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Request for Information Regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

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General Comment

by Email
Alan D. Lebowitz, Deputy Assistant Secretary for Program Operations
Office of Health Plan Standards and Compliance
Assistance, Employee Benefits Security Administration
Room N-5653
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

Attention: MHPAEA Comments

Dear Alan Lebowitz,

Please accept the following comments from the Drug and Alcohol Service Providers Organization of Pennsylvania to the Request for Information regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

Throughout the multi-year debate over Federal Parity legislation, we argued that any such legislation must preserve existing state insurance laws that provide

treatment for alcohol and other drug addiction where such laws are more favorable to the insured.

In the attached response to the Request for Information, our attorney Greg Heller provides an analysis and review of the legislative history of the debate over this issue and its resolution so clearly preserving more favorable state laws.

We respectfully request that any regulation prepared as part of this process fully respects the preservation of state laws and does nothing to undermine this important decision by Congress.

Sincerely,

Deb Beck
President/DASPOP

May 25, 2009

Attachments

EBSA-2009-0010-DRAFT-0102.1: Comment on FR Doc # E9-9629

Response to Request for Information Regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (the "MHPAEA")

Submitted by: Greg Heller
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The Drug and Alcohol Service Providers Organization of Pennsylvania ("DASPOP") has asked me to respond to the joint Request for Information Regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (the "MHPAEA") published in the April 16, 2009 Federal Register. 75 F.R. 19155. In particular, DASPOP has asked me to provide input on an absolutely critical area – the protection of state laws that are more favorable than the requirements of the MHPAEA. This is fundamental to, and cuts across, each one of the specific subject areas mentioned in the Request for Information. Whatever the regulations ultimately have to say about treatment limitations, financial requirements, and communications with plan members and insureds, these requirements will have to coexist alongside state laws.

I was very involved in some of the discussions leading up to enactment of the MHPAEA. Most of my work involved analysis of the preemption problems raised by some initial drafts of that legislation. Many of the proposed bills would have eliminated or seriously threatened many state consumer protection laws that were more favorable to insureds and plan members than the provisions in the proposed federal law. The MHPAEA did not move forward and become law until these preemption concerns were addressed. The bill as signed into law reflects and

embodies a well-aired, widely-understood intention to preserve state laws. As enacted the MHPAEA does not pose a preemption threat to state laws that are more favorable to consumers than the federal floor established in the MHPAEA. This is clear from the language of the MHPAEA itself, and becomes even more clear when the evolution of the bill is considered.

It is important that regulations, and proposed regulations, respect this fundamental deference to more-favorable state laws. While regulatory silence on the preemption issue will do no harm, **any statements that could be used to embolden preemption arguments – to call into doubt the continued availability of state laws – would be catastrophic for the very patients the MHPAEA is designed to protect.** State laws would cease to play the essential, life-saving role that they play every day. Litigation over preemption questions would be a disaster because litigation can take years to produce a definitive resolution. More devastating still, patients and their families might have no way of knowing that an insurer or managed care organization had decided to stop complying with a state law based on a preemption argument, because much of the detailed legal analysis that guides managed care conduct takes place within private companies out of public view. Important decisions can also be made deep within state regulatory bureaucracies, in ways that are visible only to industry insiders and a small handful of regulators. An insurer could stop complying with a state law based entirely on its own self-serving interpretation of a fabricated ambiguity about the preemptive reach of the MHPAEA, and no consumer would know about it for a long time.

These concerns are important to the development of regulations in this area, because comments and proposed regulations that cast doubt upon (or that could be used to cast doubt

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upon) the preservation of more-favorable state laws could create considerable harm to the very individuals the MHPAEA was designed to protect.

I. ERISA Preemption Before The MHPAEA

For most citizens, the relationship between federal law and state consumer protections is governed and defined by the Employee Retirement Income Security Act of 1974 ("ERISA").

ERISA eliminates many state remedies through an express preemption provision, 29 U.S.C. § 514, and through related doctrines of implied preemption. Oceans of ink have been spilled over ERISA preemption, and it is not my intention to revisit any of that discussion here. For present purposes it is sufficient to note that the legal rules are well-settled and understood by all. States are free to enact and enforce laws that regulate insurance companies and managed care companies. States are free, for example, to establish mandated benefit laws, and to establish laws that govern the procedures through which those benefits can be accessed. States are not, however, permitted to create or enforce additional remedies beyond those provided under ERISA.

The substantive provisions of the MHPAEA that are applicable to private group health plans are codified within Part 7 of ERISA. Everything in Part 7 is subject to an additional preemption standard found at Section 731 of ERISA. That section provides:

> (a) Continued applicability of State law with respect to health insurance issuers
>
> (1) In general
>
> Subject to paragraph (2) and except as provided in subsection (b) of this section, this part *shall not be construed to supersede any provision of State law* which establishes, implements, or continues

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> in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage *except to the extent that such standard or requirement prevents the application of a requirement of this part.*
>
> (2) Continued preemption with respect to group health plans
>
> Nothing in this part shall be construed to affect or modify the provisions of section 1144 of this title with respect to group health plans.

ERISA Section 731, 29 U.S.C. § 1191(a) (emphasis added). This language, and this preemption standard, apply to the substantive provisions of the MHPAEA. In general, state laws that "prevent the application of a requirement of" the substantive provisions of the MHPAEA are subject to preemption.

Many important state laws survive preemption under this analysis. The overwhelming majority of states have their own laws bearing on coverage of mental health services, and the overwhelming majority of states have laws that require private insurers to cover treatment for addiction to alcohol or other drugs.[1]

One example of a state consumer protection law that survives preemption under this analysis is Pennsylvania's Act 106 of 1989. Act 106 requires that group health plans include detoxification, non-hospital residential, and outpatient benefits for addiction treatment, and

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[1] Nat'l Conf. of State Legislatures, State Laws Mandating or Regulating Mental Health Benefits, Dec. 18, 2008, http://www.ncsl.org/ programs/health/Mentalben.htm.

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prescribes the method by which individuals can access the benefit in a way that leaves no room for managed care interference.[2]

These state laws can be, and are, applied to and enforced against insurance companies and managed care companies. They save lives.

The potential preemptive effect of the bill that became the MHPAEA was a source of considerable discussion and dispute throughout the legislative process. As initially introduced, the Senate version of the bill, S. 558, would have significantly *expanded* the scope of ERISA preemption and would have eliminated many state consumer-protection laws. The House version of the bill, H.R. 1424, as reported out of the various Committees that considered the bill, was met with opposition on the grounds that it went too far in *narrowing* the scope of ERISA preemption. Opponents of H.R. 1424 argued that the bill would give states new powers to establish remedies against insurers.

In the end, both the House and the Senate agreed to an approach that established a federal floor and preserved the preemption *status quo*. More favorable state laws are preserved and are not preempted.

II. The Importance of Preserving State Laws was Recognized from the Outset.

H.R. 1424 was introduced by Representatives Patrick Kennedy and James Ramstad, who of course were joined by many others. Representatives Kennedy and Ramstad remained the bill's champions and stewards throughout.

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[2] 40 Pa. Stat. § 908-1 to 908-8 (West 2009).

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In a May 2, 2007 monograph, Representatives Patrick Kennedy and James Ramstad explained at length the importance of state laws and state efforts:

> [B]ecause regulations are always imperfect, and because the federal government is often slower to act than states, this conclusion also counsels in favor of a preemption regime that allows states to extend protections beyond those afforded by federal law. The last eleven years provides a practical example of why setting a federal parity floor, rather than a ceiling, makes sense. In 1996, when the Mental Health MHPAEA became law, only 8 states had similar laws on the books. Today, in the eleven years that Congress has been unable to close down the massive loopholes left in the 1996 Act, an additional 38 states have stepped into the breach.
>
> More recently, states like Pennsylvania and Washington have enacted legislation to clamp down on abusive managed care practices while Congress has been unable to act. If in the future, lawmakers discover that certain practices are violating the spirit and intent of mental health and addiction equity legislation, states are far more likely to act quickly in response than the federal government, and we should encourage them to do so.

Representative Patrick Kennedy and Representative Jim Ramstad, Ending Insurance Discrimination: Fairness and Equality for Americans with Mental Health and Addictive Disorders (May 2, 2007), at 23 (hereinafter "Ending Insurance Discrimination").

Representatives Ramstad and Kennedy also recognized the central role played by managed care abuses, and the importance of state efforts to combat those abuses:

> 5. Equalizing Benfits is Only Part of the Solution.
>
> The testimony from both consumers and providers reveals barriers to care that extend beyond those written into policies. The challenges include onerous and repetitive preauthorization requirements, opaque medical necessity criteria, phantom networks, and arbitrary denials of coverage reversed on appeal that seem to reflect a policy intended to create additional hoops for beneficiaries. These managed care abuses may be exacerbated in the mental health and addiction field but are endemic to managed

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> care in general. Correcting them is probably beyond the scope of legislation intended to equalize benefits.
>
> To the extent that the purpose of equity legislation is to improve access to mental health and addiction care, however, there is a need to explore separately possible legislative responses to these managed care problems. At the very least, in the context of equity legislation, Congress should ensure that it does not stand in the way of states seeking to place limits on abusive managed care practices.

Ending Insurance Discrimination at 25.[3]

Throughout the legislative drafting process, this balance between a claimed need for federal uniformity and the need to respect states' rights was discussed and debated extensively. The House bill (H.R. 1424) contained language that was seen as strongly protective of state laws (indeed, in the views of some actually *expanded* the powers of state laws); the Senate version of the bill (S. 558) would have eliminated many state laws. The House view – the view that state laws should be protected – prevailed.

At the end of the day, Congress decided upon an approach that simply left the current regime standing. To the extent that state laws were protected before the enactment of the MHPAEA, they remain protected today. By the same token, to the extent that states were

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[3] Ending Insurance Discrimination does refer to medical necessity review; it does so in a way that confirms an intention to preserve state laws: "Health plans will retain the ability to make case-by-case medical necessity determinations, but they should not be able to arbitrarily decide that conditions recognized by the medical establishment are not worthy of coverage." Ending Discrimination at 22. This speaks of *retaining* the ability to make medical necessity determinations, not establishing any new right or ability to do so. Thus, Representatives Kennedy and Ramstad obviously did not intend H.R. 1424 to create new rights of medical necessity review that did not previously exist.

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prohibited from fashioning new remedies for misconduct before enactment of the MHPAEA, they are prohibited from doing so today.

III. In the Legislative Drafting Process Those Favoring Broad Preemptive Reach Lost and Those Favoring Protection of State Laws Prevailed.

A. The Evolution of S.558 in the Senate

The Senate version of the bill, as originally introduced and as reported out of the Committee on Health, Education, Labor and Pensions (hereinafter "HELP Committee"), contained an express preemption provision that would (if enacted) have squarely preempted state laws:

> (c) Special Rule in Case of Portability Requirements. –
>
> (1) In General. – Notwithstanding any provision of section 514 to the contrary, the provisions of this part relating to a group health plan or a health insurance issuer offering coverage with a group health plan shall supercede any provision of any State law that establishes, implements, or continues in effect any standard or requirement which differs from the specific standards or requirements contained in subsections (a), (b), (c), or (e) of Section 712A.

S. 558 § 731(c) (as set forth in Senate Report 110-53, which is the April 11, 2007 report of the HELP Committee). The Help Committee report expressly recognized that "S. 558 would preempt State laws governing mental health coverage that are different than those in this bill and that apply to firms with 50 or more employees . . . ." S. Rep. 110-53, at 5.

This preemption provision was not acceptable to many members of Congress, and the bill was not sent over to the House of Representatives until Senators believed the problem was fixed. This is clear from the following colloquy involving Senator Kennedy (who introduced the bill)

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and the two Senators from Pennsylvania, Senator Specter and Senator Casey. This colloquy is directed to a version of the bill that no longer contained the express preemption provision found in S. 558 as originally introduced. *See* 153 Cong. Rec. S11679 (Sep. 18, 2007). It is worth quoting this colloquy at length.

> Mr. CASEY: Mr. President, I rise today to clarify my support for S. 558, the Mental Health Parity Act of 2007. This bipartisan legislation introduced by Senators Domenici and Kennedy, seeks to provide parity between health insurance coverage of mental health benefits and benefits for medical and surgical services. I join my colleague, the senior Senator from Pennsylvania, Mr. Specter, in establishing for the record today the reasons for our joint support for this bill. I also thank Chairman Kennedy and Senator Domenici for joining us in this discussion.
>
> Mr. SPECTER: I thank my colleague Senator Casey. Mr. President, as a cosponsor of S. 558, I am pleased that the Senate is taking up this important legislation. I thank Health, Education, Labor, and Pensions, HELP, Committee Chairman Kennedy, Senator Domenici, who along with HELP Committee Ranking Member Enzi and others, have worked to establish mental health parity for millions of American citizens.
>
> Mr. KENNEDY: I thank my colleagues from Pennsylvania and appreciate their dedication to and support for the cause of mental health parity. I welcome this opportunity to discuss this critical legislation.
>
> . . . .
>
> Mr. SPECTER: In 1989, in the Commonwealth of Pennsylvania, the State legislature passed a bill, Pennsylvania Act 106, which requires all commercial group health insurance plans and health maintenance organizations to provide a full continuum of addiction treatment including detoxification, residential rehabilitation, and outpatient/partial hospitalization. The only lawful prerequisite to this treatment and to coverage is certification to need and referral from a licensed physician or psychologist. Such certifications and referrals in all instances control the nature and duration of treatment. I support existing Pennsylvania law and, before agreeing to support S. 558, assured myself that S. 558 will not serve to supplant greater Pennsylvania protections for those seeking treatment for substance abuse.

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Mr. CASEY: I join my esteemed colleague in having assured myself that S. 558 will not serve to preempt in any way the services and benefits provided to the citizens of Pennsylvania by Pennsylvania Act 106. I know that our offices have collaborated extensively in this analysis and have consulted with HELP Committee staff and Senator Domenici's staff, and that our views are borne out by extensive legal and scholarly analysis of the preemptive provisions of S. 558.

Mr. KENNEDY: I can assure the Senators from Pennsylvania that we have labored to ensure that S. 558 will serve only to benefit States and the coverage that citizens receive.

Mr. CASEY: I thank Chairman Kennedy and Senator Domenici, and I note in particular that Professor Mila Kofman, Associate Research Professor, Health Policy Institute, Georgetown University, wrote to Senator Specter and myself on August 2, 2007, extolling the benefits of S. 558. I ask unanimous consent to print in the Record Professor Kofman's letter.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

GEORGETOWN UNIVERSITY

HEALTH POLICY INSTITUTE,

August 3, 2007

Hon. ROBERT P. CASEY, Jr.,
U.S. Senate, Russell Senate Office Building, Washington DC.
Hon. ARLEN SPECTER,
U.S. Senate, Hart Senate Office Building, Washington, DC.

> DEAR SENATOR CASEY AND SENATOR SPECTER: This is a response to a request for an analysis of the preemption provisions in the Mental Health MHPAEA of 2007 (S. 558 as amended 8/3/07 Managers' Amendment).
>
> The changes made to the preemption section in S. 558 mean that the current HIPAA federal floor standard would apply to the new Mental Health Parity law (just like it applies to the current law passed in 1996).

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This would mean that more protective (of consumers) state insurance laws would apply to insurers that sell coverage to employers. This bill would also mean new federal protections for people in self-insured ERISA plans.

This would be a tremendous victory for patients who need coverage for mental health services. This approach continues the public policy established in 1996 in HIPAA--an approach that allows states to be more protective of consumers while setting a federal minimum set of protections for workers and their families.

While not every word or phrase is perfect (meaning not 100% litigation proof), using the current HIPAA preemption standard would certainly make it difficult to win a case that seeks to challenge more protective state insurance law.

If enacted, this bill would provide much needed minimum protections for people in self-insured ERISA plans who currently are not protected by states because of ERISA preemption. It also raises the bar for insured products.

If you have additional questions, please contact me at 202-784-4580.

Very truly yours,

Mila Kofman, J.D.,
Associate Research Professor.

Mr. SPECTER: For the purpose of further clarifying congressional intent of S. 558 and its application to state law and specifically Pennsylvania Act 106, will the senior Senator from Massachusetts and the senior Senator from New Mexico yield for questions from Senator Casey and myself?

Mr. KENNEDY: I will be happy to do so.

Mr. DOMENICI: As will I.

Mr. SPECTER: I thank Chairman Kennedy and Senator Domenici. Why doesn't the Mental Health MHPAEA have its own preemption provision?

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Mr. KENNEDY: It is our intention to establish a Federal floor and not a Federal standard or Federal caps. Thus, we decided to use the already-existing language and standard found within part 7 of ERISA, which is where the current mental health parity law already resides, and where S. 558 will be codified. This law contains the narrowest possible preemption language, and is meant to preempt only those state laws that are less beneficial to consumers and insured, from the standpoint of the consumer and insured, than this new Federal law.
Mr. CASEY: The Health Insurance and Portability Accountability Act, HIPAA, preemption standard that will apply prevents State laws that ``prevent the application of requirements of this part," which refers to part 7 of ERISA. Do the medical management provisions of section 712A(b) constitute ``requirements of this part" that might preempt State laws under this standard?

Mr. DOMENICI: No. Section 712A(b) says that managed care plans ``shall not be prohibited from" carrying out certain activities. It does not require them to do so, and this is not a ``requirement of this part." This section recognizes that plans have flexibility. It is not our intention to preempt any State laws that regulate, limit, or even prohibit entirely the medical management of benefits. That is one of the reasons we are using a preemption standard--the existing HIPAA standard that so clearly does not preempt such a law.

Mr. SPECTER: Would a State law that establishes a physician or psychologist's certification, as the only lawful prerequisite to managed care coverage of a particular treatment, be preempted?

Mr. KENNEDY: Such a law is not preempted, and it is not our intention to preempt any such law.

Mr. CASEY: What about a State law requiring insurers or managed care companies to cover an entire continuum of care?

Mr. DOMENICI: Mr. President, it is my understanding that such a law would not be preempted. S. 558 is a Federal floor, and nothing in such a State law Senator Casey describes would prevent the application of any requirements of part 7 of ERISA.

Mr. SPECTER: Would State laws that place coverage decisions squarely in the hands of treating clinicians be preempted?

Mr. KENNEDY: Absolutely not.

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> Mr. CASEY: Focusing specifically on Pennsylvania, as you may be aware, the citizens of Pennsylvania just received a significant court victory from the Commonwealth Court, upholding a Pennsylvania law that was previously mentioned here, Pennsylvania Act 106. That State law and the recent decision in The Insurance Federation of Pennsylvania, Inc. v. Commonwealth of Pennsylvania Insurance Department, removes managed care barriers to addiction treatment. What effect will S. 558 have on that State law, or on State efforts to enforce that law or to find remedies for violations of that law?
>
> Mr. KENNEDY: This bill would have no effect upon that law.
>
> Mr. CASEY: Would any State laws be preempted?
>
> Mr. DOMENICI: Yes, State law requirements that would prevent the application of a requirement of S. 558 by, for example, endorsing a less consumer-friendly level of coverage or benefits. For example, a State law that prohibited an insurance company from selling policies providing for full parity in coverage for mental health services and medical/surgical services would be preempted.
>
> Mr. CASEY: Would the current legislation, S. 558, have any effect on any provisions of Pennsylvania Act 106, or on any State efforts to enforce provisions of that law or to find remedies for violations of any provisions of that law?
>
> Mr. KENNEDY: It would have no effect. Pennsylvania's Act 106 is an example of the kind of consumer protection law that is not preempted by the federal floor created in S. 558.

153 Cong. Rec. S10883-85 (August 3, 2007).

This urgent commitment to protecting Pennsylvania's Act 106 – and other more-favorable state laws – from preemption by S. 558 is also delineated in a March 30, 2007 letter to Senators Specter and Casey from Pennsylvania's delegation to the House of Representatives.

For present purposes, the point of the colloquy is not so much that the preemption problem was fixed – in fact, troubling ambiguities regarding preemption remained and would not

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be cleared up until later – but rather that the intention of the MHPAEA's sponsors and champions was always to preserve state laws that protected consumers.

The version of S. 558 as sent over to the House no longer included an express preemption provision, but it did include language that explicitly endorsed the use of managed care. This could have given rise to arguments that state laws were preempted under the preemption standard already in place within the MHPAEA – in other words, it could have given rise to an argument that state laws "prevent the application of a requirement" that managed care companies be permitted to use utilization review and all the other tools and techniques of managed care. Under this analysis (so the argument would go) state laws such as Pennsylvania's Act 106 that prohibit the application of utilization review would have been preempted. Senators Specter, Casey, and Kennedy believed that the risks posed by this argument were fairly remote. Other experts disagreed and thought the risk of preemption (and of litigation over preemption) was very real.

For present purposes, the more important point is that the disagreement between the House and the Senate regarding preemption was not over the goal of the MHPAEA but rather over whether the Senate's language achieved that goal. There can be no dispute that when the bill left the Senate in 2007, it was a bill that was intended to preserve state laws as a floor.

B. The Evolution of H.R. 1424 in the House

1. Consideration by House Committees

In 2007, H.R. 1424 was referred to three different committees: the Committee on Education and Labor; the Committee on Ways and Means; and the Committee on Energy and Commerce. Each one of these Committees produced a report that confirms that preemption was

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considered, discussed, and debated. Each of these Committees recommended that the bill pass, as amended and as reported out of Committee. In each Committee, legislators favoring the preservation of more favorable state laws won, and legislators favoring broad preemption lost.

(a) Committee on Education and Labor

As reported out by the Committee on Education and Labor, H.R. 1424 contained both (a) language expressly authorizing the use of managed care techniques and (b) language expressly saving state laws from preemption. These provisions went hand in hand: the presence of language expressly authorizing managed care techniques made a savings clause necessary. Otherwise, the bill would have invited the argument that state laws that limited the use of managed care techniques "prevent[ed] the application of" the federal law and were therefore preempted.

The bill as reported out of Education and Labor contained the following language:

> (7) Construction. – Nothing in this section shall be construed to limit a group health plan (or health insurance offered in connection with such a plan) from managing the provision of medical, surgical, mental health or substance-related disorder benefits through any of the following methods:
>
> (A) the application of utilization review;
> (B) the application of authorization or management practices;
> (C) the application of medical necessity and appropriateness criteria; or
> (D) other processes intended to ensure that beneficiaries receive appropriate care and medically necessary benefits for covered services.

H.R. Rep. No. 110-374, pt. 1, at 4. H.R. 1424 as reported out of the Committee on Education and Labor also included, as a necessary counterpart to this language, a provision that expressly preserved, and saved from preemption, state laws:

> (f) Preemption, Relation to State Laws.

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> (1) In General - This part shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any consumer protections, benefits, methods of access to benefits, rights, external review programs, or remedies solely relating to health insurance issuers in connection with group health insurance coverage (including benefit mandates or regulation of group health plans of 50 or fewer employees) except to the extent that such provision prevents the application of a requirement of this part.
>
> (2) Continued Preemption with Respect to group health plans. Nothing in this section shall be construed to affect or modify the provisions of section 514 with respect to group health plans.
>
> (3) Other State Laws. – Nothing in this section shall be construed to exempt or relieve any person from any laws of any State not solely related to health insurance issuers in connection with group health coverage insofar as they may now or hereafter relate to insurance, health plans, or health coverage.

Id. at 5.

The Education and Labor report includes an extensive discussion of the need to strike a balance between the important role that states play in protecting their citizens and the demands of federal legislation. Much of this discussion appears in the context of the Committee's discussion of a rejected amendment that sought to replace H.R. 1424 with a version of the Senate bill, S. 558. Within the Committee on Education and Labor, this proposed substitute was referred to as the "Kline Substitute." As the Committee on Education and Labor explained in its report:

> [T]he Kline Substitute differed from H.R. 1424 in its preemption of state health care laws. The Majority and minority face fundamental differences on the issue of preemption. Historically, states have had the primary responsibility for protecting the public health of their citizens. States have regulated the provision of insurance, including health insurance, for hundreds of years. In fact, even into current times, the insurance community has

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> preferred state regulation over federal regulation of insurance practices.
>
> . . . .
>
> Through a federal standard that is a floor, not a ceiling, Congress has recognized that state policymakers may determine that to protect patients in state-regulated plans, a stronger set of standards are necessary than those provided in federal law. In fact, many states now require insurance companies to cover mental health services. This bill recognizes and encourages states to enact stronger consumer protections.
>
> In addition to benefit requirements, many states have set standards to improve the quality of coverage to ensure that health insurance actually works for people who need it, while establishing rules to combat abusive practices by some in the health insurance industry. States have used a myriad of strategies to accomplish that, including patient protections and standards for medical management. ***Nothing in this bill is intended in any way to affect those (or future) state efforts.***

Id. 22. It is crystal clear that the Committee on Education and Labor intended to leave those state-law protections intact. The bill as reported out of the Committee did precisely that.

In the Dissenting Views section of the Education and Labor report, dissenters objected to this savings language on the grounds that it frustrated their stated goal of encouraging national uniformity. The dissenters also argued that in their view, the savings clause authorized states "to enact 'greater consumer protections, benefits, methods of access to benefits, rights or remedies' than the provisions set out in the legislation. . . . A further concern is that virtually limitless state law remedies could be available to participants in insured plans for disputes involving mental health benefits." *Id.* at 80. According to dissenters, H.R. 1424 as reported out of the Committee

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on Education and Labor would not only preserve states' rights; it would expand them considerably. The dissenters lost.

(b) Ways and Means

The Ways and Means Committee reported out a version of the bill that also contained a savings clause.

> (f) Preemption, Relation to State Laws.
>
> (1) In General. – Nothing in this section shall be construed to preempt any State law that provides greater consumer protections, benefits, methods of access to benefits, rights or remedies that are greater than the protections, benefits, methods of access to benefits, rights or remedies provided under this section.
>
> (2) ERISA. – Nothing in this section shall be construed to affect or modify the provisions of section 514 with respect to group health plans.

H.R. Rep. No. 110-374, pt. 2, at 4. As with the other two House committees, dissenters objected on the grounds that the bill would change the existing ERISA preemption regime and give states new rights to enact remedies. According to the dissenters, the bill would "allow[] state enforcement action and remedies to be established, which would apply to mental health benefits but not other medical benefits. Under current law, plans have operated under the rights and remedies set forth under ERISA for three decades." *See also id.* at 55 ("Under H.R. 1424, states would be authorized to enact 'greater consumer protections, benefits, and methods of access to benefits, rights, or remedies" than the provisions set forth in the legislation. This change would create a new legal basis to allow states to take action against ERISA plans.")

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An amendment was offered that would have replaced H.R. 1424 with the language of the S. 558 (and its broader preemptive effects); this was defeated. H.R. Rep. No. 110-374, pt. 2, at 21. An amendment was offered that would have placed explicit medical management provisions within the bill; this was defeated also. *Id.* at 20.

In short, those favoring broad preservation – expansion even – of state rights prevailed; those favoring federal preemption lost.

(c) Energy and Commerce

Preservation of state laws also figured prominently in the Committee on Energy and Commerce's consideration of the bill. As reported out, the bill contained a preemption provision identical to the one contained in the bill reported out of Ways and Means.

The dissenters quoted at length from a joint letter submitted by a wide coalition of industry groups, challenging the bill in its current form because it "failed to eliminate . . . the authority for states to establish new remedies." See H.R. Rep. No. 110-374, Pt. 3, at 58 (quoting a joint letter signed by the National Retail Federation, Aetna, the American Benefits Council, the U.S. Chamber of Commerce, the Blue Cross Blue Shield Association, the National Association of Health Underwriters, the National Association of Wholesalers-Distributors, the Society for Human Resource Management, the National Association of Manufacturers, the Retail Industry Leaders Association, the National Business Group on Health, the National Restaurant Association, and the Corporate Health Care Coalition). The dissenters lost.

(d) House Passage

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H.R. 1424 was passed on March 5, 2008. 154 Cong. Rec. 1274 et seq. (March 5, 2008). During floor debate in the House on March 5, protection of state laws arose again as a subject of debate. H.R. 1424 was criticized because it granted too many rights to states; the Senate version of the bill was extolled by some because it expressly protected managed care practices. Representative McKeon criticized the House version of the bill because it "will increase litigation against ERISA plans by permitting application of State remedies to federally mandated benefits." 154 Cong. Rec. H1292 (March 5, 2008). Representative Hulshof criticized the bill because it "contains no provision to protect medical management practices . . . ." *Id.* at H1302.

The bill as passed on March 5 included the savings provision reported out of Education and Labor. As set forth above, that language expressly saved state laws from preemption, "except to the extent that such provision prevents the application of a requirement of this part." H.R. 1424, 110th Cong. (2008) (as passed by the House on March 5, 2008); § 102(h); *see also* H.R. Rep. No. 110-374, pt. 1, at 5.

III. The MHPAEA in 2008

The MHPAEA as eventually passed and signed into law does not contain an express preemption provision that eliminates more favorable state laws, and does not contain an express endorsement of managed care that could threaten more favorable state laws. There is nothing in the statute that evidences an intention to disturb or displace more-favorable state laws.

In the face of this silence, there can be no doubt that the MHPAEA leaves intact the previous ERISA preemption regime. The only laws that are preempted are those that "prevent the application of a requirement of" the MHPAEA. By definition, more favorable state laws

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cannot prevent the application of the MHPAEA, because the MHPAEA requires that financial requirements and treatment limitations be "no more restrictive than" the corresponding medical/surgical requirements and limitations. State laws that require more generous benefits cannot, by definition, conflict with this federal requirement.

The bill that became law fully reflects the vigorous debate surrounding preservation of more favorable state laws. Those favoring protection of state laws won, those favoring preemption lost, and the MHPAEA fully honors the drafters' intentions to preserve state law. To put it another way, the MHPAEA's structure and substance reflect an intentional choice to preserve state laws. It is important that any regulations, and any proposed regulations, cast no doubt on this clear state of affairs.

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