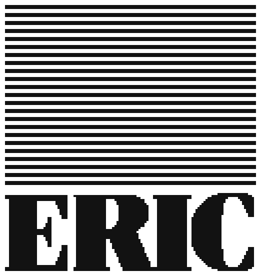

THE ERISA INDUSTRY COMMITTEE

TESTIMONY
OF
MS. EDWINA ROGERS

HEARING
ON
THE PAUL WELLSTONE MENTAL HEALTH
AND ADDICTION EQUITY ACT, H.R. 1424

BEFORE THE
HOUSE ENERGY AND COMMERCE COMMITTEE

SUBCOMMITTEE ON HEALTH

JUNE 15, 2007

Good morning, and thank you Chairman Pallone and Ranking Member Deal for the opportunity to testify at this hearing.

I am Edwina Rogers, Vice President for Health Policy at The ERISA Industry Committee (ERIC). ERIC is a non-profit trade association committed to the advancement of employee health, retirement, and compensation plans of America's largest employers. We represent exclusively the employee benefits interests of major employers. ERIC is engaged in policy affecting our members' ability to deliver benefits, their cost and their effectiveness, as well as the role of employee benefits in America's economy.

Today I will speak from a plan-sponsor perspective, representing companies that pay for health coverage for tens of millions of Americans. My testimony will focus on issues of concern in the Kennedy-Ramstad Mental Health Parity bill, H.R. 1424.

ERIC members are broadly in favor of expanding coverage, but the approach contained within H.R. 1424 is fundamentally flawed. The bill fails to incentivize better

coverage options, instead injecting government into the world of voluntary benefits, creating mandates, micromanaging the distribution of benefits, failing to protect plan sponsors from burdensome and costly administrative quagmires, and failing to keep up with innovations and demands already widely accepted in the private health benefits marketplace.

Voluntary Benefits and ERISA Preemption

Today major employers offer health, pension, and other benefits to their employees on a voluntary basis. They pay the exorbitant costs associated with these benefits in order to attract and keep employees, to improve morale and productivity, and because major employers take pride in providing for their employees' life security.

Major employers operate in multiple states – some in all 50 – and their employees have common needs that are often not shared with arbitrarily-drawn regions, states, or localities. Congress developed the Employee Retirement Income Security Act of 1974 (ERISA) so that major employers could create uniform national plans that fit the needs of their employees, regardless of where the employees lived, worked, or received healthcare. ERISA was not created as a "floor" upon which states could create differing, conflicting laws; this would have made voluntarily sponsoring a plan extremely expensive and burdensome. ERISA is meant to be the ceiling – the Department of Labor regulates the operations of employer-sponsored benefit plans in every state, regardless of the laws various states create.

As Congress considers a bill that would burden those employers who have chosen voluntarily to offer mental health and/or substance abuse benefits by forcing them to

increase coverage and dissolving their plan flexibility, they should look to ERISA for guidance. Rather than leaving plan sponsors at the mercy of various state laws, Congress could choose to pass a mental health parity law that preempts conflicting state laws, giving employers clear guidance on how to be compliant on a national level. We should all be moving to support a uniform national system. Instead, by allowing states to craft their own laws, and not including preemption language, the Kennedy-Ramstad bill would further disincentivize plan sponsors from offering any mental health coverage at all. Further, there is no indication that legislators will not simply continue to expand on employer healthcare mandates, for mental and medical care, continuing to drive up costs and push employers closer to one-size-fits-all plans.

Plan Flexibility and Accountability

Major employers have used logic, experience, and experimentation to create plans that offer affordable coverage that works for their employees. Many plans have determined that certain conditions should be covered, while other conditions (particularly some that are listed in that mental illness handbook authored by the mental health lobby, the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV) are not valid. Because plan sponsors were able to make these judgments, engage in medical management, and design plans that covered the conditions they chose, many plan sponsors currently offer extremely generous mental health and substance abuse coverage.

The soundness of some conditions endorsed by the mental health lobby is not the only issue plan sponsors are wary of when purchasing mental health care – plan sponsors are also concerned about the accreditation of mental health providers and facilities, as

well as their accountability and transparency. Must employers pay preposterously high rates to treat imagined detriments like jet lag, shyness, or other ailments treated with "folk" remedies or possibly unnecessary medications from unaccredited professionals? Plan sponsors need the flexibility to define which treatments, focusing on evidence-based medicine, should be covered. They must be able to define a network of providers within (and outside) their preferred network. Plan sponsors must be able to designate which mental health facilities are bona fide and which should not be covered under their plan offerings.

If mental health and substance abuse treatment are mandated to have the same financial and treatment rules as medical coverage, they should also have the same accountability standards. Plan sponsors are moving away from a system of "trust, don't verify," and beginning to demand metrics and transparency from all medical providers – data that lets employers and patients know the costs of an episode of care, and helps them make informed decisions on where to get treatment through reporting on quality measures. A bill to promote mental health and substance abuse treatment would fail in its mission if it did not include accountability and transparency provisions for the mental health community, if not also including value-based purchasing language and urging these providers, facilities, and programs to begin using health information technology. It would be a mistake to impose a host of new elements into the healthcare coverage equation without also requiring those elements to comply with the innovations and advances (in both quality and cost efficiency) already made standard in the rest of the healthcare community. ERIC members overwhelmingly reject the one-way street of information from the mental health community – while the bill demands plan design

details and claims information from ERISA plans, it does not require any transparency from the mental health and substance abuse community. A balanced bill must include accountability provisions that include transparency of price and quality data.

Out of Control Costs

Proponents of the mental health mandate claim that it will lower healthcare costs, but the bill includes very clear provisions anticipating cost increases. No doubt the bill's backers believe that they are making a concession in offering a one-year exemption if, six months into a compliant program, a plan sponsor finds that costs are rising at more than an additional two percent in the initial year or one percent in subsequent years due to the mandate. This demonstrates a critical lack of understanding of the financial strains US employers are currently facing. While trying to stay globally competitive, employers have been burdened with double-digit healthcare inflation costs, and are under severe pressure to curb these costs – or to cut benefits. Employers have gone to great lengths to lower costs by one or two percent, and any instant infusion of greater costs could be catastrophic for workers' coverage. Numerous ERIC members have stated that simply implementing this change in their plans administratively, ignoring the costs associated with actually covering this benefit, would cost millions of dollars, requiring extensive revision to pre-existing plans. One member company cited pre-existing contracts with more than 150 plans, all of which would require amendment or renegotiation. Other major employers mentioned that a two percent increase would be more than $10 million, and that every one percent of healthcare costs shifted to employees translated to about $70 annual cost per employee.

If the federal government steps in, fencing off mental health benefits and mandating that employers provide them, the prices of mental health services are sure to rise. Creating an instant, massive increase in demand will certainly dry up the supply, making mental health providers and facilities an even rarer commodity than they already are. It is highly probable that this legislation will lead to an unnecessary rise of utilization, which will in turn lead to a lack of mental health and substance abuse services, denying care to those who need it most. Creating an artificial demand will disrupt the market, drive up prices, and lead to shortages.

Employers, not government, started all the major healthcare quality and efficiency improvement innovations in the past decade. Employers developed consumerist strategies, demanded transparency, urged adoption of health IT and evidence-based medicine, proposed paying for performance, initiated patient centered medical homes, began sponsoring disease management and drug therapy programs, and the list goes on. It took the government ten years just to decide that plan sponsors who offer more coverage to early retirees than to those eligible for Medicare are not engaging in age-discrimination. Now the government, at the urging of a lobby that has specific financial interests in the outcome, is purporting to dictate to the business community how to offer health benefits and save money – something is certainly amiss here. If in fact proponents of mental health parity can prove that it lowers plan costs and improves employee health, they do not need to force this “reform” by legislative fiat. Rather, this would be an issue of education and advocacy, not government interference and employer mandates.

Just this week the employer community proposed a new platform for life security that could serve to expand all manner of health coverage to many more individuals and

small businesses, without harming the current employer-sponsored system. ERIC's New Benefit Platform for Life Security envisions competing expert third-party administrators who manage employers' voluntary contributions, as well as individuals' contributions, and provide affordable, effective, and innovative retirement and healthcare security benefits. These administrators will allow major employers, small businesses, and individuals all to purchase fully portable coverage at equal rates. This private market system, coupled with tax parity, an individual mandate, and subsidies for low-income individuals, embodies a revolutionary step forward in expanding access and coverage to all Americans, while improving our global competitiveness.

The current healthcare system actively discourages employers from participation with a regulatory structure so burdensome that it effectively requires an employer to operate two businesses, in which one operates the employer's core business and the other provides and administers benefits. As employers are moving to simplify the system and build a level playing field, this bill moves in the wrong direction, complicating providing coverage and increasing financial burdens on plan sponsors and beneficiaries.

The government specializes in micro-mismanagement and reducing coverage; between crowd-out by entitlement programs, ill-conceived healthcare mandates, and other botched attempts, the government has failed to address with any real success the more than 40 million uninsured Americans. This is partially because government has failed to address costs before pushing for coverage – instead of deregulating and making the individual and small business healthcare market more affordable, they have continued to pile on cost-drivers. Instead of enacting tort reform, allowing small businesses to band together for purchasing clout, or allowing insurance to

be purchased over state lines, government continues to regulate how voluntary benefits are provided, further incentivizing plan sponsors to cut back coverage. If this bill is enacted, some ERIC members have stated they will reduce coverage, increase employee contributions, and implement treatment limits on medical care.

What Treatment Is Covered?

In defining the minimum scope of the new mandated benefits, this legislation works in a very round-about way. The bill reads that if a plan offers any related benefit, it must cover all the mental health and substance abuse benefits (with significant enrollment) covered by the Federal Employees Health Benefit (FEHB). The FEHB implemented mental health parity in 2001 – and according to a 2005 study by HHS, has seen cost increases due to it. More than 56 percent of FEHB beneficiaries are enrolled in Blue Cross Blue Shield plans. This, in essence, means that Blue Cross plans will always be in compliance, while other plans will be forced to conform to the models adopted by Blue Cross. This has serious implications for plan competition and flexibility, and may lead to increased costs (and decreased participation and coverage).

The legislation does not clearly define how much enrollment in FEHB is necessary such that a condition or substance is mandated to be covered. It also does not designate which conditions or substances might require "emergency care" that would surely incur substantially increased costs. These facets of the legislation leave the door wide open for price-fixing, as any mental health or substance abuse group that can convince a particular plan to adopt coverage for a particular condition or substance can

thus force all other plans to adopt it – and can charge vastly different rates to Blue Cross than to other plans.

It is doubtful that this was the intention of the legislation – in the rush to legislate, the bill's backers may have been attempting to avoid the pitfalls of using the overtly lobbyist-driven DSM IV. However, the option selected is only slightly better – perhaps an omen to alert Congress that plan design is best left to plan sponsors, not outside actors who have financial incentives to overcharge ERISA plans.

Conclusion

The bottom line is that this legislation will very likely reduce coverage, not improve quality or increase coverage. Plan sponsors, already stretched thin, will have no avenue to deal with their increased costs other than to reduce coverage or to further shift costs to employees. In mandating how plans design and offer their voluntary benefits, this legislation will reduce plan sponsors' flexibility and force one-size-fits all policies on diverse and varying pools of workers. The bill will open floodgates of state mental health and substance abuse mandates, which will be extremely costly and burdensome, if not impossible, to comply with. The scope of benefits being mandated is hazy, but clearly written in favor of mental health interest groups, and leaves room for serious vice. Those pushing this legislation are not taking into account the extremely volatile financial situations of current voluntary benefit plans. Further, the bill does not even approach the issue of mental health and substance abuse treatment providers and facilities keeping up with the necessities and innovations of today's healthcare market – transparency of quality and pricing data, use of information technology, and performance-based

reimbursement systems. If Congress wants to increase mental health and substance abuse coverage, it should address transparency, accountability, and affordability and education issues, rather than creating a new mandate.