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August 16, 2010

Mr. Jim Mayhew
Office of Consumer Information and Insurance Oversight
Department of Health & Human Services
Attention: OCIIO-9991-IFC
P.O. Box 8016
Baltimore, MD 21244-1850

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Attention: Grandfathered Plans

Dear Mr. Mayhew:

The Bazelon Center for Mental Health Law—the nation’s leading national legal-advocacy organization representing children and adults with mental illnesses—is pleased to submit the following comments on the Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Affordable Care Act. We appreciate the opportunity to provide feedback on these most important regulations.

General Comments

We strongly support the Departments’ efforts to provide robust regulations that ensure the protection of health insurance consumers, and continued access to high quality, affordable care. We applaud the efforts of the Departments to honor the intention of the Affordable Care Act to preserve an individual’s right to maintain their current health insurance plan, to reduce short term disruptions in the market, and to ease the transition to market reforms that phase in over time.

Many Americans remain happy with their insurance coverage, and it is important that consumers continue to have access to the benefits that they enjoy. In light of this, we commend the Departments for seeking to make certain that consumers are also afforded certain protections when choosing to retain grandfathered coverage, including requiring the disclosure of information about an individual’s plan status, and ensuring that plans are not significantly altered without affecting their status as a grandfathered plan.

Additional Comments

The Bazelon Center would like to submit additional comments on the following aspects of the interim final regulations:

- I. Disclosure Requirements
- II. Changes in Plan Structure
- III. Mental Health Parity
- IV. Monitoring and Oversight

Disclosure

We applaud the Departments for ensuring that consumers are well informed about their plan's grandfathered status, and value the inclusion of model language to facilitate this disclosure. Consumers may find it challenging to fully appreciate the different rules that apply to grandfathered plans and to non-grandfathered plans, and we commend the Departments for acknowledging that they must be provided with adequate information about their benefits in order to make informed choices.

In response to the request for comments regarding this model disclosure, we recommend that language be included in the rule that affirms the requirement in §2715 of the ACA mandating that plan documentation must be presented in a “culturally and linguistically appropriate manner and” utilize terminology understandable by the average plan enrollee. We urge that this standard be applied to the disclosure of grandfathered status that is required under the interim final rule. We also urge the Departments to consider requiring that this disclosure be communicated to enrollees annually.

We believe that the model disclosure language provided in the regulation can be strengthened in several other ways. First, the disclosure statement could be improved by incorporating the definition of a grandfathered plan as defined in Paragraph (a) of 26 CFR 54.9815–1251T, 29 CFR 2590.715–1251, and 45 CFR 147.140 of the interim final regulations. Currently, the model language simply indicates that grandfathered plans can maintain certain basic health coverage that was already in effect when that law was enacted. Many consumers, however, may be unaware of when the law was enacted, and thus it is important to provide consumers with the definition under law, which acknowledges the March 23, 2010 proviso.

Also, the disclosure statement could be strengthened by expressly stating which consumer protections in the ACA apply to grandfathered plans, and which do not. This will help to reduce consumer confusion about the differences between grandfathered and non-grandfathered plans and further clarify what protections apply to their coverage.

Finally, the disclosure statement would be more helpful to plans and consumers alike if it included language to the effect that grandfathered plans are required to comply with the mental health parity law (see below) and other significant protections enacted prior to the enactment of the ACA.

Changes in Plan Structure

We commend the Departments for ensuring that plans comply with a number of vital consumer protections in order to preserve their grandfathered plan status. We agree that the elimination of all or substantially all benefits necessary to diagnose or treat a particular condition, including a mental health or substance use condition, should trigger a loss of grandfathered status.. We are particularly pleased to see the specific inclusion of a scenario involving mental health treatments among the examples of this prohibition. We also agree that an alteration in employer contribution rates is just cause for the loss of grandfathered status.

Additionally, we applaud the inclusion of limitations on changes in cost-sharing, including coinsurance, copayments and deductibles, which may impose a greater burden on beneficiaries. Research has shown that co-payments that people from seeking care, and all forms of cost-sharing present particular challenges for people with little discretionary income, including those with mental illnesses.

In response to the solicitation of comments on whether the list of plan changes provided in the interim final rule is appropriate and what other changes, if any, should be added to this list, we urge the Departments to consider issuing additional guidance clarifying that other major plan changes that would have a significant harmful impact on access to care and would also prompt the loss of grandfathered status. We suggest inclusion of the following:

- Restrictive changes in plan structure, such as changing from a Preferred Provider Organization (PPO) to a Health Maintenance Organization (HMO), should cause the termination of a plan's grandfathered status. Such changes may affect beneficiaries' access to services by, for instance, modifying the network of specialty providers to which they have access (including specialty mental health providers).
- Switching from a fully insured health plan to a self-insured plan, which may lead to adverse selection of plans in the fully-insured market.
- Making substantial modifications to provider networks which may limit the number of providers (including primary care, mental health and addiction service providers) accessible to plan beneficiaries. It is reasonable to allow some network modification to account for normal fluctuations in provider networks, or if providers are limited in a certain geographic region. However, major changes in network often result in treatment delays and interruptions for beneficiaries or negatively affect continuity of care, and thus must be considered when evaluating the preservation of grandfathered status.
- Changes to a plan's prescription drug formulary. These changes may have a significant impact on individuals with mental illnesses who often experience multiple chronic conditions and rely on a number of medications to manage their illnesses. Changes that would affect grandfathered status should include changing the formulary in a way that increases enrollees' cost-sharing requirements, restricting the formulary by shifting from open formulary to a closed or tiered formulary, restricting a formulary to generic

medications only, and additional practices that significantly restrict enrollees' access to medications, including those prescribed for the treatment of mental health and substance use disorders.

A final clarification that may be necessary involves the reference to "all or substantially all benefits to diagnose or treat a particular condition." The interim final regulations fail to define what standards will be used to determine what benefits should be included among those essential to diagnose or treat a condition, and by whom the determination will be made. We recommend that a clear definition be included that will describe the process or method by which such benefits will qualify as necessary.

Implementing Mandates Not Required in Grandfather Plans

We commend the Departments' assessment that plans should not lose grandfathered status if they voluntarily comply with provisions in the Affordable Care Act beyond those that are required by law, such as increasing the scope of benefits or making changes in order to comply with federal or state law. Allowing insurers to offer consumers more robust benefits or those protections that will become mandatory for non-grandfathered plans under the ACA should be encouraged. Additionally, state laws that impose requirements on health insurance issuers that are more stringent than the requirements of the ACA must not be superseded by the Act. However, we also believe that the regulations should explicitly state that any change in coverage that does not prove beneficial to plan members should result in the loss of grandfathered status.

Mental Health Parity

We commend the Departments for requiring that grandfathered plans comply with the mental health and addiction parity provisions of the ACA. The MHPAEA eliminates barriers that have prevented thousands of individuals with mental illnesses and substance use disorders from accessing critically important treatment services. We also ask that information communicated to plans, plan enrollees, and the public clearly and explicitly acknowledges and explains the law's mental health and addiction parity requirements.

Monitoring and Oversight

We also encourage the Departments to promulgate further guidance regarding the monitoring of health plans for violations that would result in the loss of a plan's grandfathered status. There is a great need for a strong, well-defined mechanism for enforcement and oversight of plans, and the interim final regulations do not describe such a means. The regulations should also clarify who may submit challenges to a plan's grandfathered status (consumers, providers, state agencies, or advocacy organizations), as well as what entity will be responsible for reviewing such claims.

We are particularly concerned about the monitoring of self-insured ERISA plans. It may prove especially difficult for the Department of Labor to adequately regulate and enforce applicable provisions in the law and regulations in the large self-insurance market, given the competing priorities of this considerable Department. The system for reporting concerns and the process by

which concerns will be reviewed must be further delineated to ensure transparency, adequate enforcement, and plan accountability.

We thank you again for the opportunity to comment on these regulations, and appreciate your consideration of our proposed recommendations. We welcome the opportunity to discuss any of these thoughts in greater detail. Please contact Allison Wishon Siegwarth at 202-467-5730 x 113 or allisonw@bazelon.org for additional information or further clarification.

Sincerely,

Chris Koyanagi
Policy Director