



AMERICAN BENEFITS  

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COUNCIL

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On Behalf of the

American Benefits Council

Hearing on the  
"Paul Wellstone Mental Health and Addiction Equity Act of 2007"  
Subcommittee on Health, Employment, Labor and Pensions  
Committee on Education and Labor  
United States House of Representatives

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Mr. Chairman and members of the Subcommittee, thank you for the opportunity to share the views of the American Benefits Council on the Paul Wellstone Mental Health and Addiction Equity Act of 2007. My name is Jon Breyfogle. I am the Executive Principal of the Groom Law Group. Groom Law Group is a Washington DC based law firm that specializes exclusively in employee benefits law. In my practice, I represent a wide range of large employers and insurers on the legal issues surrounding sponsoring health plans and offering services to health plans. I am a member of the Board of Directors of the American Benefits Council and am testifying on behalf of the 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 our members are very large companies that have employees in most or all 50 states and provide extensive health coverage to active employees and retirees. The Council's 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 have long recognized the importance of effective health coverage for the treatment of both physical and behavioral disorders. Because of the importance our members place on these services, we have repeatedly urged Congress not to expand the current federal parity requirements 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 behavioral 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 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 often involves 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**

Before I address the concerns we have with the House of Representatives mental health parity bill, H.R. 1424, I want to emphasize that employers understand and appreciate how vitally important effective behavioral health care is for millions of Americans. Employers spend considerable sums of money providing behavioral health care coverage and are not irrevocably opposed to any legislation enhancing parity requirements.

Over the past several months, three Senate sponsors of mental health parity legislation (Mental Health Parity Act of 2007 - S. 558) - Senate HELP Committee Chairman Kennedy, HELP Committee ranking member Senator Enzi and Senator Domenici - have tried to resolve the difficult and important issue of changing the current law federal parity requirements. Their bill has been developed through an inclusive and thorough 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 concerns heard and addressed.

The American Benefits Council has been privileged to have participated in this process 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 resulted in a bill that balances the interests of a divergent set of stakeholders. We believe the process employed could serve as a model for how Congress might be able to tackle other similarly challenging health policy issues.

S. 558 is not perfect from our perspective, but no true compromise proposal ever is. That said, the Senate parity measure has gained the support of mental health parity proponents and a broad range of organizations representing employers and insurers. In that regard, the Senate bill is unique. 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 careful attention to details, even when our preferred outcome would be no new legislation or an even better bill.

Here are the key reasons why the American Benefits Council strongly prefers the Senate bill over other parity measures that have been considered by the Senate, as well as H.R. 1424, the parity bill that is the subject of this hearing.

First, the Senate proposal does not mandate that health plans cover specific mental health benefits. It leaves those decisions up to employers. In the case of fully insured health plans, however, the Senate bill permits States to continue to determine whether to require any particular benefits.

Second, the Senate bill includes a provision making clear that medical management of mental health benefits is not 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, the Senate bill provides for a very targeted and narrow preemption of State insurance law (applicable to fully insured plans, as well as to self-insured plans) that assures a uniform federal rule for the specific parity requirements of S. 558 (e.g., treatment limits, financial requirements, cost exemption).

We recognize that this modest preemption rule in the Senate bill has generated some criticism and that the provision deviates from the "federal floor/state ceiling" preemption rule that currently applies to fully insured plans under the existing federal mental health parity requirements in section 712 of the Employee Retirement Income Security Act (ERISA). However, this provision is targeted and well justified. This narrow preemption rule was included in S. 558 because the sponsors of the legislation recognize that the parity rules of the Senate bill are very comprehensive and deserving of a uniform Federal approach. In fact, it is hard to imagine a broader parity requirement pertaining to treatment limits and financial requirements. Indeed, S. 558 would extend broad new parity requirements to participants in insured plans in the 8 states that currently have no parity requirement and expand upon the parity requirements applicable to insured plans in approximately 17 other states.

The sponsors of the Senate bill have approached this matter with great thought and care to ensure that the targeted new preemption rule preserves the traditional role of the States to regulate mental health benefits provided under insurance policies in all other respects. For example, special rules are included in the bill that ensure that:

- State laws that mandate mental health benefits for fully insured plans are preserved;

- State laws that include parity requirements together with non-parity requirements (e.g., some form of mandated benefit) will not be completely preempted as they apply to fully insured plans – only the State's specific and different parity requirements will be preempted and the other aspects of State law will be preserved;
- State laws that set parity requirements for insurance offered in the small group market are preserved;
- State laws that set parity requirements for the individual insurance market are preserved;
- State laws that define the term “mental health benefits” will not be preempted for fully insured plans;
- State laws that require that insurers offer out of network coverage for mental health benefits are not preempted; and
- State laws that regulate the ability of insurers to manage mental health benefits for fully insured plans are not preempted.

To ensure that there are no unintended preemption consequences associated with the Senate bill, the sponsors of the Senate bill have set out all of these rules explicitly in the text of S. 558. In my view, these provisions are belts and suspenders to begin with – arguably they are not even needed because the basic preemption rule in the bill is narrowly targeted to begin with. The fact that employers have worked closely with the Senate sponsors in the crafting of these comprehensive clarifications relating to State insurance laws demonstrates the good faith negotiations that have occurred. As a practicing lawyer in this area, there is no doubt in my mind that any court or regulator that would be called on to interpret the Senate bill will fully understand that the Congress went out of its way to preserve and respect the traditional role of the States to set standards for participants of fully insured plans. Any arguments to the contrary are simply without merit.

### **Employer Concerns with the House Mental Health Parity Bill**

Unfortunately, the House parity bill does not address the issues of key concern to employers in the same balanced fashion as the Senate bill. As such, we urge that several changes be made to the legislation as it is further considered. 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.

We 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. In our view, 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 a "parity" rule – it is a benefits mandate. In fact, it does not establish "parity" at all because it 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.

In addition, state laws currently govern which benefits are required to be covered for fully insured health plans 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 for Medical Management Practices

Another major concern with the House bill is that, unlike the current Senate measure, there is no specific protection for medical management practices for self-insured plans. It is important to preserve the ability of plans to manage coverage for mental health conditions and substance-related disorders. We believe that employers should be able to design plans so that proposed treatments for these conditions are, whenever possible, consistent with standards for evidence-based care. Indeed, in our view, the Senate bill's protection for medical management does not go far enough – we would have greatly preferred that the Senate bill preempt State insurance laws that limit the ability of insurers to manage mental health benefits for fully insured plans. But not doing so is one of the many compromises included in the Senate bill.

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 ensure that coverage is provided for quality health care services and protect themselves and their participants from unnecessary costs. Advocates of H.R. 1424 maintain that it is not their intention to interfere with medical management and that nothing in the legislation would explicitly do so (i.e., the bill is simply silent on the matter). This is very encouraging, but to ensure that result, we urge the House to amend H.R. 1424 to include the Senate bill's specific language to make that point absolutely clear.

### 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). This requirement limits important discretion in plan design. It also *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 adopt the Senate approach 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 even where out-of-network coverage is offered for other medical benefits. As noted above, the Senate bill 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 mental health coverage.

#### 4. Changes Needed to Preemption Provisions

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 the provisions set out in the legislation. Clearly, this language gives States the ability to develop parity laws, at least for fully insured health plans, that are more extensive than the federal standards provided in the House bill. We prefer the approach adopted in the Senate bill, which would establish uniform federal parity rules applicable to treatment limitations and financial requirements for both self-insured and insured plans while preserving the traditional authority of States to require fully insured plans to provide mental health coverage.

The more troubling aspect of this provision in the House bill is that it opens the door for greater State law remedies for disputes involving mental health benefits for participants in insured plans. The Supreme Court has issued numerous rulings making clear that ERISA's enforcement scheme is exclusive for both fully insured and self-insured plans and completely preempts alternative State remedial schemes. It makes no sense whatsoever to allow access to State law remedies for one category of benefits – i.e., participants in fully insured plans for disputes over mental health benefits. To the extent the House bill is interpreted to revise remedies for all types of benefit disputes, H.R. 1424 is certainly not the vehicle to do so. The debate over ERISA's remedies has occurred over many years, generally in the context of the Patients' Bill of Rights. Such a fundamental issue as ERISA's remedial scheme should not be an adjunct to a bill whose purpose is to address mental health parity.

The uniformity that ERISA establishes for employer-sponsored coverage, including its enforcement and remedies scheme, is sound public policy and is something employers consider crucial to their voluntary decision to offer health coverage to their employees. If Congress believes that changes are needed in this area, such changes should be debated on their 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 Federal Programs**

One of the many omissions of both the House and Senate parity bills is that they fail to extend the same parity 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 indefensible for Congress to impose parity requirements on employer-sponsored health coverage, for both private sector employers and state and local government health plans, while ignoring the same issues in the programs that the Federal government sponsors and pays for. If either the House or Senate bills were 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.

It would send a fundamentally different message to employers if 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.

### **Conclusion**

Thank you for the opportunity to testify today and share our views with you on these important issues. 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 expand upon the current federal mental health parity requirements. The American Benefits Council has played a constructive and active role in the multi-stakeholder negotiations that have helped shape the Senate mental health parity bill. We 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.