California Mental Health Planning Council

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January 28, 2012

Steve Larsen
Deputy Administrator and Director
Center for Consumer Information and Insurance Oversight
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue S.W., Room 445-G
Washington, DC 20201

Dear Mr. Larsen:

The California Mental Health Planning Council is under federal and state mandate to provide advice and feedback to legislators and governmental entities on mental health policies. It partners with the Coalition for Whole Health to create a stronger voice for mental health parity, which is especially important during the rollout of California's 1115 Waiver, the Bridge to Healthcare Reform in 2014. Because we recognize the parallels between the state and the federal governments' reorganization of a health care system that relies on integration of services, we are especially concerned that the minimum levels of care proposed in the guidance will be sufficient to meaningfully serve those that need it the most. The Planning Council fully supports The Coalition for Whole Health's recommendations for EHB guidance to states. They include:

1. Develop a detailed, comprehensive essential health benefits package that would serve as a "federal floor." We continue to believe that a comprehensive federal EHB that States could go beyond to meet their specific needs is the preferred approach, and ask the Department to develop a comprehensive federal minimum package. However, if the Department continues to allow States to define their EHBs absent a federal floor, we ask the Department to provide strong oversight and ensure that each of the ten categories of benefits is comprehensive and robust in all States. HHS should also aggressively enforce the consumer protections outlined in §1302(b)(4)(A-D) of the ACA.

2. Aggressively enforce the MHPAEA on the federal level and work with the appropriate State officials to enforce the MHPAEA on the State level to ensure meaningful protection.

3. More closely align EHB benchmark flexibility to that allowed under the CHIP and Medicaid programs by limiting States' choices to the standard BCBS FEHBP plan, a plan that is offered and generally available to State employees, and the largest non-Medicaid HMO in the State. If the Department continues to allow States to benchmark to a small group plan—which may be the weakest and most variable option—we urge the Department to change the default plan to the Blue Cross Blue Shield FEHBP plan or another comprehensive benefits package defined by HHS.

4. Ensure comprehensive, appropriate coverage within the EHB by: (a) Requiring that each of the ten EHB categories be comprehensive in the benchmark plan, and if a category is not comprehensive in the benchmark plan, the Department should require the State to supplement the category using a benchmark option that does provide comprehensive benefits in that category; (b) including language in the final EHB guidance and the forthcoming actuarial value guidance clearly stating that both the MHPAEA and CHIP flexibility standards preclude downward actuarial adjustment to MH and SUD benefits; (c) developing a federal definition of medical necessity; and (d) ensuring robust prescription drug coverage, including medications for MH/SUD.

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5. Annually review and update the EHB in all States and assess whether plan enrollees are being well served, and take appropriate action when plans fail to provide a comprehensive EHB package consistent with the requirements of the ACA. The Department should also provide annual guidance to States requiring that they update their EHBs to reflect changes in medical evidence and scientific achievement.

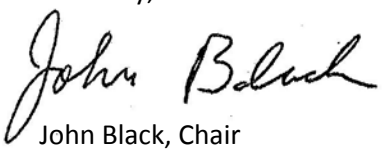
6. Work with States to ensure consumers and providers have opportunities to participate in the process of determining the EHB on the federal and State levels. Moving forward, there should be a strong consumer and family education campaign to ensure MH and SUD service consumers understand their coverage and can identify potential violations of their EHB rights.

The Council appreciates and thanks you for your close and continued work with SAMHSA on the EHB and your work with the MH/SUD fields. We look forward to working closely with national and state level entities to ensure that the EHB effectively addresses the MH/SUD needs of impacted enrollees. We strongly encourage everybody at the national and state level to recognize that money spent treating substance use and mental illness saves twice as much in medical care later. Care that has been deferred due to those disabilities becomes much more expensive to treat due to the progression and duration of chronic disease.

Absent defined requirements for the level of services included in the States' EHBs, we encourage the Department to define and clearly indicate limits on State flexibility to *reduce* any of the ten EHB categories, remind States of the MHPAEA prohibition against limiting the MH/SUD benefits, and to clearly state its intention of enforcement of the MHPAEA law and provisions. We also support limiting States' flexibility to benchmark their EHB packages to only include large plans, as modeled by CHIP and Medicaid in §2103 and §1937 of the Social Security Act, respectively.

Thank you again for the opportunity to provide feedback on the essential health benefits Bulletin. We strongly support the goals of the ACA to ensure that all Americans have access to high-quality, affordable health care, including comprehensive care for MH and SUD. We appreciate your careful consideration of our comments and look forward to working at the state level on the development and implementation of the EHB and related provisions. Please contact us if you have any questions or if we can be of further assistance.

Sincerely,



John Black, Chair
California Mental Health Planning Council

cc: Dan Belnap, Legal Action Center