National Retail Federation
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National Retail Federation Testimony

Hearing on the

"Paul Wellstone Mental Health and Addiction Equity Act of 2007" (H.R. 1424)

Subcommittee on Health, Education, Labor and Pensions

Committee on Education and Labor

United States House of Representatives

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E. Neil Trautwein
Vice President and
Employee Benefits Policy Counsel

Liberty Place
325 7th Street NW, Suite 1100
Washington, DC 20004
800.NRF.HOW2 (800.673.4692)
202.783.7971 fax 202.737.2849
www.nrf.com

Mr. Chairman and members of the Health, Employment, Labor and Pensions Subcommittee, I thank you for the opportunity to appear before you today and to share our views regarding the Paul Wellstone Mental Health and Addiction Equity Act of 2007. My name is Neil Trautwein and I am Vice President and Employee Benefits Policy Counsel of the National Retail Federation (NRF).

The National Retail Federation is the world's largest retail trade association, with membership that comprises all retail formats and channels of distribution including department, specialty, discount, catalog, Internet, independent stores, chain restaurants, drug stores and grocery stores as well as the industry's key trading partners of retail goods and services. NRF represents an industry with more than 1.6 million U.S. retail establishments, more than 24 million employees - about one in five American workers - and 2006 sales of $4.7 trillion. As the industry umbrella group, NRF also represents more than 100 state, national and international retail associations.

As a labor-intensive industry, retailers are strong advocates of quality health coverage for both physical and behavioral needs in order to help keep our employees healthy and productive. As an industry that frequently endures wafer-thin profit margins, we are also well acquainted with the need to manage the collective cost of labor in as cost-effective a manner as is possible. Maintaining balance between these two imperatives is not always easy – it's borderline impossible.

Mandated coverage for benefits and other government interventions disrupts this balance and increases the cost of health coverage for retailer and employee alike. Thus we have tended to resist benefit mandates both generally and specifically. Indeed, we strongly oppose H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act of 2007.

However, our opposition to mental health parity legislation is not simply reflexive. We support the manager's amendment to the Senate bipartisan Mental Health Parity Act of 2007, S. 558. Our first preference always is for no governmental intervention into benefit design. But, should Congress determine to act, then the Senate bill would make the better law by far – an outcome we could support. I will discuss our views on these competing approaches in greater depth below.

NRF Opposes House Parity Bill

The House bill [H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act of 2007, introduced by Representatives Patrick Kennedy (D-RI) and Jim Ramstad (R-MN)] is similar in many respects to the bills we have opposed in the past. In some respects, it is worse. We strongly oppose H.R. 1424, principally because of its broad benefit mandate, its lack of protection for medical management, provisions allowing the states to enact more extensive provisions and provisions mandating out-of-network coverage.

Broad Coverage Mandate

H.R. 1424 appears on the surface to be less expansive of coverage than previous bills, but that appearance is deceiving. Previous mental health parity bills have tied coverage to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Under H.R. 1424, no coverage for behavioral needs must be offered, but if any coverage is offered, then coverage must match all that offered under the most heavily subscribed plan under the Federal Employee Health Benefit Program (FEHB). All FEHB plans must cover all the conditions listed in DSM-IV. Thus, H.R. 1424 still ties coverage to DSM-IV. Although advocates of the House bill will point to FEHB's low cost impact implementation of DSM-IV, I will also note that FEHB plans are allowed to medically manage covered benefits – a significant failing of H.R. 1424, which does not meet the FEHB standard.

My purpose today is not to make sport of any specific category or condition under DSM-IV. Employer-sponsored plans cover conditions broadly but target to the needs of specific employee populations to help keep employees healthy and productive. But, this blanket DSM-IV coverage mandate is out of place in a bill addressing parity in covered days and reimbursement. It is also out of place in both the benefits world and the insurance world. To my knowledge, no other professional manual is enshrined as mandated coverage. I suspect other professions would quickly beat a path to your door to secure similar treatment if H.R. 1424 were to be enacted.

The better approach is taken by the manager's amendment to S. 558. This bill continues to allow employer plans to define the scope of covered benefits in their plan. In keeping with the states' traditional role in regulating insurance, individual states can define the coverage regulated insurers must offer. We favor this status quo approach because it works in practice today.

No Protection for Medical Management

We are troubled by the lack of specific protection for the medical management of benefits in H.R. 1424. Previous House and Senate bills have included such protections; indeed, such protection was at the heart of proponents' arguments that parity legislation would not greatly increase health coverage costs. Surely the sponsors of H.R. 1424 are not advocating unfettered access to coverage and reimbursement, are they?

Medical management is at the heart of coverage for millions of retail employees today: a process of matching the type and level of coverage to individual need. Most of the states and the FEHB explicitly allow for the medical management of benefits. Medical management is critical to the provision of good quality and affordable benefits. We urge that H.R. 1424 be amended to specifically protect the medical management of covered benefits.

Role of the States

We are also worried by provisions of H.R. 1424 that would allow the states to provide "greater consumer protections, benefits, methods of access to benefits, rights or remedies" than those in the bill. H.R. 1424 would create an uneven patchwork between the states that could ultimately undermine the federal ERISA law which serves as the backbone of employer-sponsored coverage.

Relatively few members of the broad retail community represented by NRF are confined to a single state. The ability to maintain common benefit designs in stores located in several states is critical to the retail community's ability to compete in today's demanding economy. We strongly oppose the "federal floor/state ceiling" approach taken by H.R. 1424 as inherently unworkable.

Our first preference would be for a completely preemptive federal standard covering all plans in all markets. But, good faith negotiations brought us to this balanced outcome. We support the final negotiated compromise on preemption outlined in the manager's amendment to S. 558 that essentially preserves the status quo between federal standards for employee benefits and state regulated insurance products. Anything that seeks to alter this negotiated compromise would be unacceptable to us.

Out-of-Network Coverage

Finally, I would like to join in drawing attention to the provision of H.R. 1424 that mandates out-of-network coverage. As noted by others, this provision exceeds that required of FEHB plans and would greatly undercut employers' ability to manage networks of providers and thus would result in increased costs to everyone, including patients and employees. Our shared preference would be for H.R. 1424 to either conform to the FEHB standard (parity required only for in-network services) or to the manager's amendment to S. 558 (out-of-network coverage not required, but parity coverage in financial requirements and treatment limitations required if so).

Collaborative Senate Process

The mental health parity debate has been both long and fierce. I have been an advocate in this debate for a number of years, both before and after the 1996 law addressing parity in annual and lifetime limits. We all have contributed heated rhetoric to this debate. Unfortunately, it has really obscured our shared objective of helping individuals get the coverage and care they needed.

It is this last point that has encouraged a running dialogue between the advocates and Senate sponsors. I have been privileged to have participated over a number of years as a principal representative of the employer community in intense discussions and negotiations with both the Senate sponsors as well as advocates for the mental health

and addiction communities. I would like to give special thanks to Senators Ted Kennedy (D-MA), Michael Enzi (R-WY) and Pete Domenici (R-NM) for their longstanding advocacy on this legislation as well as for their willing ear and fair and responsive negotiations through the years.

The Senate compromise that I have highlighted throughout this testimony is the product of those negotiations. It has also created a broad coalition among erstwhile opponents – surely somewhat of a distinction.

NRF is joined in this coalition not only by traditional allies like the American Benefits Council, Aetna, the U.S. Chamber of Commerce and the National Association of Manufacturers (among others) but also by the National Alliance on Mental Illness, the American Psychiatric and the American Psychological Associations and the American Hospital Association and the Federation of American Hospitals (among others). I have attached a copy of our joint letter at the conclusion of my testimony. I respectfully ask that it be made part of the hearing record.

Conclusion

Again, NRF greatly appreciates the opportunity to appear before you today. Though we oppose the legislation before you (H.R. 1424), we are not opposed to all parity legislation. We support the balanced Senate compromise legislation and would gladly work with you to see it enacted into law this year.

We would also welcome an opportunity to work with you and the House sponsors of H.R. 1424 on similar issues in the future. In fact, it is our hope that our collaborative work in the Senate will be a model for future debates and issues. Who knows – perhaps there is a collaborative federal cure for common gridlock after all. We hope so! I thank you and will look forward to your questions.

[ATTACHMENT]

June 14, 2007

The Honorable Edward M. Kennedy
The Honorable Michael B. Enzi
The Honorable Pete V. Domenici
United States Senate
Washington, DC 20510

Dear Chairman Kennedy and Senators Enzi and Domenici:

We write in joint and strong support of prompt Senate action on the manager's amendment to the bipartisan Mental Health Parity Act of 2007, S. 558. We support enactment of your balanced legislation into law this year.

Organizations representing consumers, family members, health professionals, and health care systems and administrators, business associations and insurance organizations negotiated in good faith with you and your staff over an extended period to produce this bill. We believe that it is a strong bill that will advance the interests of the greater mental health community while balancing the interests of employers who voluntarily sponsor benefit coverage. This bill also respects the role of the states in the regulation of insurance.

We urge its prompt adoption by the full Senate and will join you in opposing unacceptable or weakening amendments during the Senate debate and will remain committed to this bipartisan approach as this legislation moves forward. Thank you again for your joint leadership on this important issue.

Sincerely,

National Retail Federation
National Association of Wholesaler-Distributors
National Association of Health Underwriters
Society for Human Resource Management
National Association of Manufacturers
National Federation of Independent Business
Aetna
U.S. Chamber of Commerce
BlueCross BlueShield Association
CIGNA
American Hospital Association
American Psychiatric Association
American Psychological Association
Association for Behavioral Health and Wellness
Federation of American Hospitals
National Alliance on Mental Illness
National Association of Psychiatric Health Systems