



AMERICAN BENEFITS

COUNCIL

Testimony of James A. Klein
President
American Benefits Council

Hearing on the
“Paul Wellstone Mental Health and Addiction Equity Act of 2007”
Subcommittee on Health
Committee on Energy and Commerce
United States House of Representatives

June 15, 2007

Mr. Chairman and members of the Health Subcommittee, thank you for the opportunity to share our views with you today on the Paul Wellstone Mental Health and Addiction Equity Act of 2007. My name is James Klein and I am President of the American Benefits Council.

The American Benefits Council's members are primarily major employers and other organizations that collectively sponsor or administer health and retirement benefits covering more than 100 million Americans. Most of the Council's members are very large companies that have employees in most or all 50 states and provide extensive health coverage to active employees and retirees. Our membership also includes organizations that provide benefits services to employers of all sizes, including small employers who often face the greatest challenges in providing health coverage for their workers.

Employers Recognize the Importance of Behavioral Health Care

The American Benefits Council's members highly value and have long recognized the importance of effective health coverage for the treatment of both physical and behavioral disorders. Indeed, because of the importance our members place on these services, we have repeatedly urged Congress that the current federal parity requirements not be expanded in a way that would add to plan costs or increase the complexity of plan administration. Doing so could unintentionally risk a reduction in coverage for these or other benefits provided to employees and their families.

We also recognize that much has changed in the behavior health care field over the past decade since the enactment of the current federal mental health parity requirements in 1996. Better medical evidence on behavioral health conditions has become available and better treatment options have advanced during this period. In a great many cases, the way in which behavioral health conditions are covered by health plans has also changed, particularly with the emergence of health plan administrators that specialize in the management of behavioral health care services in a wide range of outpatient and inpatient settings.

As the field of behavioral health care has changed during this time, it has become increasingly clear that the ability of employers to provide access to affordable and appropriate health care services, including for behavioral health conditions, depends on the ability of health plans to do an effective job in the medical management of health benefits. This involves often challenging tasks to try to ensure that plan participants get the right care and effective care under the terms of their plans and for the health conditions they have. Employers have a strong interest and an enormous stake in seeing that these tasks are performed well, not only because employers are the primary payers for the health care coverage for

millions of American workers, but also because of the importance they place in maintaining a healthy and productive workforce.

Senate Parity Legislation Developed through Inclusive Process

Before I address the concerns we have with the House mental health parity bill, H.R. 1424, let me see if I can dispel the myth that employers are simply irrevocably opposed to any legislation in this area or that employers somehow do not understand or appreciate how vitally important effective behavioral health care is for millions of Americans.

Over the past several months, the three Senate sponsors of mental health parity legislation – Senate HELP Committee Chairman Edward Kennedy, HELP Committee ranking member Senator Mike Enzi and Senator Pete Domenici, who is a longtime champion of mental health parity and an author of the original legislation enacted a decade ago – have taken a fresh approach to trying to resolve the difficult and important issue of changing the current law federal parity requirements. Under their joint leadership, a new bill was developed, S. 558, through a balanced, candid and extensive process that has given all the major stakeholders on this issue – employers, health plans, behavioral health care providers and patient advocates – the opportunity to have their priority concerns addressed.

The American Benefits Council has been privileged to have participated in this process with the three Senate sponsors as a representative of employer interests. While these discussions have been demanding and have required much give and take on all sides, we also think that it has unquestionably resulted in a bill that is a bipartisan in the best sense of the term. In fact, we believe it could serve as a model for how Congress might be able to tackle other similarly challenging health policy issues, ones which members of this subcommittee must frequently work to resolve, too.

The Senate parity measure is not perfect. No true compromise proposal ever is. But the Senate parity measure is the only one of its kind which includes among its supporters a leading coalition of mental health parity proponents as well as a broad range of organizations representing employers and insurers. We hope this good faith effort sends an important message that employers will support legislation where their priority concerns are addressed in a thoughtful manner and with a careful attention to details, even when our preferred outcome would be no new legislation or an even better bill.

Unlike previous parity measures considered by the Senate or the parity bill which has been introduced here in the House of Representatives, the Senate proposal does not mandate that plans cover specific mental health benefits. It

leaves those decisions up to employers and, in the case of fully insured health plans, the Senate bill permits States to continue to determine whether to require any particular benefits. In addition, the Senate bill includes a provision making clear that medical management of these important benefits may not be prohibited and preserves flexibility for employers and health plans in the formation of networks of health care providers who deliver these services. These provisions are vitally important because they allow employers to appropriately design and manage the health coverage they offer to meet their employees' needs.

Finally, and most importantly, several of the key provisions of the Senate parity bill are subject to a rule which is intended to ensure uniformity between the federal parity requirements and those established by the States, while maintaining the traditional role of the States to regulate the business of insurance in all other respects. Major, multi-state employers, in particular, rely upon the uniform federal framework established by the Employee Retirement Income Security Act (ERISA). It is crucial to these employers, who provide health coverage to over 70 million Americans, that this framework not be eroded.

Employer Concerns with the House Mental Health Parity Bill

Unfortunately, we do not see the same balanced approach in the House parity bill to the issues of key concern to employers and we would urge that several changes be made to the legislation as it is considered further by this subcommittee and the other committees of jurisdiction in the House of Representatives. The primary issues which we believe need to be addressed are the following:

1. Flexibility Needed in Covered Benefits

Under the House parity bill, if a health plan provides "any" mental health or substance-related disorder benefits, then the plan must cover all of the same mental health and substance disorder benefits as are provided to federal employees under the Blue Cross and Blue Shield standard option health plan (the most heavily enrolled health plan offering under the Federal Employee Health Benefits Program). Plans offered to federal employees are required to cover all conditions listed in the so-called DSM-IV manual, the diagnostic manual used by mental health care professionals to identify and categorize all disorders in this area. So, while the benefit mandate is stated somewhat differently than it has been in previous mental health parity bills, the basic requirement in the House bill is to cover all mental health and substance-related disorders if a plan covers any services at all in this area. Of course, the vast majority of plans do provide such services.

Employers have several concerns about this sort of requirement. First, it is not necessary to achieve the purposes of the legislation, which is to provide parity in any financial requirements and treatment limits which a plan applies to the benefits it covers. Requiring a plan to provide coverage for all of the conditions which are identified in the diagnostic manual used by health care providers is not “parity”, it is simply a benefits mandate. It also requires much more specificity of coverage than is required for any non-behavioral health conditions. Such a requirement would send an immediate message to employers that they no longer have any discretion over decisions about what benefits they cover for their employees in this area of their plan, except the decision to provide no coverage for these conditions at all, which is an unacceptable alternative.

In addition, state laws currently govern which benefits are required to be covered for fully insured health coverage, so this is a matter that can be, and often is, decided by the states for the health plans which they regulate. In terms of self-insured health plans which are regulated under federal law, there are no similar requirements applied to any other broad category of health conditions or services which are typically covered by employer-sponsored health plans, in recognition that this is an important area of discretion for employers when they voluntarily choose to provide health coverage to their employees.

2. Protection Required for Medical Management Practices

Another major concern with the House bill is that, unlike previous mental health parity bills considered by Congress or the current Senate measure, there is no specific protection for plan medical management practices. It is very important to protect the ability of plans to appropriately manage coverage for mental health conditions and substance-related disorders as part of any federal parity legislation. Proposed treatments for these conditions should, whenever possible, be consistent with standards for evidence-based care. Ultimately, to quote the conclusion of an April 11, 2007 op-ed column in the New York Times by Maia Szalavitz, “we need parity in evidence-based treatment, not just in coverage” for mental health conditions.

One of the most important developments now occurring in the health care field is in the preparation of measures by numerous clinical specialty groups to help define appropriate care and expected outcomes for patients for a wide range of conditions. Purchasers, health care providers, consumer groups and many others are actively working in several different forums to reach consensus on evidence-based measures of quality health care. While much more needs to be done to achieve a fully transparent and more accountable health care system, there can be little doubt that the movement to achieve consistent measures of quality care is a major step in the right direction and can help drive overall health system reform.

We need to be careful to ensure that neither State nor federal laws undercut or diminish efforts by plans to try to ensure that the health care services received by plan participants are medically necessary and appropriate for their conditions. Some health plans contract with managed behavioral health care organizations for this purpose while others perform medical management services as part of their core plan operations. Either way, it is essential to safeguard these important activities so that plans are able to both protect themselves and their participants from unnecessary costs as well as to try to ensure that coverage is provided for quality health care services. Indeed, an August 2006 report by the Congressional Research Service on the impact of health parity laws cited evidence that there was little adverse impact in the Federal Employee Health Benefits Program in terms of access, quality or cost of care *because* the parity requirements for mental health benefits covered under that program were coupled with the management of care by plans offered to federal employees.

3. Discretion Needed for Out-of-Network Coverage

A third significant concern that employers have with the House bill is that it mandates coverage for mental health and substance-related disorders by out-of-network providers if a plan provides coverage for substantially all medical or surgical services on an out-of-network basis in any of three different categories (emergency services, inpatient services or outpatient services). Again, this requirement limits important plan discretion and *exceeds* what is required under the Federal Employee Health Benefits Program where parity is required only for services provided on an in-network basis.

We would recommend that the House bill be modified to conform to either the FEHBP requirement or the comparable provision in the Senate parity bill which includes a federal standard that calls for parity in plan financial requirements and treatment limitations for any out-of-network mental health coverage provided by a plan, but the Senate provision does not require plans to offer out-of-network coverage. The Senate bill also preserves the traditional role of the States to regulate fully insured health plans in this area, so it does not interfere with State laws which may require insurers to offer out-of-network health coverage.

4. Changes Needed to Provisions Related to State Laws

Finally, we have significant concerns with the provisions in the House parity bill which would authorize States to provide “greater consumer protections, benefits, methods of access to benefits, rights or remedies” than those in the legislation. This is extraordinarily broad language and arguably gives States the ability to develop parity laws, at least for fully insured health plans, that could differ

significantly from the federal standards provided and that are determined to be even “greater” than those in the House bill.

More troubling, however, is that the House bill provision on the relationship to State laws would give States broad authority to enact greater “consumer protections...methods of access to benefits, rights and remedies” than any applicable federal standards. This provision appears to go far beyond a mental health parity requirement in that it opens the door for the States to develop separate enforcement and remedy schemes, a matter of frequent review by the United States Supreme Court which has ruled unanimously that the federal remedy scheme included in ERISA is exclusive for all health benefits covered by employer-sponsored benefit plans.

Moreover, if the bill is intended to only change enforcement and remedy schemes for mental health coverage, then there is no justification for a separate set of rules for just one category of benefits. If, in fact, this provision is intended to permit states to create a new enforcement and remedy scheme for all benefits, then such a fundamental change in the law should not be an adjunct to a bill whose purpose is to address mental health parity.

The uniformity ERISA establishes for employer-sponsored coverage, including its enforcement and remedy scheme, is based on sound public policy and is something employers consider crucial to their voluntary decision to offer health coverage to their employees. Federal preemption is not unlimited, but where it does apply it fosters uniform administration of covered benefits and reduces costly burdens of complying with differing State laws which would occur in the absence of ERISA’s uniformity provisions.

If Congress believes that changes are needed in this area, it should be fully debated on its own merits rather than included as one of many provisions of a mental health parity bill.

House and Senate Parity Bills Fail to Apply to Medicare or Medicaid

One of the most glaring omissions of both the House and Senate parity bills is that they fail to apply the same requirements to the mental health benefits provided to millions of elderly and low-income Americans who are covered under Medicare and Medicaid. While we are aware that separate legislation sponsored by Rep. Pete Stark, H.R. 1663, would partially address this situation by requiring parity for benefits covered by Medicare, nearly all of the debate and focus concerning mental health parity over the past decade in Congress has been around employer-sponsored health coverage.

We believe it is simply indefensible for Congress to impose parity requirements on employer-sponsored health coverage while ignoring the same issues in the programs where it has direct responsibility. Failing to do so would mean that if either the House or Senate bills were to be enacted, mental health parity would be the law for employer-sponsored coverage and, through previous action by Executive Order, for coverage offered to federal employees (including members of Congress), but not for those covered under Medicare or Medicaid.

This committee has jurisdiction over Medicare outpatient services covered under Part B and the Medicaid program. We would be in a very different place in this debate if the fundamental policy decision had been made long ago that mental health parity was not simply something that Congress was seeking to apply solely to employer-sponsored health coverage, but was being done as part of a more omnibus effort to achieve the same standards in all federal health programs as well. Such an approach would send a substantially different message to employers that sponsor health benefits for their employees and it is an approach that we strongly urge be done before you compel private sector employers to make changes to their plans.

Conclusion

Again, I appreciate the opportunity to testify today and share our views with you on these important issues. The American Benefits Council has played a constructive and highly engaged role in the multi-stakeholder negotiations that helped shape the Senate mental health parity bill. We and our allies on this issue are prepared to do the same with the House bill if a similar approach is taken to making what we believe are important and needed changes to ensure a more balanced proposal.

Employers understand the importance of quality mental health coverage for their employees and to maintaining a productive, healthy workforce. We also fully understand the strong sentiment in Congress to change current federal mental health parity requirements. We believe the candid discussions among all the major stakeholders which were used to develop the Senate bill have demonstrated that employers and insurers are prepared to engage seriously in resolving this longstanding issue, provided that the process is respectful of the priority needs of all the parties involved. As this legislation moves forward, we urge that you consider the merits of this approach so that a consensus measure can ultimately be considered by the House of Representatives.