁶

In the HHS discussion of findings from a survey of large employer plans, small employer products, and plans offered to public employees, HHS found that “plans do not differ significantly in the range of services they cover. They differ mainly in the cost-sharing provisions, but cost-sharing is not taken into account in determining EHB.”⁷

Although cost-sharing may not be taken into account in determining EHB, it appears that quantitative limits on services are, as the CCIIO EHB Bulletin stated that the EHB package would include “any limits offered” by the benchmark plan selected. In the HHS press release, the document was more explicit in noting that “health plans also would have flexibility to adjust benefits, including both the specific services covered and any quantitative limits...”⁸

So, while it may be accurate to state that “plans do not differ significantly in the range of services they cover,” plans may (and likely do) vary significantly across the large and small group markets, and potentially by State, in the quantitative limits the plans impose on the services they cover in their benefit package. The TTAG’s concerns in this regard are two-fold. First, quantitative limits somewhat arbitrarily limit access to needed medically-necessary services. In effect, essential health benefits will be excluded from the EHB package as a result of adopting quantitative limits. These quantitative limits can greatly impact the value of the plan.

Second, the TTAG is concerned that the benchmark plan selected for one State may have a substantially lower value than a benchmark plan selected in another State. And for States that decide not to select the benchmark plan, HHS has indicated “the default benchmark plan for that

⁶ CCIIO EHB Bulletin, page 8.

⁷ CCIIO EHB Bulletin, page 4.

⁸ HHS Press Release, “Essential Health Benefits: HHS Informational Bulletin,” page 3, on healthcare.gov January 17, 2012.

State would be the largest plan by enrollment in the largest product in the State’s small group market.”⁹ It is likely that the typical plans available in the small group market in a State would have substantially greater quantitative limits on covered services. So, whereas the Affordable Care Act called for the Secretary of HHS (Secretary) to “ensure that the scope of the essential health benefits under paragraph (1) is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary,”¹⁰ the benchmark plan in these States would be a typical plan in the small group market. The TTAG recommends that the Secretary modify the quantitative limits in any default benchmark plan to equal what is provided in typical employer plans generally, and not those in the small group market alone.

EHB Design Flexibility and Consumer Choice

In the design of the Affordable Care Act, a core cost-containment component was the establishment of Exchanges and the ability of consumers to compare like products effectively. Key to being able to compare like products, is to have “like products” to compare. If there are variances in the basic benefit package across plans, this would frustrate, if not disable, a consumer’s ability to make plan-to-plan comparisons. In contrast, if there is a standardized benefit package, consumers could then compare plans based on price and the plan’s provider network.

After selection of the benchmark plan by a State (or by HHS in instances where a State did not choose a benchmark plan), a health plan would then, according to the CCIIO EHB proposal, be able to “offer benefits that are ‘substantially equal’ to the benchmark plan selected by the State... Health plans also would have flexibility to adjust benefits, including both the specific services covered and any quantitative limits, provided they continue to offer coverage for all 10 statutory EHB categories and the coverage has the same value.”¹¹

The CCIIO EHB Bulletin suggests an approach that appears to significantly weaken the ability of consumers to compare like products. The CCIIO EHB Bulletin states that “permitting flexibility would provide greater choice to consumers.”¹² Although differing options would become more numerous and available to consumers under this approach, it would have the significant downside of impeding effective comparisons and choice between the various options available to consumers. As such, the TTAG encourages HHS to minimize the variance in the EHB package that is allowed to be made by health plans/issuers. And, to the extent variance is allowed, it should be easily identifiable by consumers through the mandatory preparation of HHS-approved templates by the plans and by the Exchanges.

The CCIIO EHB Bulletin continues by noting that “we are considering permitting substitutions that may occur only within each of the 10 categories specified by the Affordable Care Act. However,

⁹ CCIIO EHB Bulletin, page 9.

¹⁰ Affordable Care Act, section 1302(b)(2).

¹¹ HHS Press Release, “Essential Health Benefits: HHS Informational Bulletin,” page 3, on healthcare.gov January 17, 2012.

¹² CCIIO EHB Bulletin, page 12.

we are also considering whether to allow substitution across the benefit categories.”¹³ Again, the TTAG would encourage HHS to minimize any variance allowed within benefit categories, not allow variance across categories, and require a standardized presentation of any variances that are allowed.

Updating Essential Health Benefits

The CCIIO EHB Bulletin acknowledges on page 13 that the ACA directs the Secretary to periodically review and update EHB. CCIIO proposes to assess whether enrollees have difficulties with access, changes in medical evidence, market changes not reflected in the benchmarks and the affordability of coverage. CCIIO is seeking comments on the process for gathering information, making assessments and evaluating the benchmark approach. Particularly because the Secretary has deviated from the ACA intent of having a national standard for EHB, we believe that the annual evaluation of the proposed approach is extremely important. Here are some of the items that we recommend to be included in the evaluation:

- Are there differences in utilization, health status and health outcomes for those enrolled in Exchange plans living in rural areas versus urban areas? The concern is that the benchmark plan chosen by a State based on level of enrollment will have bias toward serving urban areas where most businesses are located and the health benefits may not meet the needs of people in rural areas.
- Are there differences in utilization, health status and health outcomes for people of different races and ethnicities, including American Indians and Alaska Natives, enrolled in Exchange plans? The concern is that the benchmark plan chosen by a State based on level of enrollment will have a bias toward serving predominately white employees of small businesses and may not offer the kinds of services or culturally-competent services that are needed by a more diverse population.
- How do the plans selected as benchmarks compare with other plans on the basis of patient satisfaction, measures of quality of care, and covered services (e.g. mental health, substance abuse, behavioral health)? The concern is that small businesses may be selecting the least expensive plan without regard to quality of care and comprehensiveness of services, and that plan may not be the best basis for improving health in our country.
- How consistent are health benefits selected by Exchanges and the plans they offer with the recommendations of the Institute of Medicine for EHB? The concern is that the ACA set out a process for determining EHB based on scientific and medical evidence and that may be subrogated to issues of cost to an extent that the country does not receive the benefits intended from ACA.
- How have substitutions been used to diminish or increase benefits in each of the 10 categories required by law? In addition to requiring States to report on this question, CCIIO

¹³ CCIIO EHB Bulletin, page 12.

should establish a complaint process for people who are denied care to have a data base from which to analyze the types of denials that are issued on the basis of being outside the scope of benefits. A separate log should be kept by CMS to record the types of questions that States have regarding substitutions. This will indicate the areas in which States are seeking Federal guidance.

- Has market share increased for the issuer of the plan designated as the benchmark and thereby reduced competition among health insurers? The concern is that small businesses may seek to avoid confusion about whether the plan they purchase meets the minimum EHB by simply purchasing the plan designated as the benchmark. This, in turn, would make the plan that already has the largest enrollment in the State have an even larger market share and thereby reduce competition.
- Tribal consultation and stakeholder input is needed in an evaluation in addition to collecting quantitative data. Tribal governments, State governments, providers, consumer advocacy organizations, and others should be asked to comment on whether it would be better to have one national standard for EHB, or more than 50 State-specific standards. Exchanges should be asked about their enrollment process that determines whether employer-sponsored coverage offers the minimum benefits and if there are difficulties determining whether individuals qualify to use the Exchange on this basis. Employers that have been assessed fines for failing to offer the minimum benefits should be asked about the clarity of regulations and how they are applied.

The evaluation report should be available publically and help to inform our country about future directions for determining EHB.

Defining the Ten Benefit Categories

The 10 benefit categories designated in the Affordable care Act were, in part, designed to remedy gaps in covered services from plan to plan. The categories, though, are not uniformly defined by commercial health plans. It is critical that HHS provide clear standards for what must be covered, and what may be covered, under each of the 10 benefit categories to ensure a standard from which to compare proposed State benchmark plans.

Defining what is included in each benefit category is necessary in order to be able to make a reasonable comparison across plans as to the covered services. This is needed for both required services (those that are contained in the benchmark plan) and substitution services (those that a health plan may substitute in to replace required services.) For example, in instances in which the benchmark plan selected for use in the individual and small group markets (inside and outside an Exchange) in a State includes adult dental benefits, it will be necessary to indicate within which of the ten categories that comprise the EHB package the adult dental services would be grouped. This will enable consumers to more readily compare plans, and defining the services that may be included in a particular category will permit identifying when a plan attempts to substitute across categories (which the TTAG recommends not be allowed to happen.)

Preventive and Wellness Services

Under the ACA, section 1302(b)(1)(I) calls for inclusion of “[preventive and wellness services and chronic disease management” in the EHB. The underlying rationale is that an emphasis on prevention will reduce the costs of health care downstream by reducing expensive diseases such as diabetes and cancer. Under ACA section 2713, “Coverage of preventive health services,” all *new* plans are required to cover preventive services and immunizations recommended by the U.S. Preventive Services Task Force (USPSTF) and the Centers for Disease Control and Prevention (CDC), certain child preventive services recommended by the Health Resources and Services Administration (HRSA), and women’s preventive care and screening recommended by HRSA, without any cost-sharing. This requirement became effective for plan or policy years beginning September 23, 2010. The benchmark plan selected by a State, or by CMS in instances when a State did not select a benchmark plan, would then be modified to include these designated preventive services if not already contained in the benchmark plan, so it is anticipated that every proposed benchmark plan would include, at a minimum, these designated preventive services without cost-sharing. This will put the Exchange plans in line with Medicare benefits that became effective January 1, 2011, at which time co-payments for preventive services are eliminated and preventive services are exempted from deductibles. It also aligns Exchange³ plans with Medicaid, with the possible exceptions of EPDST screening and coverage of tobacco cessation services for pregnant women in Medicaid.

While it would appear that preventive and wellness services are going to be covered by the benchmark plans, it is less clear whether the benchmark plans will offer chronic disease management services to the extent that ACA envisioned. This is particularly significant for AI/AN populations who have among the highest rates of diabetes in America. People with diabetes are more likely to have other chronic diseases, such as heart disease and kidney failure. People with multiple chronic illnesses may be unable to work and therefore the services that they need may not be covered in health plans that are primarily designed for employees. Because the Health Insurance Exchanges are intended to provide coverage to those who are uninsured, and a significant proportion of the uninsured are unemployed or part-time employees who may have chronic illnesses, the proposed benchmark plans may not be the best way to define EHB for chronic disease management.

The Early, Periodic Screening, Diagnosis and Treatment service (EPSDT) under the Medicaid program is an excellent model for how preventive and wellness services should be structured (and some of the other specified categories of services), not only for children at whom it is directed in Medicaid, but also for adults. Medicaid requires States to make available and reimburse for comprehensive preventive health screenings according to a designated schedule and then to make additional diagnosis and treatment services available as needed to address health issues that are identified in the EPSDT screening. This model should be required for child health and extended to adults in order to ensure that the focus of health care stays on prevention and on focusing health services to the specific needs of the covered individuals.

It is not clear how Federal and State governments plan to address the issue of cultural competency for plans offered on Exchanges. Tribes have developed some culturally-based approaches to prevention that may not be covered by the urban-oriented benchmark plans, while the benchmark plans may offer coverage for some types of services that are not available in Tribal areas.

Pediatric Health Services: Dental and Vision

One of the 10 EHB in the Affordable Care Act is pediatric oral and vision care. The analysis by CCIIO states that it is likely that small employer health plans used as the benchmark may not offer these services. As an alternative, it is proposed in footnote 27 on page 10 of the CCIIO EHB Bulletin that people purchase a second plan to cover dental services:

A qualified health plan may choose to not offer coverage for pediatric oral services provided that a standalone dental benefit plan which covered pediatric oral services as defined by EHB is offered through the same Exchange.

This is not a good arrangement for AI/ANs (as well as other Americans) who will likely have difficulty navigating an Exchange to enroll in one health plan and figure out the advanced tax credits, and they may be even more overwhelmed by having to pick two plans – one for medical and one for dental. Furthermore, it will be more difficult and expensive administratively for Tribes to sponsor individuals if it involves enrolling in two health plans instead of one.

If HHS continues to approve the concept of separate medical and dental plans, then there needs to be greater explanation of how to calculate the combined minimum value for employer-sponsored plans that is used to determine whether people qualify for enrolling in Exchange plans. Also, the proposed rules regarding the advanced tax credits need further explanation for the coverage of both plans. One question that should be addressed is whether a single person or a couple without children would be required to purchase a dental plan in order to receive the EHB of pediatric dental care when they will not use pediatric dental care. Furthermore, the actuarial value of pediatric oral health services needs to be calculated and deducted from the actuarial value of the health care plans to assure that the total maximum payments do not exceed the standards set by the ACA.

We also recommend that even if pediatric oral and vision benefits are separated, that screening for these issues be required to be included under the preventive and wellness category of essential health benefits. Failure to identify and address these issues in children have serious and long term consequences that will increase the cost of health services if not managed as they arise.

Mental Health and Substance Use Disorder Services, Including Behavioral Health Treatment

Like the rest of the United States, AI/ANs have a need to access mental health and substance use disorder (MHSUD) services, including behavioral health treatment services and it is critical an EHB package includes sufficient coverage for mental health and substance use disorders for children, youth and adults. This is central to efforts to ensure that health reform meets its potential

to allow individuals and families access to prevention services as well as ameliorate mental health conditions and to recover from diseases, improve health, and decrease other types of costs associated with not providing adequate MHSUD services.

It is broadly understood that AI/AN people are at a higher risk for MHSUD problems than other racial and ethnic groups in the United States. The current most alarming statistic is the devastating act of suicide.¹⁴

The Indian Health Service data indicates that at least one-third of the demand for services in its health facilities is related to MHSUD issues. The most significant mental health concerns today are the high prevalence of substance abuse, depression, anxiety, violence, and suicide. Substance abuse, most notably alcoholism, has been the most visible health disorder crisis. Depression is also emerging as a dominant concern. These illnesses are commonly attributed to isolation on distant reservations, pervasive poverty, hopelessness, and a lack of access to care and health professionals to deliver services.

Reservation communities are facing significant barriers to the receipt of effective prevention and treatment services for MHSUD problems. Many Indian reservations are located in some of the most remote and rural areas of the United States. This further complicates access to and the availability of mental health and drug abuse professionals, such as psychiatrists, psychologists, drug counselors, and social workers is seriously lacking. Poverty, geographic location, and cultural differences further limit the amount and quality of services available. Research confirms that limited insurance coverage, scarce availability of services, excessive travel distances, weather hazards, increased personal monetary costs, and stigma related to behavioral health needs additionally contribute to poor access.

The Affordable Care Act, Mental Health Parity and Access

The inclusion of mental health and substance use disorder services, including behavioral health treatment as an EHB, clearly demonstrated the intent of Congress to finally recognize the desperate needs of Americans for adequate MHSUD services. Nearly the entire Country is experiencing a Mental Health Professional shortage as noted by data from the HRSA, Bureau of Health Professionals, July 5, 2009. Especially impacted by this shortage are AI/AN people and other rural populations.

Importantly, it is also clear that essential health benefits are just that, not necessarily what health plans have defined or have traditionally provided for their participants. The premise that Congress intended to limit EHB to “historical covered” services is not logical nor will escalating health care costs ever be contained unless essential mental health, substance use disorder services, and behavioral health treatments become accessible, high quality, and required of all health plans.

The literature clearly demonstrates critical deficits for employer mental health benefits. A

¹⁴ American Indian and Alaska Natives have the highest rates of suicide than any group in the nation (* 2007, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS): www.cdc.gov/ncipc/wisqars)

2008 GAO report shows that 87 percent of the surveyed employers had a limit on mental health benefits lower than what is offered for other medical/surgical benefits. Another study shows that cost-sharing for addiction benefits was 46 percent higher than for medical/surgical benefits, and that 44 percent of the plans that were studied contained no out-of-pocket spending caps for addiction spending. Since, according to the National Institute of Mental Health, an estimated 26.2 percent of Americans 18 and older, or about one in four adults, suffer from a diagnosable mental disorder in a given year, an imbalance in these benefits has wide-ranging impact.¹⁵

Another report documents the changes in the health plans of medium and large employers provides more recent evidence for these trends.¹⁶ Between 1988 and 1997, the proportion of such plans with day limits on inpatient psychiatric care increased from 38 percent to 57 percent, whereas the proportion of plans with outpatient visit limits rose from 26 percent to 48 percent. On the basis of this and other information, the Hay Group estimated that the value of behavioral health care benefits within the surveyed plans decreased from 6.1 percent to 3.1 percent from 1988 to 1997 as a proportion of the value of the total health benefit.

Appropriate, accessible, and timely mental health, substance abuse services, and behavioral health services will decrease costs in the medical and public health system and increase the quality and length of life of millions of Americans. This impact would not simply be realized by individuals, but also families, friends, employers, communities, and ultimately the entire Nation.

Current parity legislation does not guarantee adequate or equitable services compared to physical health services. In order to be equitable to physical health services there would need to be a major increase in the number of available mental health, substance use, and behavioral health services. Rather, parity legislation seeks to correct the imbalance between the benefits afforded mental health and substance use disorders under group health plans and general medical and surgical benefits typically afforded under such plans. The Paul Wellstone and Peter Domenici Mental Health Parity and Addiction Equity Act of 2008 (Wellstone Act) tried to correct the imbalance.

The Wellstone Act does not state that qualifying health plans must offer mental health or substance use disorder benefits. No such coverage is mandated by the Wellstone Act. Rather, the Wellstone Act provides that group health plans that do offer such benefits must do so in parity with medical/surgical benefits. Specifically, the Wellstone Act provides that financial requirements applicable to mental health or substance use disorder benefits, such as deductibles, copayments, coinsurance, and out-of-pocket expenses, can be no more restrictive than the predominant financial requirements applied to substantially all medical/surgical benefits covered by the plan. Moreover, the Wellstone Act precludes separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits.

¹⁵ (Luongo, T. (2008). The Mental Health Parity and Additions Equity Act of 2008: Equal footing for those suffering from mental health and additions disorders. www.thehumanequation.com/en/news_rss/articles/2008/12-02-mental-health-parity-and-addiction-equity-act-of-2008.aspx)

¹⁶ The Hay Group. (1998). Health care plan design and trends. Arlington, VA: The Hay Group.

The Wellstone Act also requires parity in treatment limitations applicable to mental health or substance use disorder benefits. Treatment limitations include limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment. Under the Wellstone Act, treatment limitations pertaining to mental health or substance use disorder benefits can be no more restrictive than the predominant treatment limitations applied to substantially all medical/surgical benefits. The Wellstone Act also precludes separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

In the context of out-of-network providers, the Wellstone Act states that if a plan makes medical/surgical benefits available through out-of-network providers, the plan must also authorize coverage for mental health or substance use disorder benefits by out-of-network providers. Although the Wellstone Act creates a federal parity requirement, it does not serve to displace State laws containing stronger parity protections. Thus, plans must comply with their State's parity and protection measures if they provide greater protection than the Wellstone Act. In addition to the parity requirements, the Wellstone Act also contains exemptions that group health plans can use to avoid the Wellstone Act's requirements. The small employer exemption provides that the Wellstone Act's requirements shall not apply to any group health plan of a small employer. The Wellstone Act generally defines a small employer as an employer averaging at least two but not more than 50 employees during the preceding calendar year. Thus, employers with 50 or fewer employees may be considered exempt from the Wellstone Act under the small employer exemption.

The Wellstone Act also contains a cost exemption, which operates to exempt a group health plan from the Wellstone Act's requirements if compliance with the Wellstone Act becomes too costly. Specifically, a group health plan is not required to comply with the Wellstone Act if such compliance results in an increase of the actual total costs of coverage by two percent during the first year of the Wellstone Act's applicability, or one percent during each subsequent year.¹⁷

Mental health, substance abuse, and behavioral health issues have many limitations in our society. Two of the most limiting detrimental factors that affect recognition, utilization, prevention, and recovery are stigma and individual, family, and community readiness (understanding and acceptability).

A report from the Surgeon General found:

- Care and treatment in the real world of practice do not conform to what research determines as best. For many reasons, at times care is inadequate but there are models for improving treatment.
- Substance abuse is a major co-occurring problem for adults with mental disorders. Evidence supports combined treatment, although there are substantial gaps between what research

¹⁷ (Luongo, T. (2008). The Mental Health Parity and Addictions Equity Act of 2008: Equal footing for those suffering from mental health and additions disorders. www.thehumanequation.com/en/news_rss/articles/2008/12-02-mental-health-parity-and-addiction-equity-act-of-2008.aspx)

recommends and what typically is available in communities.

- Several special problems in care and treatment of adults have been recognized, beyond traditional mainstream mental health concerns, including racial and ethnic differences, lack of consumer involvement, and the consequences of disability and poverty.¹⁸

Veterans' Mental Health Needs

Determining minimum EHBs should take into consideration concerns about access to care and services for this special population, particularly in rural locations. The barriers to health and mental health care access for rural people are compounded if the rural person is a combat veteran. There is a national misconception that all veterans have access to comprehensive care because they are served by the Veterans Administration (VA). While this may be true for many veterans, it is not true for many small town and isolated rural veterans; those isolated by living in rural remote areas or isolated by choice due to the complicated symptoms of post-traumatic stress disorder (PTSD). The VA-provided health care to 4.5 million of the 7.2 enrolled veterans in fiscal year 2003. While the quality of VA care is equivalent to, or better than, care in other systems, it might not be accessible to rural and frontier veterans. In addition, VA services are not always adequately funded. The VA medical care appropriations from 1996 to 2000 were only increased by slightly more than 2 percent. The increase in 2003 was slight, and the VA's Under Secretary for Health estimate of a "13 to 14 percent increase fell short just to maintain current services".¹⁹ While these appropriations may have increased in recent fiscal years, it should cause alarm for policy makers and rural health advocates because the young wounded American serving in Iraq, Afghanistan, and other theaters of our war on terror today, will still need these benefits in 2014 and beyond.

Limited MHSUD resources in rural areas make access to these services difficult. Compounding the problem is the fact that mental health providers are not always trained to recognize the symptoms of PTSD. Outpatient services may not be available to treat those who are diagnosed. Knowing that the character of PTSD impacts not only the veteran but also his or her loved ones, the number of rural people now suffering with the impact of PTSD from combat related experiences is staggering, and represents a national crisis of health care. The veteran's need for a functional and integrated family support system becomes even more critical as he or she ages and coping skills decline. A healthy supportive family can become the first line of defense to prevent homelessness, and other more costly forms of care and services for these vets, yet Vet Outreach Centers (if they can afford it) can offer only psycho-social educational classes for family members and significant others, and are not required to do so. Only those Vet Outreach Centers with substantial budgets hire trained family therapists, and again they are not required to do so.

CCIO should be aware of the special and unique needs of rural veterans and their families, and of the demands these needs present to the existing rural health care delivery system to ensure that appropriate MHSUD services are included in an EHB design. The current barriers to access for

¹⁸ *Mental Health: A Report of the Surgeon General* (U.S. Department of Health and Human Services, 1999).

¹⁹ National Rural Health Association Policy Brief, "Rural Veterans: Special Concern for Rural Health Advocates", July, 2004, available at: www.NRHArural.org.

all rural people exist for rural veterans and their families. Policy makers need to prepare for the demand for geriatric, psychiatric, and all forms of long-term care for veterans as these will increase significantly relative to acute care as the largest group of veterans (i.e., Vietnam-era veterans) age. Nursing home care policies, programs, and services will require continual monitoring and re-assessment.

While the VA will continue to be a “safety net” for veterans with no insurance or with insurance coverage problems, policy makers should support veterans to take advantage of other rural health systems that could provide EHB services in rural and frontier areas as these serve as the “safety net” for all rural people.

MHSUD: Indian Reservations, Rural America and Access Issues

Barriers of access exist in the organization and financing of services for adults. There are specific problems with Medicare, Medicaid, income supports, housing, and managed care.²⁰ Of major concern is the lack of acknowledgement of rural mental health, substance abuse, and behavioral health issues by the CCIIO in their EHB proposed plan. There is overwhelming evidence that “one plan” does not fit all Americans. Secondly, there is not one rural America. In fact, the Office of Rural Health Policy claims over 200 different definitions of “rural”. The rural United States is a place of great diversity, which is perhaps a surprise to many in the majority metropolitan population. Rural is many small places scattered across the vast landscape of America.

Rural America has always been a place of diversity. The picture many hold of a homogeneous agrarian hinterland is simply a myth. Even prior to European discovery, diversity was the norm with an indigenous population made up of hundreds of Tribes speaking nearly as many different languages. Some farmed in settlements, while others were nomads. Small places may have been the norm, but even then these places were very different.

The different experiences that rural persons with mental health, substance abuse, and behavioral health issues face are influenced by three factors (variables) that may prevent them from receiving the mental health care they need:

- Accessibility
- Availability
- Acceptability

These variables lead rural residents with mental health, substance abuse, and behavioral health issue needs to: enter care later in the course of their disease than do their urban peers; enter care with more serious, persistent and disabling symptoms and require more expensive and intensive treatment response. The New Freedom Commission on Mental Health, Subcommittee on Rural Issues (Subcommittee on Rural Issues) finds a confluence of issues relating to rural mental health accessibility, availability, and acceptability that create critical barriers to care for the 25% of

²⁰ Mental Health: A Report of the Surgeon General (U.S. Department of Health and Human Services [DHHS], 1999).

Americans who reside in non- metropolitan areas across our nation. These barriers result in an “experience of care” for rural Americans that too often include a delay in care, inconsistent care, or no care.

- Rural teens and rural older adults have a much higher rate of suicide than do their urban peers
- Rural residents are less likely to have health insurance with a mental health benefit, and financial resources available to support mental health systems are less robust
- Programs to specifically train and promote the placement of rural mental health professionals are not available, and those that do exist are often not located in rural areas
- Federal agencies tasked with mental health public policy, research, and services support lack any systemic structure for coordinating their efforts.

The Subcommittee on Rural Issues contends that one policy option is paramount: “...rural Americans should be provided the same access to mental health emergency response, early identification and screening, diagnosis, treatment, and recovery services as their non-rural peers.”

Access to mental health care, practitioners, and delivery systems to provide care, and attitudes and cultural issues influencing whether people seek and receive care differ profoundly between rural and urban areas. The Subcommittee on Rural Issues proposed that the Secretary of HHS require a “rural impact statement” of all behavioral health rules, policies, and initiatives within the department retrospectively and prospectively to ensure rural equality of access. Public mental health policies and programs are routinely based on urban models and experiences and are scaled down to fit the rural environment. The challenges and pitfalls of adapting one significant intervention—assertive community treatment—have been well documented.

While specific attention on rural health has risen to the level of importance warranting the establishment of both the Federal Office of Rural Health Policy and a National Advisory Committee on Rural Health within HRSA, a similar focus is not present in the Substance Abuse and Mental Health Services Administration (SAMHSA). With the exception of the National Institute of Mental Health (NIMH) Office of Rural Mental Health Research, no bureau, division, or staff member is exclusively devoted to rural mental health issues. The implication of this lack of attention is manifested in many ways and has been noted in many reports issued over the years relating to rural mental health. For example:

Short response times for grant funding applications and requests for proposals put rural programs with human resource shortages at a disadvantage in assembling the resources required to prepare a competitive submission.²¹ Other examples include:

- Matching fund requirements that do not take into account the available resource pool in rural markets (e.g., programs on Native American reservations that are required to show the same non-Federal match as all programs, when most health resources available are

²¹ New Freedom Commission on Mental Health, Subcommittee on Rural Issues: Background Paper. DHHS Pub. No. SMA-04-3890. Rockville, MD: 2004.

- Federally funded);
- Lack of research and demonstration of rural- specific evidence-based practices;
 - Continued focus on specialty-driven practice and policy, when the rural literature supports a generalist model; and
 - The assumption that metropolitan-tested policies and practices only need to be “downsized” to fit rural area needs.
 - Indigenous healers and informal caregivers should be an option for services and an integral part of service delivery.

EHB Recommendations for Mental Health and Substance Use Disorder Services, Including Behavioral Health Treatment

Although HHS found that the small group products and State and Federal employee plans cover similar services within most of the ten categories of EHB, coverage in some of the statutory EHB categories is limited, including behavioral health treatment, habilitative services, and pediatric oral and vision services. The extent to which plans and products cover behavioral treatment, a component of mental health and substance use disorder category, is still unclear. An examination of benefits covered in employer-sponsored insurance in the small group market and State and Federal employee plans found that behavioral health treatment (separate from mental health and substance abuse services) was not frequently mentioned in plan booklets.²² This concludes that the level of behavioral services varies widely and using employer sponsored plans to develop a baseline for essential health benefits is not the most effective manner to develop a benefit structure.

As we indicated previously, the GAO found that 87 percent of employers had a limit on mental health benefits lower than what is offered for other medical/surgical benefits. The research proves that cost-sharing for addiction benefits was 46 percent higher than for medical/surgical benefits, and that 44 percent of the plans that were studied contained no out-of-pocket spending caps for addiction spending. Other research documents that health plans of medium and large employers place limitations on critical behavioral health services and that these services have been significantly reduced in actuarial value relative to the value of the medical and other health benefits. This is why it is important that CCIIO define a minimum level of services based on our recommendations.

The ACA has numerous sections that relate to “integration of services” (including § 1322, 2401, 2704, 2801, 3021, 3023, 3502.) The integration of physical and behavioral health (includes all mental, substance, behavioral and abusive services) model in the primary care setting has shown much promise for AI/ANs as well as all of rural American. This is not only a cost effective model, but has proven to reduce the stigma related to seeking behavioral health services. The results have shown cost savings (sharing support staff) and an increase in the amount of services provided (in areas where there is access to services). All of these elements contribute to a positive impact in respective communities, including literally saving lives. The current limitation to this model is the

²² Essential Health Benefits: Comparing Benefits in Small Group Products and State and Federal Employee Plans. ASPE Research Brief, Office of the Assistant Secretary for Planning and Evaluation, Office of Health of Health Policy, U.S. Department of Health and Human Services, December, 2011.

number of “covered/reimbursable” behavioral health services compared to physical health services. Essential health benefits must include a core set of services able to be provided in the primary care setting.

When substance use and mental health conditions are recognized as the treatable chronic diseases they are, systems reap substantial cost savings while dramatically improving health. Inclusion of prevention, treatment and recovery of mental illness and substance use disorders through the ACA’s EHB package will reduce health costs and ensure that millions of people lead healthier lives, thereby strengthening individuals, families, communities, and our nation as a whole.

The TTAG makes the following EHB recommendations for mental health and substance use disorder services—

Emergency Services: Services include immediate response services available on a 24-hour, seven-day-a-week basis for persons having a psychiatric crisis, a mental health crisis, or emergency; emergency crisis intervention; and supportive therapy for victims of "Post- Traumatic Stress" resulting from violence or other trauma.

Behavioral Health Crisis Services: Services include twenty-four hour access to assessment, stabilization, and medication if needed.

Crisis Services: Services include respite provider network, mobile crisis outreach services, and in-home skills-building aimed at crisis prevention and crisis management.

Case Management/Care Coordination Services: Services include a functional assessment; individual, family, and community support plan; referral and assistance in getting needed mental health and other services; coordination of services and monitoring of and follow-up from the delivery of services, including coordination of mental health services with other agencies that specialize in drug and alcohol and behavioral health treatment and services.

Family Based Services: Services include the following--

- In-Home Services: Early Intervention, family community support services (family ties), and professional home-based family therapy aimed at providing necessary supports to families with children who are at risk of out-of-home placement. This support is provided through: in-home skills-building, outreach support services, family therapy, and coordination with schools and/or other agencies that impact the lives of children and families.
- Asset based therapies
- Therapy for children who are victims of physical, emotional, or sexual abuse.
- Support services for the families of abuse victims. Services for adults with long-term mental health needs:
 - Community Support Program: Personal support services and home visits to help adults who suffer from severe psychiatric disorders remain in the community and improve their level of functioning.
 - Mental health services for homeless adults and families.

- Psychological evaluations: intellectual and academic ability; personality assessment; competency; child custody disputes; civil commitment hearings; peace officer evaluations
- Sub-acute inpatient psychiatric care (can be less intensive than a hospital and provided at a group home).
- Temporary shelter/foster care Parent support such as parent coaching, respite care, educational support.

Outpatient Services: Services include counseling and therapy for Individual, family, and group; individual treatment planning; diagnostic assessments; medication management; and psychological testing of intelligence, personality, school abilities, assets and other needs. Specific ways for handling stress, depression, and anxiety. Screening and behavioral health assessment (mental health and addictions integrated assessment), psychiatric evaluation and medication management, and domestic abuse treatment program for abuse offenders

Rehabilitative and Habilitative Services and Community Support Services: Services, other than inpatient or residential treatment services, designed to help adults with serious and persistent mental illness to function and remain in the community. Services include mental health services which are rehabilitative and/or and enable the recipient to develop and enhance psychiatric stability, social competencies, personal and emotional adjustment, and learn or relearn independent living and community skills, when these abilities are impaired by the symptoms of mental illness and behavioral health problems.

Interactive Telemedicine Equipment: Services include technologies that permit timely access to need services for patients in rural areas.

Assertive Community Treatment: Services include an intensive, non-residential rehabilitative mental health service that is an identified evidence-based or proven practice. Services are consistent with adult rehabilitative / habilitative services, except assertive services are provided by multidisciplinary staff using a total team approach, and directed to adults with a serious mental illness who require intensive services.

Day Treatment: Services include a short-term structured program consisting of group psychotherapy and other intensive therapeutic. Day treatment services are provided to stabilize a recipient's mental health status while developing and improving his/her independent living and socialization skills. The goal of day treatment is to reduce or relieve the effects of mental illness and provide training to enable the recipient to live in the community. Day Treatment — a program to teach vital skills, and provide support in the local community.

Residential treatment: Services include 24-hour-a-day program under the clinical supervision of a mental health professional, in a community residential setting other than an acute care hospital or regional treatment center inpatient unit.

Partial hospitalization program: Services include sub-acute inpatient psychiatric care (can be less intensive than a hospital and provided at a group home). Partial hospitalization is a time limited,

structured program of psychotherapy and other therapeutic services as defined by Medicare and provided in an outpatient hospital facility or Community Mental Health Center that meets Medicare requirements to provide partial hospitalization programs (PHP) services. The goal of PHP is to resolve or stabilize an acute episode of mental illness. Partial hospitalization consists of multiple and intensive therapeutic services provided by a multidisciplinary staff to treat the recipient's mental illness. Examples of PHP services include: individual, group, and family psychotherapy services; individualized activity therapies; and patient training and education. Recipients are admitted to a partial hospitalization program based on a physician referral.

Acute care hospital inpatient treatment: Services include short-term medical, nursing and psychosocial services provided in an acute care hospital, including medical detoxification.

Regional treatment center inpatient services: 24-hour-a-day comprehensive medical, nursing, or psychosocial Services Provided: Mental health services, urgent care, outpatient services, group therapy, psychiatric services for children, adolescents and adults, adolescent and adult day treatment, family counseling.

The Affordable Care Act holds tremendous promise for the millions of Americans with, at risk for, or in recovery from mental health and substance use disorders. Providing the full range of mental health and substance use disorder prevention, treatment, recovery and rehabilitation/habilitation across the lifespan will save lives, improve health, and reduce health costs. We appreciate your consideration of the above recommendations and ask that you use us as a resource moving forward.

Habilitation Services

As with the other specific benefit categories that must be included as essential health benefits, we believe that it is critical that habilitation services be precisely defined and that the minimum scope of the required coverage be set forth by CMS. The bulletin specifically asked for comments regarding defining habilitation. We recommend the Medicaid program be used as a guide for determining the specific services to be included under habilitation and that the coverage of services and devices be at least equivalent to those available for rehabilitation. Further the need for habilitation services should not be tied to any particular diagnosis, but rather it should be based on clinical judgments of the functional deficits of the individual and of the effectiveness of therapy, service, or device to address the deficit. Maintenance of function should be included in the definition of habilitative services, in order to avoid deterioration in capacity. It is not enough to reach new heights of capacity, they must be sustained and that very often requires ongoing levels of supportive care.

The EPSDT program establishes an ideal model (again for both children and adults) of how functional needs can be identified early and treatment plans developed that respond specifically to the patient's functional limitations. As with EPSDT, medical necessity should be defined broadly to include services that improve, maintain, or prevent deterioration in capacity to function. Habilitation services must not be focused on acute episodes or treatment outcomes, but rather on achieving maximum functional capacity and maintaining it.

Service limits need to be minimized and carefully monitored to avoid restrictions in actual access to habilitation services and the effectiveness of such services. Some limits and exclusions should be barred entirely, even if they are built into the benchmark plan, if the effect will be to undermine access to effective habilitation services or any of the other specified categories of care.

Finally, it is critical to note that there will be substantial overlap among the specific service categories. Limitations in one, to the extent they are allowed, should not preclude coverage under another. For instance, seriously emotionally disturbed children and chronically mentally ill adults, often require a wide range of mental health services and additional habilitation services that may or may not be considered part of mental health services. Service limitations on mental health services will seriously undermine the effectiveness of habilitation if they are allowed to limit the scope of habilitation services.

Application of EHB Package to Medicaid

We appreciate that the CCIIO EHB Bulletin addresses only the implementation of section 1302 of the Affordable Care Act and that further guidance is planned regarding essential health benefit implementation in the Medicaid program. In anticipation of that we choose to offer a few comments that we hope will be considered in developing that guidance, and that may help focus attention on many of the comments provided in response to the current bulletin.

In these comments, we have highlighted many concerns about how implementation of the intent of Congress can be achieved that ten categories of care must be included in the essential health benefit package: ambulatory patient services; emergency services; hospitalization; laboratory services; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; pediatric services, including oral and vision care; prescription drugs; preventive and wellness services and chronic disease management; and rehabilitative and habilitative services and devices. Current health care plans frequently do not include these services or set limits on them that make them virtually unavailable.

It is essential to remember that the benchmark plans are those available largely for employed individuals or those with sufficient means to pay for health insurance. And, as we have noted many of the potential benchmark plans will not adequately address these ten specific categories of care without uniform, detailed direction.

Those concerns are even more glaring when one takes the next step to examine the application of essential health benefits for Medicaid, which largely covers lower income and sicker individuals. For the concept of essential health benefits to have the meaning, achieve the outcomes, intended by Congress, the benefits must be paired to the individuals using the services. Thus, definitions of each of the categories of essential health benefits must be sufficient, and broad enough, to meet the needs of not only the currently insured population, i.e. the users of the private insurance being used as benchmarks, but also the new users of health insurance under the Affordable Care Act and of the lowest income Medicaid clients.

We recommend a synergistic analysis of the essential health benefits under Section 1302

and of implementation in Medicaid. First, to implement section 1302 we believe that the available options under the Federal Medicaid program be used in the development of the definitions and the scope of coverage. Secondly, we recommend that when essential health benefits are considered for Medicaid that they are tailored to the population to be served and not artificially limited as if there were no meaningful differences between the people who can afford health coverage, even with subsidies, and those eligible for Medicaid.

We also recommend that the current EPSDT benefit under the Federal Medicaid program be included in the essential health benefits for both the traditional and expanded Medicaid program. As our earlier comments note, it is an essential tool for assuring early identification of health issues and for assuring diagnosis and treatment services are made available in a timely and comprehensive way. As with many other preventive health services, insurers (and States) may argue that the costs are too high. However, nothing can be further from the truth. The cost of health care goes up when health problems are not identified and not treated. EPSDT is a bulwark against short-sighted health planning.

On-going Federal and State Oversight

The State-by-State approach will lead to different benefits for American Indians and Alaska Natives living in different areas of the country. It is our belief that Congress intended for the Secretary of HHS to approve a single EHB that would apply nationally. The analysis offered by CCIIO suggests that there is actually little variation from State to State, so a national standard is, in fact, feasible. A national standard is preferred because it is easier and less expensive for national Tribal organizations to review one set of standards rather than 52 different sets of standards. Tribes and urban Indian organizations in many States do not have the expertise or resources to review State-specific EHB policies.

On page 12, the CCIIO EHB Bulletin discusses permitting flexibility in the design of benefits, including substitutions in each of the 10 categories specified by ACA. It is not clear what CCIIO means by the concept of “substitution” and how far States would be allowed to deviate from the benchmark plans. In the absence of a national standard for EHB for Exchanges, Tribes urge the Federal government to use the powers delegated to the Secretary of HHS to provide oversight on implementation of EHB at the State level. It is anticipated that a Federal review process will bring issues to the attention of the TTAG for consideration, deliberation, and recommendations.

Tribal Consultation

There are three issues related to Tribal consultation on EHB: 1) Tribal consultation in States where the State is designing the Exchange; 2) tribal consultation in States where the Federal government is designing Exchanges; and 3) tribal consultation by CMS in the exercise of their on-going oversight responsibilities for EHB.

At the present time many States are not working with Tribes and urban Indian programs in the development and design of Health Insurance Exchanges, despite direction from the Secretary of

HHS to do so. On-going Federal oversight may be the only way that there will be input regarding Indian health care because of federal Tribal consultation policies and practices.

The Federal government will have responsibility for deciding on EHB for those States where the Federal government is designing and operating the Exchanges. The CCIIO EHB Bulletin issued on December 16, 2011, proposes that the Federal government would use as a default benchmark plan the largest plan by enrollment in the largest product in the State's small group market. In adapting this benchmark to the 10 EHBs in ACA, the Federal government will need to make some decisions with regard to services that may be absent from the benchmark, such as habilitation and pediatric oral care. The Federal government must consult with Tribes in the State with regard to the EHB for that State's Exchange.

A persistent concern is that the largest enrollments will come from urban areas and it is not clear what types of implications this may have for rural areas. One might assume that it will set a higher standard for rural areas than they might otherwise have. On the other hand, people living in rural areas may have different types of needs. For example, if a plan sets a limit on days of stay in a hospital that might affect rural residents who do not have as many supports available to them when they return home. Another example is that emergency care may include ground ambulances but not air ambulances. It is not clear whether plans chosen for benchmarks will define their benefits by the types of providers that are covered. The Indian health care systems use a variety of types of providers that may not be covered by plans that are based in urban areas. Some examples are community health aides, midlevel behavioral health practitioners, and dental health therapists. Even though these approaches are cost effective and offer quality care, the definition of covered benefits may determine whether the I/T/U would be reimbursed for these types of providers.

The third area for Tribal consultation involves the on-going oversight of State Exchanges by the Federal government with regard to EHBs and other issues where the Secretary of HHS has delegated authority from ACA to the States. As the Federal government provided the needed oversight, it should not only insist that State Exchanges consult with Tribes in their States, but also the Federal government should consult with Tribes.

There was a very brief discussion of EHBs on a White House teleconference with Tribes that did not suggest that this decision, which was envisioned in the ACA as a federal decision made by the Secretary of HHS, would be delegated to the States. At the teleconference, it was stated that the Federal government would hold listening sessions on this topic with Tribes. Tribes were never notified of these listening sessions. However, the paper released by CCIIO on December 16, 2011, states on page 3:

Following the release of the IOM's recommendations, HHS held a series of sessions with stakeholders, including consumers, providers, employers, plans, and State representatives in both Washington, D.C. and around the nation to gather public input.

It appears that Tribes are not being consulted at either the Federal or State levels in the planning for EHB for Exchanges, Medicaid and the Basic Health Plans allowed under the ACA.

Request for Information on Benchmark Plans and Applicable Laws

HHS indicated that it analyzed the four benchmark plan types identified in the CCIIO EHB Bulletin and from which a State may choose as their benchmark EHB package. These benchmark plan types are:

- (1) the largest plan by enrollment in any of the three largest small group insurance products in the State’s small group market;
- (2) any of the largest three State employee health benefit plans by enrollment;
- (3) any of the largest three national FEHBP plan options by enrollment; or
- (4) the largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the State.²³

In order to provide more informed comments on this proposal, as well as the subsequent proposed rule on EHB, it would be advantageous to have additional information on the type and scope of services covered by these benchmark plan types. Prior to issuance of a proposed rule for the EHB, please provide information on the type and scope of services covered by these plans, by State, in a standardized format across the plans.

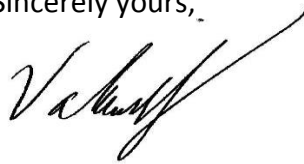
Given that if a State does not exercise the option to select a benchmark health plan, HHS intends to propose that the default benchmark plan for that State would be “the largest plan by enrollment in the largest product in the State’s small group market”, it will be particularly important to, at a minimum, have access to standardized information from HHS on these small group market plans, by State.

And given the flexibility offered to States in the designation and design of the EHB for their State, it would be helpful for HHS to indicate which provisions of Federal law are applicable to the design of the EHB. For instance, under section 2713 of the Affordable Care Act, all plans offered through an Exchange are required to cover preventive services and immunizations recommended by the USPSTF and the CDC, certain child preventive services recommended by HRSA, and women’s preventive care and screening recommended by HRSA, and to do so without any cost-sharing. This requirement was not mentioned in the CCIIO EHB Bulletin. In contrast, the applicability of the Mental Health Parity and Addiction Equity Act was mentioned. If HHS could provide a listing of these and other provisions of Federal law, from the ACA and otherwise, that place requirements on the design of the EHB, it would be useful to consumers, insurers, employers and providers alike.

²³ CCIIO EHB Bulletin, page 9.

Thank you in advance for consideration of these recommendations as we jointly work to advance the health status of American Indian and Alaska Native individuals and communities across the United States.

Sincerely yours,

A handwritten signature in black ink, appearing to read "Valerie Davidson", with a long, sweeping flourish extending to the right.

Valerie Davidson
Chair, CMS Tribal Technical Advisory Group

Cc: Dr. Yvette Roubideaux, Director, Indian Health Service
Kitty Marx, Director, CMS Tribal Affairs Group