National Alliance on Mental Illness

August 16, 2010

Jim Mayhew
Office of Consumer Information and Oversight
Department of Health and Human Services
P.O. Box 8016
Baltimore Maryland 21244-1850

Attention: OCIIO-9991-IFC

Re: NAMI Comments regarding the Interim Final Rule and Proposed Rule 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:

On behalf of the National Alliance on Mental Illness (NAMI), I am writing to submit the following comments on the interim final rule and proposed rule relating to status as a grandfathered health plan under the Patient Protection and Affordable Care Act (PPACA, P.L. 111-148). As the nation's largest organization representing individuals living with serious mental illness and their families, NAMI supports the efforts of federal agencies to ensure effective implementation of PPACA to ensure access to high quality, comprehensive, affordable health care that meets their individual needs and enables them to be healthy, functional, live as independently as possible, and participate in the community.

NAMI applauds the Department of Health and Human Services (HHS) for requiring grandfathered plans to adhere to a number of important consumer protections in order to retain status as a grandfathered plan. Specifically, NAMI commends the HHS Secretary for requiring grandfathered plans to disclose their status to their enrollees and specifically state which consumer protections they are exempt from providing; and for requiring grandfathered plans to lift lifetime limits on essential health benefits.

The purpose of grandfathering plans is to provide a transition period that allows individuals satisfied with their current insurance plan to keep it intact during a period of rapid change in the insurance market, perhaps leading to an avoidance of disruption in their coverage. The regulation needs to ensure a smooth transition so as not to disrupt current coverage and consumer protections without inadvertently establishing a permanent "underclass" of grandfathered plans to which PPACA does not apply. Establishing grandfathering rules that are too permissive risks the creation of a separate insurance market where patients and consumers do not gain the benefits of health care reform and would ultimately work to the detriment of persons with disabilities and chronic conditions that need PPACA's protections to ensure access to quality care.

On the other hand, NAMI acknowledges some risk in making grandfathering rules too strict, especially if the essential benefits package is not as expansive as the disability community expects it to be. Individuals and enrollees in group plans with relatively generous benefit packages that cover disability and rehabilitation services may stand to lose access to important benefits if their plan loses grandfathering protection and the new essential benefits package is not as comprehensive in terms of benefits coverage. But above all, this underscores the importance of defining the essential benefits package in a way that meets the needs of people with disabilities and chronic conditions.

In order to protect participants with disabilities that are covered under a grandfathered plan, on balance, NAMI believes that HHS should broaden the circumstances under which grandfathered plans must become subject to the consumer protections that apply to all other new plans. In addition to the provisions in the regulation that trigger a loss of grandfathered status such as changes in cost sharing and employer contributions, which NAMI supports, NAMI lists below additional circumstances under which grandfathered plans should lose their status:

- Any significant decrease in benefits should result in the loss of grandfathered status. The current version of the rule only retracts status when grandfathered plans eliminate all or substantially all benefits linked to a specific condition. While this language serves as an important protection against singling out specific types of conditions or disabilities, NAMI believe additional guidance should be promulgated that all significant decreases in the scope or breadth of the benefit package will trigger this loss of grandfathered status. For example, if a plan were to decide to cap the number of covered inpatient days or outpatient visits, these restrictions in benefits should trigger a loss of grandfathered status. If these types of benefit limits are imposed by plans with grandfathered status, such status should be rescinded. This should also apply to any enhanced benefits for mental illness and substance abuse treatment benefits as required by the Mental Health Parity and Addiction Equity Act of 2008, as referenced below.

- Any substantial change to the structure of a grandfathered plan should result in the elimination of the plan's grandfathered status. These structural changes could fundamentally change the existing coverage in a manner that significantly affects enrollees, particularly individuals with disabilities and chronic conditions whose coverage may be severely limited by a change in plan structure. For example, if a grandfathered preferred provider organization (PPO) becomes a closed-panel health maintenance organization (HMO), these plans should lose their grandfathered status.

- Significant changes to the prescription drug formulary should result in loss of grandfathered status. Although the use of prescription drug formularies may provide valuable cost containment and quality assurances to health plan enrollees, changes in the design and administration of prescription drug benefits can have a major and negative impact on some of a plan's most vulnerable enrollees. To encourage plans to maintain grandfathered status through the continued provision of "all or substantially all benefits to diagnose or treat a particular condition", grandfathered status should cease upon any

of the following changes to the administration of prescription drug benefits and formularies.

1. Restricting the formulary overall by shifting from an open formulary to a closed or tiered formulary;

2. The establishment of new, higher, or specialty tiers with the effect of increasing enrollees' cost-sharing requirements;

3. The elimination of one or more tiers with the effect of increasing certain enrollees' cost-sharing requirements;

4. Imposition of new formulary requirements such as step therapy and "fail first" mandates;

5. The re-arrangement of tiers among a covered class of drugs resulting in a reduction in the total number of drugs with the lowest cost-sharing requirement;

6. Formulary restrictions such as "generics only";

7. Requirements for mail-order delivery for some or all drugs on the formulary;

8. Elimination of specialty pharmacy support services for certain plan members with special needs;

9. Imposition of an extended moratorium period before new therapies can be added to the formulary; and/or

10. The elimination of a drug(s) from the formulary for reasons other than patient safety.

- Plans that place significant additional limits on a provider network should also lose grandfathered status. Under the existing regulations, an enrollee could see their provider network drop to 5 doctors while the plan maintains its grandfathered status. Even losing one or two physicians could have a serious impact to individuals with disabilities and chronic conditions who often rely on specialized care.

Additionally, the interim final and proposed rules do not establish an effective mechanism for oversight and enforcement of these important rules. Without such a process in place, there is no way to ensure adherence, and plans may avoid complying with the rules and simultaneously claim continued grandfathered status. Without an effective process for challenging grandfathered status, consumers will be without a remedy in the face of significant changes to their grandfathered plan that may keep them indefinitely from the protections afforded under the Affordable Care Act.

NAMI recognizes the value of grandfathered status of some plans as a means to smoothly transition into a completely reformed private insurance market. At the same time, grandfathered

status must be viewed as a temporary option to those plans that make a good faith effort to retain current coverage, not a permanent exemption from the new rules of the insurance market.

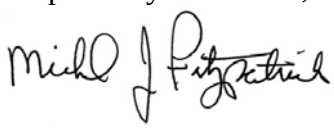
Compliance With MHPAEA

In 2010, and continuing through 2013, a large number of employer-sponsored group health plans are being charged with initial compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). This law requires employer-sponsored group health plans to cover treatment for mental illness and substance abuse treatment on the same terms and conditions as all other medical conditions – particularly with respect to durational treatment limits and financial limitations. Initial compliance with MHPAEA in 2010 and 2011 will require many group health plans to remove arbitrary limits on covered inpatient days or outpatient visits, or change cost sharing and deductible requirements to equalize or integrate financial limitations for behavioral and medical-surgical benefits.

Likewise, if a group health plan exercises their option to completely drop mental illness and substance abuse coverage rather than comply with MHPAEA – which is permitted under law for many plans not otherwise required to have such coverage under state law – such a change in scope of coverage should also trigger loss of grandfathered status.

It will be important for CMS and other federal agencies responsible for enforcing MHPAEA and assisting with its implementation to make clear that changes made in order to meet its requirements are to be treated just like all other plans changes that trigger loss of grandfather status. In other words, CMS, DoL and Treasury need to make clear that a change in benefit structure, enrollee cost sharing or covered services required by MHPAEA is NOT exempt from rules and standards governing grandfather status.

Respectfully Submitted,



Michael J. Fitzpatrick, M.S.W.
Executive Director