

Employers on Telehealth: Government Standing in the Way

Remove antiquated, counterproductive rules to unleash real markets, better care, and greater coverage via telemedicine

**Statement for the Record by The ERISA Industry Committee
to the
Committee on Health, Education, Labor & Pensions (HELP)
U.S. Senate**

Hearing:

“Telehealth: Lessons from the COVID-19 Pandemic”

June 17, 2020

Introduction and About The ERISA Industry Committee (ERIC)

Chairman Alexander, Ranking Member Murray, and members of the Committee thank you for this opportunity to submit a statement for the record on behalf of The ERISA Industry Committee (ERIC) for the hearing entitled, *“Telehealth: Lessons from the COVID-19 Pandemic.”* Our key finding is that, while telehealth is one of the only areas in health care with a vibrant, functioning market, that market is severely curtailed by government rules, and some of the special interest proposals in Congress would go in the exact wrong direction. ***We have included our top three recommendations to improve telehealth for private sector workers and their families.***

ERIC is a national nonprofit organization exclusively representing the largest employers in the United States in their capacity as sponsors of employee benefit plans for their nationwide workforces. ERIC’s member companies voluntarily provide benefits that cover millions of active and retired workers and their families across the country. With member companies that are leaders in every sector of the economy, ERIC is the voice of large employer plan sponsors on federal, state, and local public policies impacting their ability to sponsor benefit plans and to lawfully operate under ERISA’s protection from a patchwork of different and conflicting state and local laws, in addition to federal law.

You are likely to engage with an ERIC member company when you drive a car or fill it with gas, use a cell phone or a computer, watch TV, dine out or at home, fly on an airplane, visit a bank or hotel, benefit from our national defense, receive or send a package, go shopping, or use cosmetics.

ERIC’s member companies have been pioneers in offering robust telehealth benefits. Telehealth enables our beneficiaries to obtain the care they need, when and where they need it, in an affordable and convenient manner. It reduces the need to leave home or work and risk infection at a physician’s office, provides a solution for individuals with limited mobility or access to transportation, and has the potential to address provider shortages and improve choice and competition in health care. Nearly every ERIC member company offers comprehensive telehealth benefits and did so long before the COVID pandemic. As in most aspects of health insurance and value-driven plan design, self-insured employers have been the early adopters and drivers of telehealth expansion. With the onset of the pandemic, ERIC’s member companies led the way in rolling out telehealth improvements – held back only by various federal and state government barriers.

**Federal Actions Greatly Improve Telehealth for Medicare Beneficiaries...
and Leave the Private Sector Behind**

Early on in the pandemic, the Administration and Congress quickly realized that unnecessary barriers to telehealth care were going to be a major problem for Medicare beneficiaries. Many of those individuals were quarantined or in areas undergoing lockdowns. Many were in different states and regions that were experiencing peaks in hospital and provider capacity. And Medicare's own coverage of telehealth was nowhere near broad enough to replace much of the care that would otherwise be foregone due to medical facilities being closed to non-COVID patients.

The Administration and Congress acted quickly and decisively:

- Medicare promptly eliminated state licensure barriers, allowing a willing and qualified provider to see a willing Medicare patient via telehealth, without regard to their locations;
- Medicare promptly eliminated state telehealth barriers, such as requirements that patients travel to specific originating sites before they can access telehealth, limitations related to modality (video-only requirements, etc.), requirements that the provider and patient have a pre-existing relationship, and more; and
- Medicare expanded coverage to include more services for more patients, covered via telehealth.

These changes massively improved telehealth benefits for Medicare beneficiaries, instantly unleashing telehealth's vast potential to fill the voids created by the pandemic and its response – and paving the way for permanent improvement. In fact, in a [June 15 letter](#), 30 U.S. Senators (including numerous members of the HELP Committee) called for making these changes permanent.

Unfortunately, very few improvements have been made for patients in the private sector not covered by Medicare, despite employer efforts to expand and improve telehealth. For private sector patients:

Care is still limited in many states only to a patient and provider both physically located in that state.

Many states have failed to join interstate medical licensing compacts that provide reciprocity for mental health and other medical providers in other states, expanding the network of available providers for state beneficiaries to access. Congress waived these requirements for Medicare and should do the same for private sector beneficiaries, or otherwise effectuate interstate licensing. While some states have signed limited interstate reciprocity compacts, to recognize limited practice by limited types of providers, many have provided little or no licensure relief. No licensure relief helps some of the state's providers by essentially outlawing competition from out of state providers, but it stymies others from expanding their practice. The failure to recognize interstate medical licensure reciprocity for telehealth means that for many patients, the state government has banned them from logging on to their computer or smartphone and connecting with a readily available and qualified provider.

Many states still impose unnecessary barriers to the use of telemedicine. These barriers can range from requiring that a patient travel to a specific telehealth site before they can connect to a provider, limiting telehealth to specific technologies (for instance, requiring two-way video which may be out of reach by those in rural or other areas without broadband access or the sophistication to work it, outlawing the use of “portals” and store-and-forward communications particularly helpful to identify skin conditions, pink eye, etc.), and mandating that a patient can only do a telehealth visit with a doctor they already have a relationship with, and other barriers. While these barriers may be imposed under the guise of imposing a standard of care or protecting patients, these requirements really serve to stymie telehealth, driving more care to (more expensive) in-person settings, and preventing wider telehealth adoption.

Rules imposed by the federal government prevent employers from offering telehealth to many beneficiaries. Employers cannot offer telehealth as an employee benefit, separate from health coverage, because the previous Administration deemed telehealth benefits to be “a plan” for the purposes of the Affordable Care Act (ACA) rules. This determination requires telehealth benefits to be paired with a full medical benefit that meets all of the different ACA requirements – 1st-dollar coverage of vaccines, meet essential health benefit and annual limit rules, and much more. Because telehealth is, by definition, limited and conducted remotely, it simply cannot meet all of the ACA requirements on its own. In fact, employers often use a separate vendor to design and administer their telehealth benefits, rather than the insurance company or third-party administrator that runs their full medical plan. The result is that telehealth **cannot be offered standalone** to anyone not enrolled in the full medical plan, which effectively bans employers from extending telehealth to all populations, including:

- Full-time employees who are not enrolled in the medical plan, or employees’ family members, if the employee is on a self-only plan;
- Part-time employees ineligible for the medical benefit;
- Seasonal, agricultural, or other temporary workers;
- Interns, trainees, and the like; and,
- New employees on a waiting period for the full medical plan, among others.

ERIC notes that this is a serious anomaly – perhaps the first time in living memory that beneficiaries of government programs have more access, more flexibility, and in some ways, better benefits than private sector workers on employer-sponsored plans. Employers are generally the pioneers in health benefits, experimenting with and leading the way in driving value, innovation, quality, and flexibility for patients. **Now, because of government barriers, private sector workers are being left behind.**

We will note one considerable improvement in telehealth that Congress has made for private sector workers: individuals enrolled in a high-deductible health plan (HDHP) with a health savings account (HSA) can now benefit from 1st-dollar coverage of telehealth, thanks to the enactment of the “*Telehealth Expansion Act*” (S. 3539) by Senator Steve Daines (R-MT), which was passed into law as part of the CARES Act (H.R. 748). Unfortunately, this telehealth improvement is time-limited and set to expire at the end of 2021. **We urge Congress to make the *Telehealth Expansion Act* permanent. And we note, this legislation was in the jurisdiction of the Senate Finance Committee.**

Key Steps the HELP Committee Must Take to Improve Telehealth

The solutions to all of these problems are within the HELP Committee's jurisdiction, and employers have provided technical assistance to Congress to develop solutions. We urge the Committee to include in the next COVID legislative package provisions to address each of these barriers to care for private sector workers and put them on more equal footing with Medicare beneficiaries.

First, Congress should enable providers to practice telehealth across state lines. Congress has two avenues to achieve interstate licensure reciprocity for telehealth providers – either simply require that states recognize medical licenses from other states for telehealth purposes, or create a new comprehensive interstate compact with sufficient incentives to ensure widespread adoption by states. A provider who has achieved a medical license in their own state should be permitted to practice on the internet, without states blocking them from seeing patients – and likewise, a patient who goes online to see a doctor, should not be prevented by state rules from seeing a qualified provider who is licensed in another state. States should retain their rights to determine whether providers licensed in that state will be qualified to write prescriptions, or otherwise develop a scope of practice. However, if a provider in another state has been deemed qualified, a state should not be permitted to prevent patients from seeing that provider or prevent the provider from operating at the top of their license in that interaction.

Congress has several options to address concerns related to providers' scope of practice and similar issues; these issues should not serve as an impetus to do nothing. Instead, immediate action should be taken to ensure that patients who use telehealth will have the best chance possible of finding a provider ready and willing to see them on the other end. This will also enable more competition in telehealth, creating incentives for providers to improve quality and affordability for patients. At a time when 40 million Americans have lost their jobs, relief for patients is sorely needed.

Second, Congress should establish a simple set of federal standards for telehealth, eliminating state barriers. We can think of no better example of interstate commerce than a willing doctor and willing patient connecting electronically via the internet to do a telehealth visit. While it is entirely appropriate for a state to place standards to regulate the practice of medicine at brick-and-mortar medical facilities within the state's geographic boundaries, it makes little sense to have 50 different rules for telehealth (practiced remotely on the internet or via phone) depending on where a provider or patient may be located at any given moment.

And Congress can develop a set of rules that protects patients while maximizing flexibility and care, rather than some of the current protectionist rules that serve to block patients from care on the state level. The new set of rules should:

- Allow telehealth to establish a patient-provider relationship through an initial telehealth visit;
- Apply the same medical standard of care used for in-person to telehealth visits;
- Ensure that reimbursement is privately negotiated between providers and payers;
- Encourage interstate practice among providers;

- Promote continuity of care by encouraging telehealth providers to coordinate with a patient's primary care provider;
- Implement "technology-neutral" rules for telehealth, to "future-proof" rules for advances in technology and best practices, and eliminate discrimination for patients who may not have access to broadband internet;
- Eliminate all "originating site" requirements that arbitrarily limit patient access to telehealth;
- Preserve the same informed consent requirements for patients in telehealth that apply in person; and
- Ensure that telehealth providers may prescribe medication to patients, with reasonable limits.

This simple, streamlined set of rules will provide clarity to providers and maximize access for patients.

Third, Congress should designate standalone telehealth as an "excepted benefit" so that it can be offered to more patients. This is the way Congress treats other "add-on" benefits like vision, dental, long-term care, cancer-only plans, hospital indemnity insurance, and other benefits that are health-related but do not constitute a full medical plan. It would be a simple change by adding the word "telehealth" into the appropriate sections of the Health Information Portability and Accountability Act (HIPAA), the Employee Retirement Income Security Act (ERISA), and the Internal Revenue Code (IRC).

Doing so would not affect an employer's responsibility to offer minimum essential coverage to employees, nor would it weaken an individual's responsibility to enroll in such. Employers or insurers could not swap out telehealth, which is limited in scope and closer to a supplement than a full medical plan, for a full medical benefit. It would simply open up the ability for employers to offer telehealth benefits to millions of patients who currently are not allowed – by Congress – to access those benefits. There is precedent for Congress expanding the definition of excepted benefits (e.g., Congress previously acted to allow "limited duration long term care" benefits to be offered outside a medical plan.

In a recent survey, more than 25 percent of ERIC member companies stated that they would expand telehealth offerings if Congress permitted it to be offered as a standalone benefit. This represents billions of dollars in private sector money that is currently being left on the table, and millions of Americans who could have access to telehealth coverage and care, if only the government would get out of the way.

**Counterproductive, Protectionist, Anti-Market Proposals:
Worse Than Doing Nothing**

Meanwhile, some stakeholders are asking Congress to implement telehealth changes that would go in the exact opposite direction, eliminating competitive markets, promoting low-value care, and reducing the potential for telehealth to be transformational for the medical system.

For instance, the "*Health Care at Home Act*" (H.R. 6644) would mandate ERISA health plans to cover telehealth for any service that is covered in person, as well as mandate that telehealth services be

reimbursed at the same amount as in-person services. Both of these changes fail to expand and improve telehealth and instead would uproot the blossoming market.

Large employers that offer health coverage through ERISA plans make decisions on services to cover based on clinical guidelines, evidence, and best practices. We learn from experience, advice from medical professional societies, bodies that evaluate quality and efficiency in health care, and other sources, and then use this information to develop benefits that drive the most value for our beneficiaries. The prospect of government imposition of a sweeping coverage mandate within ERISA plans would be an extreme break from precedent, not to mention a counterproductive endeavor that would inject more unproven and potentially low-value care into employer-sponsored coverage. This, in turn, would reduce the quality of coverage, while increasing costs for participants. It should be the responsibility of ERISA plan sponsors, not the government, to determine what care is appropriate to cover via telehealth settings.

Under current law, providers are free to negotiate telemedicine rates with payers – which has given rise to a thriving market in which competition drives cost efficiency, value, quality, and innovation. So, it should come as no surprise that certain provider groups are eager to destroy this market, and instead set reimbursement by government fiat. It is wholly inappropriate and unprecedented for the federal government to mandate payment rates between two private parties. **In fact, the same provider groups advocating for this new government interference in private markets are simultaneously lobbying to defeat legislation sponsored by this Committee to eliminate surprise medical bills under the guise of opposing “government rate setting.”**

Further, telehealth is cheaper than in-person care. Telehealth enables providers to treat more patients, more efficiently, with less overhead cost, less staff needed, and fewer expenses associated with operating brick-and-mortar retail health settings. This has enabled telehealth providers to offer more competitive rates than in-person, which has been in no small part responsible for the telehealth renaissance. This has caused many employers to adopt and offer telehealth benefits long before the COVID emergency and driven the continuing exploration and innovation that serves to produce ongoing improvements for patients. Losing this successful competitive market would be a significant setback for patients and employers, and ultimately for up-and-coming providers who otherwise could cultivate opportunities in the telehealth space.

Conclusion

Thank you for this opportunity to share our views with the Committee. The ERISA Industry Committee and our member companies are committed to working with Congress to expand and improve telehealth for millions of patients in the private sector, and to defeat proposals that would impose government mandates that make the situation worse, not better. We look forward to working with you to develop and perfect telehealth proposals that can be included in the next COVID legislative package.