

COALITION FOR WHOLE HEALTH

August 16, 2010

Mr. Jim Mayhew
Office of Consumer Information and Oversight
Department of Health and Human Services
Attention: OCIO-9991-IFC
P.O. Box 8016
Baltimore, MD 2144-1850

RE: Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan under the Patient Protection and Affordable Care Act

Dear Mr. Mayhew:

Thank you for this opportunity to provide comments to the Departments of Labor, Health and Human Services, and the Treasury (the Departments) regarding the interim final rule on grandfathered health plans under the Patient Protection and Affordable Care Act (PPACA). On behalf of the Coalition for Whole Health, a coalition of national organizations advocating for improved coverage for and access to mental health and substance use disorder prevention, treatment, rehabilitation, and recovery services, we strongly support the goals of healthcare reform to ensure that all Americans have access to high quality, affordable health care, including mental health and addiction care. We appreciate the opportunity to submit comments on the interim final rule on grandfathered plans.

Below is our response to the proposed regulations. We are particularly pleased that the Departments:

1. Require that Grandfathered Plans Comply with the Mental Health and Addiction Parity Provisions of the PPACA
2. Require that Plans Adhere to Certain Consumer Protective Practices to Retain Their Grandfathered Status
3. Acknowledge that State Laws Providing Greater Consumer Protections than the PPACA Remain in Effect

1. Requirement that Grandfathered Plans are Subject to the Mental Health and Addiction Parity Provisions of the PPACA

First, we applaud the Departments for requiring that grandfathered plans must comply with the mental health and addiction parity provisions of the PPACA. These provisions, found in Title I, Subtitle D, Part II, Section 1311 of the PPACA, incorporate by reference the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and require that qualified health plans under the PPACA must adhere to the provisions of MHPAEA. Moving forward, we ask that the Departments continue to explicitly affirm that MHPAEA requirements apply to grandfathered plans and to make the monitoring and enforcement of these requirements a high priority.

We thank the Departments for making clear that grandfathered plans are required to comply with the MHPAEA. Section 2590.715-1251(c)(2) of the Interim Final Rules states that “a grandfathered health plan must comply with the requirements of the PHS (Public Health Services) Act, ERISA (Employee Retirement Income Security Act) and the Internal Revenue Code applicable prior to the changes enacted by the Patient Protection and Affordable Care Act.” The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) became law in October 2008, amending Section 712 of ERISA, Section 2705 of the Public Health Service Act, and Section 9812 of the Internal Revenue Code of 1986. Further, the guidance preceding the interim final rule clearly states that, “the mental health parity provisions...continue to apply to grandfathered health plans.”

We were extremely pleased with the passage of the MHPAEA, and with it the promise of eliminating barriers that have kept thousands of individuals with substance use disorders and mental illnesses from receiving critically important treatment services. We thank the Departments for clarifying that grandfathered plans are subject to the provisions of MHPAEA and ask, as you work to inform plans, stakeholders and the public about the requirements of the PPACA and the regulations implementing the new law, that this information clearly and explicitly identifies the law’s mental health and addiction parity requirements and the new rights and benefits afforded to plan participants by the ongoing regulatory requirements.

2. Requirement that Plans Adhere to Certain Consumer Protective Practices to Retain Their Grandfathered Status

The interim final rule affirms that a plan will lose its grandfathered status if it makes certain major changes that disadvantage enrollees. We urge the Departments to create strong enforcement mechanisms to strip plans of their grandfathered status if they violate the requirements for maintaining that status.

We applaud the Departments for requiring plans to comply with a number of critically important consumer protections in order to retain their status as grandfathered plans. We are particularly pleased that the interim final rule identifies the following practices as those that would cause a plan to lose its grandfathered status:

- Eliminating all or substantially all benefits necessary to diagnose or treat a particular condition, including a mental health or substance use condition
- Changes in cost-sharing, including coinsurance, copayments and deductibles, that impose unreasonable cost-sharing requirements on individuals
- Changes in employer contribution rates

We urge the Departments to issue additional guidance clarifying that other major changes plans make that would have a significant harmful impact on access to care would also trigger the loss of grandfathered status. These activities include:

- Imposing additional requirements that make it more difficult for individuals to afford and access certain health services and providers, including care for mental illness and substance use disorders
- Making major changes in provider networks that serve to further limit the number of providers (including primary care, mental health and addiction service providers) in a plan
- Instituting major changes to the administration of prescription drug benefits and drug formularies; this would include restricting the formulary by shifting from open formulary to a

closed or tiered formulary, changing the formulary in a way that increases enrollees' cost-sharing requirements, and additional practices that significantly restrict enrollees' access to medications, including those prescribed for the treatment of mental health and substance use disorders

We also ask for clarification from the Departments that health plans that drop coverage for dependents or spouses are in violation of the grandfathered plan requirements.

3. Acknowledgement that State Laws Providing Greater Consumer Protections than the PPACA Remain in Effect

We applaud the recognition by the Departments that grandfathered plans should be given the flexibility to enhance their scope of services, to make voluntary changes to increase benefits, to conform to required legal changes, and to voluntarily adopt additional consumer protections in the PPACA. It is also critically important that State laws that impose requirements on health insurance issuers that are stricter than the requirements of the PPACA are not superseded by the Act. We applaud the Departments for explicitly stating that these more stringent State laws regulating health insurance issuers remain in effect and are not preempted by the new federal law.

Thank you again for the opportunity to provide comment on the interim final rule on grandfathered plans. We understand that the purpose of grandfathering plans is to provide a smooth transition allowing individuals who like their current health insurance to keep it during a period of rapid transition in our healthcare system, rather than to create a situation where certain plans can be permanently exempted from the requirements of reform. Although grandfathered plans remain exempt from a number of vital reforms of the PPACA, in the long term we look forward to working with the Departments to ensure that all small group and individual plans must comply with the PPACA's strong essential benefits requirements, including those that require mental health and substance use disorder benefits at parity with those of other medical and surgical benefits, and that other critically important reforms also eventually apply to all plans.

We appreciate the opportunity to comment on interim final regulations related to grandfathered plans under the healthcare reform law. Please contact us if you have any questions or if we can be of further assistance on this matter.

Sincerely,

Alcoholism and Substance Abuse Providers of New York State
American Art Therapy Association
American Association for Marriage and Family Therapy
American Foundation for Suicide Prevention/SPAN USA
American Mental Health Counselors Association
American Nurses Association
American Psychiatric Association
American Psychoanalytic Association
American Psychological Association
Anxiety Disorders Association of America
Association for Ambulatory Behavioral Healthcare
Bazelon Center for Mental Health Law

Center for Clinical Social Work
Clinical Social Work Association
Community Advocates Public Policy Institute
Community Anti-Drug Coalitions of America
DC Recovery Community Alliance
Depression and Bipolar Support Alliance
Hazelden Foundation
Legal Action Center
Mental Health America
NAADAC, The Association for Addiction Professionals
National Alliance on Mental Illness
National Association for Children's Behavioral Health
National Association of Addiction Treatment Providers
National Association of County Behavioral Health and Developmental Disability Directors
National Association of Drug Court Professionals
National Association of State Mental Health Program Directors (NASMHPD)
National Council for Community Behavioral Healthcare
National Council on Alcoholism and Drug Dependence - Maryland Affiliate
National Disability Rights Network
Open Society Institute - Baltimore
PAR - People Advocating Recovery
State Associations of Addiction Services
TeenScreen National Center for Mental Health Checkups
Therapeutic Communities of America
Treatment Research Institute