Employers Meeting the Moment: Improving Access to Behavioral and Mental Health Care

Statement for the Record by
The ERISA Industry Committee (ERIC) to the
U.S. Senate
Committee on Health, Employment, Labor, and Pensions

Hearing:

"Examining Our COVID-19 Response: Using Lessons Learned to Address Mental Health and Substance Use Disorders"

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Introduction and About ERIC

Committee Chair Murray and Ranking Member Burr thank you for this opportunity to submit a statement for the record on behalf of The ERISA Industry Committee (ERIC) for the hearing entitled "*Examining Our COVID-19 Response: Using Lessons Learned to Address Mental Health and Substance Use Disorders."* The ERISA Industry Committee – ERIC for short – is a national nonprofit organization exclusively representing large employers that provide health, retirement, paid leave, and other benefits to their nationwide workforces. With member companies that are leaders in every sector of the economy, ERIC advocates on the federal, state, and local levels for policies that promote flexibility and uniformity in administering their employee benefit plans.

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, enjoy a beverage, 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 member companies voluntarily offer comprehensive health benefits to millions of active and retired workers and their families across the country. Our members offer these great health benefits to attract and retain employees, be competitive for human capital, and improve health and provide peace of mind. On average, large employers pay around 85 percent of health care costs on behalf of our beneficiaries – that would be a gold or platinum plan if bought on an Exchange. But we don't buy or sell health insurance; these plans are self-insured. In other words, ultimately it is the company that is on the hook for the vast majority of the costs of our patients' care. Prior to COVID-19, there were an estimated 181 million Americans who got health care through their job, with about 110 million of them in self-insured plans like ours.

Employers like ERIC member companies roll up their sleeves to improve how health care is delivered in communities across the country. They do this by developing value-driven and coordinated care programs, implementing employee wellness programs, providing transparency tools, and adopting a myriad of other innovations that improve quality and value to drive down costs. These efforts often use networks to guide our employees and their family members to providers that offer high value care. ERIC member companies' ERISA plans are not subject to many of the requirements that apply to fully-insured products such as those sold on an ACA Exchange, because employers do not profit from health benefits – in fact, they're a huge expense.

The entire purpose of these benefits is to meet the needs of our plan beneficiaries. ERIC has noted an increasing need for mental and behavioral health care among our employees and their families, especially with the advent of the COVID-19 pandemic, and it is often far too difficult for them to obtain that care. To complicate matters further, the opioid crisis showed us that merely providing access to various treatments is not enough – plan sponsors need to work to drive quality and high-value care in this space. And, even as Congress and the private sector worked to get the opioid crisis under control, the COVID-19 pandemic hit, causing a new wave of demand for mental health care and substance abuse treatment, in an environment that made it even harder than usual to obtain such care.

Many employers' initiatives in mental health and combating the opioid epidemic have been disrupted due to the urgency to respond to the pandemic. Some even had to suspend their outreach, health campaigns, and projects early last year.[1] For example, many companies have formed state alliance groups in developing opioid education campaigns aimed at parents and caregivers, and these programs had to alter their approach strictly to a virtual setting, which took some time. Even before the pandemic, employers offered employees educational sessions on identifying and addressing drug activity. To limit employee contact, these sessions were delayed until virtual platforms were set up, and the lack of in-person contact proved to be a setback in identifying at-risk employees through this setting.

Prior to the pandemic, employers, including regional and national business groups, had taken actions to protect employees from prescription opioid overdose with a focus on the best ways to address pain management. The Midwest Business Group on Health has developed creative and effective strategies and recommendations for pharmacy benefit managers (PBMs) and health plans with an interdisciplinary approach such as promoting coordinated care for those with chronic pain, re-evaluating coverage options, and setting quantity limits.[2] Resolving the crisis takes multiple stakeholders, engagement, and action-oriented interventions to change drug behavior. Toolkits that evaluate workplace drug and alcohol policies along with policy rationale, goals, expectations, and compliance allow employers to benchmark and stay a step ahead in supporting and retaining employees who wish to recover and continue working. These resources, such as one issued by the Kentuckiana Health Collaborative, lay out best practices for helping workers receive the care that they need and transforming workforce culture.[3]

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[1] Weiner, Aaron. "An Epidemic During a Pandemic". National Safety Council. August 10, 2020. https://www.nsc.org/safety-first-blog/an-epidemic-during-a-pandemic

[2] Midwest Business Group on Health. "Addressing Pain & Opioid Abuse Strategies". https://www.mbgh.org/www/resources/employertoolkits/painmanagement/pain-management

[3] Kentuckiana Health Collaborative. "Opioids and the Workplace: An Employer Toolkit for Supporting Prevention, Treatment, and Recovery". Version 1.1. https://khcollaborative.org/wp- content/uploads/2019/07/Opioids-and-the-Workplace-1.1-1.pdf

Tools such as these have been used prior to the pandemic and will continue to be used during the current crisis.

And employers have gone beyond opioids mitigation, seeking to provide more assistance and support to employees on all manner of behavioral and mental health fronts. From telepsychiatry programs, to expansion of worksite health centers, to partnering with community groups and diversion programs, employers have led from the front, seeking to fill a gap they saw in existing benefits. With the goal of ensuring access to quality, affordable care that meets beneficiaries' needs, employers have innovated to create solutions where none existed before.

As states sought to mitigate virus transmission by enacting social distancing and lockdowns, employers saw significant upticks both in mental health claims and in self-reported incidences of anxiety, loneliness, depression, and more. We saw an increase in deaths of despair[4], some of the ground we had gained on the opioid crisis eroded as substance use disorders ticked back up[5], and some sources even report that marriage rates dropped and breakups increased.[6] Employers had to act, and they did. For example, employers working with one large insurance carrier added prescription digital therapeutics for substance use and opioid use disorder to their benefits packages, and provided telephonic medical concierge services so employees could get real-time help. Another employer involved in engineering partnered with a renowned health care think tank to explore forward-thinking health interventions.

COVID-19 also caused many companies to promote, make more accessible, or increase their employee assistance program (EAP) benefits. The National Safety Council found that many employees were unaware of their EAP benefits or unsure how to access them, so companies made the EAP information front and center online, and launched communications campaigns (including emails and short video instructions) on how to use the EAP, ultimately increasing usage.[7] Companies are also encouraging their employees to use their paid time off, and strongly encouraging their managers and supervisors to set examples for their direct reports by prioritizing mental health. While these are only a few examples of what employers have done to help their workforce during this critical time, employers have taken a diverse array of steps to help, because they understand that more needs to be done in tackling the crisis head on.

We commend the Committee for holding today's hearing, to discuss solutions that could start to turn the tide, address shortages, improve access and affordability, and ultimately ensure that a patient who needs mental or behavioral health care is able to get that care when and where they need it.

[4] Mulligan, Casey B. "Deaths of Despair and the Incidence of Excess Mortality in 2020". National Bureau of Economic Research. December 2020. https://www.nber.org/papers/w28303
[5] Centers for Disease Control and Prevention. "Overdose Deaths Accelerating During COVID-19". December 17, 2020. https://www.cdc.gov/media/releases/2020/p1218-overdose-deaths-covid-19.html
[6] Brownwell, Taylor. "Divorce Rates and COVID-19" National Law Review. October 16, 2020. https://www.natlawreview.com/article/divorce-rates-and-covid-19
[7] National Safety Council. "State of Response: The Future World of Work". https://nsccdn.azureedge.net/nsc.org/media/site-media/docs/workplace/safer/state-of-response-future- world-of-work-report120820.pdf

Recognizing the Problem: The Need to Address Mental and Behavioral Health

Unless you live in certain high-population urban centers, the likelihood is that you have a shortage of mental and behavioral health providers. This leads to myriad problems, which no doubt patients relay to members of Congress on a regular basis. For instance, many providers eschew insurance networks, since they can make more money without a prohibition on balance billing (due to lack of competition). Others move to a cash-only model that greatly reduces their administrative burdens, but obviously is a significant hardship for patients. For those patients who do stay in-network, significant wait times can exacerbate mental health issues. Numerous ERIC member companies have reported that they offer additional benefits such as employee assistance programs (EAPs) specifically to increase access to mental health professionals, but even so, the wait times can still exceed four weeks.

But the problem is much greater than simply, "not enough providers." Many employers are deeply concerned about quality and efficacy in the mental and behavioral health space. When the opioid crisis was at its worst, employers were frustrated that our beneficiaries often received 90 days' worth of oxycontin (for example), when a 3-day fill would have been more than enough. In response, employers directed their vendors to limit fills, divert employees to other medications and treatments, and implement more gatekeeping such as prior authorization. Employers were aghast to learn that their plans were reimbursing certain facilities that may actually have been making the problem worse for their beneficiaries, or even purposely keeping them hooked. Some plan sponsors reacted by curtailing their networks, or even by eliminating out-of-network coverage completely. These plan design changes were necessary to protect the plans and the participants, but there are obvious negative externalities for those seeking care.

Meanwhile, patients are pitched on treatments of a questionable nature. For example, programs that take a patient camping, for whopping prices in the thousands of dollars per day. Or in-patient programs to address eating disorders, which did not appear to have any record of success (but again, command extraordinary prices). Maybe these treatments are the right choice in some cases, but without more data and evidence, how could a plan fiduciary justify coverage?

And to complicate matters even more, the COVID-19 pandemic hit. COVID-19 caused immense pressure on employers, their workforce, and families, as they adjusted to social distancing, business operation changes, and learning at home over the past year. During this period, about four in ten adults in the United States have reported symptoms of anxiety or depressive disorder, an increase from one in ten adults reported in 2019.[8] Of the 30 million people diagnosed with COVID-19, the Centers for Disease Control and Prevention (CDC) continues to evaluate the long-term effects of the virus and whether symptoms such as fatigue, depression, anxiety, and multi-organ effects will subside.

With so many Americans diagnosed with COVID-19, the long-term physical and mental effects of the pandemic must be addressed by all stakeholders. Employers recognize that mental and behavioral health access needs improvement, and are being proactive in providing mental health, behavioral health, and substance use disorder services during the COVID-19 pandemic and beyond. Employers are part of the solution, innovating new ideas to improve access, quality, and affordability.

[8] U.S. Census Bureau, Household Pulse Survey, 2020.

Part of the Solution: How Employers Are Supporting Our Beneficiaries

Employers have quickly and efficiently set up new programs to address the mental health needs of their workforce and their families, with many establishing online mental health campaigns to increase awareness and promote overall wellness. These campaigns included self-guided resilience resources and free mobile apps to build emotional resilience, improve sleep, and manage stress. While these platforms are user-friendly and individual-based, employers are also setting up interactive and inclusive virtual sessions to discuss mental health and mindfulness between medical staff and work teams. These sessions have proven to be important to employees as they stay connected while physically distancing. And many employers that offer one-on-one counseling with a company counselor or through external clinicians are increasing access by adding virtual daily group counseling sessions for parents, adult caregivers, and those caring for family members with disabilities.

When COVID-19 caused many employers to shift to remote work or reduced employee presence onsite, many worksite clinics went virtual, offering mental and behavioral health via telehealth. Some clinics expanded eligibility to other employees in the same state, who may not be based at the same site. This helped create continuity for employees undergoing care, and a new access point for many others.

Employers are continually discussing available support resources and want to do more to help their workforce, even in addressing substance abuse and opioid addiction. Companies have made a simple change to their prescription drug plans mandating that any first-time prescription for painkillers be prescribed for only seven days. This change was done to reduce the chances of addiction. One company that initiated the change has shown that fewer than one in ten employees seeks to extend the prescription beyond the seven days. Others have been more aggressive in their approach, requiring employees to attend educational sessions on identifying and addressing drug activity and prescription drug use, and testing employees if drug use is suspected. If employees test positive, the company then finds the appropriate treatment for the employee. Employers that have onsite wellness centers are also promoting alterative pain treatment rather than prescribing pain medication such as physical therapy, acupuncture, and even massages. Other programs employers initiated were:

- Paid time off for mental health days
- Enhanced backup care benefits
- Virtual challenges relating to wellness and mental health
- Presentations and team calls to discuss mental health well-being
- Online meditation sessions or yoga classes
- Crisis hotline for emergency mental health episode

While these are only a few highlights of what benefits employers are offering to their employees, there is no one size fits all approach in addressing the crisis. ERIC member companies have actively addressed changes in their benefits, and their work does not go unnoticed. In a November 2017 report from the President's Commission on Combating Drug Addiction and the Opioid Crisis, the Commission noted that, *"[the Mental Health Parity and Addiction Equity Act] MHPAEA has been the impetus for much progress towards parity for behavioral health coverage; plans and employers have, by and large, done away with policies that are clear violations; provisions such as dollar-limits, visit limits, and outright prohibitions on certain treatment modalities that exist only on behavioral health benefits".*[9] Employers want to provide the best benefits to their employees, and stand ready to improve mental health and substance use disorder care and access to the millions on our plans.

ERIC's Proposals to Improve Mental and Behavioral Health

As part of our commitment to being part of the solution, ERIC is actively working to develop policies that can meaningfully improve the lives of our plan beneficiaries by increasing their access to high quality mental and behavioral health care. Numerous ERIC member companies are participating in ERIC's Mental Health Task Force, which will soon be releasing a report on proactive solutions that Congress can consider in this space. Below are some highlights from the Task Force's findings, many of which this Committee could directly address.

*(1) **Improve Access by Encouraging Interstate Provider License Reciprocity**.*

COVID-19 caused many provider offices to close with no way for patients to receive care for some time. Through technology advancement, telehealth enabled patients to see providers from their home or a safe setting without risking contracting the virus. Employers pivoted quickly to ensure our employees and their families would maintain access to care, greatly assisted by relationships with telehealth companies. Unfortunately, many patients who had access to good telehealth benefits were still stymied by provider shortages, because their states did not allow them to see providers licensed elsewhere.

ERIC believes that Congress can act to quickly correct this problem, by permitting ERISA plans to facilitate telehealth between a willing patient and a willing provider, so long as that provider holds a current license in a state in which the plan operates, and is affiliated with a network associated with the plan sponsor, their carriers, and vendors. This would be a novel and simpler approach, and would instantly solve a huge access problem, especially as it pertains to mental and behavioral health, for patients in self-insured plans.

[9] Department of Labor. "DOL 2018 Report to Congress: Pathway to Full Parity". 2018. https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/dol-report- to-congress-2018-pathway-to-full-parity.pdf

Employers also believe that patients and providers can benefit from the Temporary Reciprocity to Ensure Access to Treatment (TREAT) Act (H.R. 708), which would provide temporary state licensing reciprocity for all licensed and certified practitioners or professionals (those that treat physical and mental health conditions) in all states and all types of services during the COVID-19 Public Health Emergency. Under the Act, a provider who holds a valid license in good standing in any state and is not barred in another state, would be permitted to practice in every state for the duration of the emergency declaration and a limited normalization period once the declaration of public health emergency is lifted.

While only temporary, **we encourage Congress to pass the *TREAT Act* so that all can have access to health care**, especially to address the immediate need for an increase in mental health providers in many parts of the country in the wake of COVID-19. More than sixty percent of rural Americans live in mental health professional shortage areas, and the need for care has only been exacerbated during the COVID-19 pandemic. Congress' immediate action will enable more competition and access in telehealth, creating incentives for providers to improve quality and affordable access for patients. In a recent study conducted in March 2021 of 2,000 people, 61 percent have had a telehealth appointment, showing its popularity one year into the pandemic.[10]

Later, **we hope that Congress will enact a more permanent interstate licensure solution**, at least in regards to telehealth. Congress previously fixed this issue in the realm of sports medicine, and can do the same for telehealth. While there are different possible paths forward (a specific fix for ERISA plans, national reciprocity, a national telehealth license, one comprehensive interstate compact with financial incentives for states), employers urge Congress to work through this challenge and come to consensus on a solution.

ERIC commends the 18 states[11] who have currently signed on to the Psychology Interjurisdictional Compact (PSYPACT), as well as the 16 states[12] that are currently considering legislation to do so. We believe that this is an important stopgap measure. However, federal leadership is needed in order to ensure that patients in all states can see all kinds of providers they need – especially mental and behavioral health providers. As such, while states continue to pursue PSYPACT, we urge the federal government to consider alternative methods of encouraging interstate license reciprocity.

(2) ***Leverage Telehealth to Improve Access to Care***.

a. Allow standalone telehealth benefits.

Currently, telehealth cannot be offered as a standalone benefit to anyone not enrolled in the full medical plan due to Affordable Care Act (ACA) rules.

[10] SYKES. "How Americans Feel About Telehealth: One Year Later". March 2021. https://www.sykes.com/resources/reports/how-americans-feel-about-telehealth-now
[11] Current signatories include AZ, CO, DE, DC, GA, IL, MO, NE, NV, NH, NC, OK, PA, TX, UT, and VA, with AL and KY set to implement later in 2021.
[12] Legislation has been introduced in AR, CT, IN, IA, KS, ME, MD, MN, NJ, OH, RI, SC, TN, VT, WA, and WV. However, legislation introduced does not necessarily imply the legislature will act or the executive branch will sign.

If telehealth-only benefits were designated as an excepted benefit, they would be treated similarly to other "add on" benefits such as vision, dental, long-term care, and cancer-only plans, which do not constitute a full medical plan. Offering this coverage would not impact employers' responsibility in offering minimum essential coverage to employees. It would simply expand employers' ability to provide telehealth benefits for those not eligible for, or not enrolled in, the full medical plan. Employers wish to innovate in this space, including experimenting with potential benefits that could be offered to populations who currently do not or cannot take advantage of the full medical/surgical benefit – especially as this could speed access to mental and behavioral health for beneficiaries.

And progress has indeed been made: on June 23, 2020, the Department of Labor issued a Frequently Asked Question (FAQ Part 43) that for the first time, allowed employers to expand standalone telehealth offerings, but with two key restrictions:

- Standalone telehealth may only be offered to individuals ineligible for the full medical/surgical benefit; and

- Standalone telehealth may be offered to these individuals only until the end of the public health emergency.

When this guidance was issued, employers acted. In fact, as a result, millions more Americans have telehealth benefits today. A broad array of ERIC members rolled these programs out to part-time workers, seasonal workers, interns, and more – with especially significant gains in the retail industry. This is an example of nimble policymaking that resulted in tangible benefits for many people, and one we hope to build on.

Specifically, we urge Congress to act before the end of the public health emergency to ensure that these programs can remain in place – and to allow employers to offer the benefit to more workers. If permitted to offer the benefit to those who are ***unenrolled*** rather than just those who are ***ineligible***, employers could expand telehealth benefits to more beneficiary cohorts – especially benefitting younger workers and those of less economic means. **It is critical that Congress make permanent the allowance to offer standalone telehealth benefits, and expand the offering to unenrolled individuals, in addition to just those who are ineligible**.

b. Make permanent 1st-dollar coverage of telehealth in HDHPs.

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 1st-dollar coverage of telehealth permanent so that workers in these plans can receive the care they need**.

If Congress does not act, next year millions of Americans who currently enjoy cost-free access to telehealth benefits, will be required to pay the full "fair market value" of care, until they have paid their entire plan deductibles. This would be a barrier to care, and Congress should act to prevent it.

c. Establish one national telehealth standard for ERISA plans.

Further, **Congress should consider creating one consistent set of telehealth rules for ERISA plans**. Currently, telehealth is regulated at the state level, which has resulted in major barriers for plan participants depending on where they may live or work – which creates a significant equity problem within multi-state plans sponsored by national employers. Some states have implemented forward-thinking telehealth rules, while others lag behind with archaic 20th century rules – originating site requirements, mandates that telehealth cannot establish a doctor-patient relationship, or even bans on the use of telehealth for prescribing or provision of mental health services.

Congress could establish a national framework for telehealth delivered to ERISA plan beneficiaries, thus ensuring equal treatment for all of our employees no matter where they live, work, or receive care. The standard could be based upon ERIC's model state telehealth legislation, which is designed to ensure benefits are equally shared by those who may not have a medical home, those who may not have access to broadband internet, and those who live in provider shortage areas. This can be done in a way that encourages care coordination, eliminates unnecessary barriers to care, and maintains a high standard of care. ERIC stands ready to work with Congress to develop this national telehealth framework.

*(3) **Encourage innovation by reducing regulatory barriers**.*

Employers are known for innovating new benefit designs to improve access, quality, and affordability for plan participants. But major barriers created by Congress and the federal agencies serve as a significant impediment to innovation, especially in the area of mental and behavioral health. While we understand the need to provide legal protections for beneficiaries, there is also a serious need for innovation to improve benefits and meet unmet needs for patients. Employers believe that the current dire need for improved access to mental health justifies providing employers with new flexibility to innovate in this space.

Congress should consider allowing the creation of limited mental health programs that could be flexible, without being considered "group health plans." If these programs were designated not to create an employer-employee relationship, they could potentially be offered to independent contractors and gig economy workers. To encourage innovation in benefits subject to MHPAEA, Congress could consider authorizing "compliance certification" entities, who ERISA fiduciaries could rely on to evaluate group health plans for parity compliance. And reducing or digitizing many of the notice and disclosure requirements on plan sponsors would also help free up funds and bandwidth to innovate.

(4) ***Improve communication to patients by requiring providers to be clear about whether they are accepting new patients***.

With the passage of the *Consolidated Appropriations Act* in December 2020, Congress has now set in motion a requirement that provider directories offered by health plans to participants will be accurate and up to date. However, a patient will still not be able to determine whether a particular doctor is accepting new patients at a given time. The problems created by this are obvious – worst of which could be a patient actually foregoing care due to frustration with getting turned away by providers. This is an easily fixed problem.

Over the coming months, both providers and insurers will be adapting to the new requirement that directories be accurate – if Congress acts quickly, **this requirement could be augmented to ensure that insurers have an easy way for providers to "toggle" whether or not they are accepting new patients – and requiring providers to do so**. It may not sound like a significant policy change, but for millions of Americans who are leery of seeing a long list of providers who turn them away when they call, this could be the difference in obtaining care or not.

(5) ***Study the Long-Term Consequences of COVID-19***.

In 2020, for the first time in recorded history, countless Americans were asked to work from home, limit contact with the outside world, refrain from "elective" medical care, and much more. Every day we learn more about the consequences of the policy decisions made in order to combat the COVID-19 pandemic. It is imperative that the federal government develop a comprehensive categorization of "lessons learned," determine what could be done better, etc.

This is especially important in the area of mental health. ERIC member companies have reported all kinds of findings in this area, including challenges getting beneficiaries access to the care they needed (which often wasn't traditionally defined as care under medical benefits), mental health consequences related to isolation and loneliness, familial challenges related to job changes or losses, challenges obtaining needed prescriptions or counseling, and more.

But recognizing the challenges and problems is only half of what is needed; **Congress should direct an objective body to then suggest a roadmap to better prepare and eliminate said problems, should such a disaster ever befall the country again**. The roadmap should place a special emphasis on protecting Americans' health, both mental and physical, and providing the needed behavioral health support for individuals who may suffer from substance use disorders. Recent data from the Substance Abuse and Mental Health Services Administration (SAMHSA) shows that nearly 20 million people have a substance use disorder caused by dependence on or abuse of illicit drugs, with nearly 18 million not receiving treatment.[13] More needs to be done for those in accessing outpatient, residential, and hospital inpatient service treatments.

[13] Government Accountability Office. "Substance Use Disorder: Reliable Data Needed for Substance Abuse and Treatment Block Grant Program, Government Accountability Office". GAO-21-58. December 14, 2020. https://www.gao.gov/assets/gao-21-58.pdf

(6) ***Ensure Patients and Plan Sponsors Have Access to Meaningful Provider Quality and Safety Information***.

Plan sponsors work to ensure that beneficiaries have access to quality care – and this includes building networks that eschew dangerous, ineffective providers and facilities. Unfortunately, too often a plan sponsor lacks critical information needed to make such a determination. Congress should consider taking steps to alleviate the information gap, which is especially pertinent in the mental and behavioral health space.

ERIC member companies and our organizational partners have suggested a number of potential ways to improve the availability of quality information. For instance, the Centers for Medicare and Medicaid Services (CMS) could expand the availability of quality ratings, and the CDC's National Healthcare Safety Network could collect and report uniform patient safety data from different sites of care (as called for last year by many thought leaders and interest groups, led by the Leapfrog Group and the AARP). Congress could also direct the Patient-Centered Outcomes Research Institute (PCORI) to prioritize research on mental health, or direct CMS' Center for Medicare and Medicaid Innovation (CMMI) to experiment with Centers of Excellence (COE) programs, modeled off successful efforts in employer-sponsored coverage.

There is much more that can and should be done to enhance access to better information for patients and plan sponsors, and employers are especially interested in investing high-value networks for their plan beneficiaries. To do so, we would like to work with Congress to ensure that the necessary quality reporting and outcomes data are available to employers.

(7) ***Encourage care coordination to empower primary care and other nontraditional options for patients***.

One thing employers have increasingly learned is that, as access especially to psychologists and psychiatrists has proven a challenge to plan beneficiaries, they have responded by seeking out mental health care elsewhere. Participants increasingly rely on primary care providers, who oversee their "medical homes," to provision mental health care, including the prescribing of various medications. But this is by no means the only place our employees are going – and COVID-19 has revealed a number of things that Congress can do to facilitate the transition of some mental and behavioral health services to nontraditional providers.

For instance, employers know it is imperative to continue focusing on the transition to coordinated care. We have learned that "scope of practice" laws sometimes hinder the ability of various medical providers (a prime example being nurse practitioners) from meeting unmet mental and behavioral health needs. It has also become clear that a lack of fully interoperable electronic medical records (EMRs) is making it harder for providers and facilities to coordinate. And we are interested in how coverage rules may be applied or expanded in order to encourage and facilitate behavioral health options, such as attending group meetings or therapy sessions. While programs such as "Narcotics Anonymous" do not generally constitute medical care, attendance at meetings or the like could well be a part of an individual's behavioral health regimen, and disruption of that regimen could be seriously deleterious to the patient's health.

There is more that we can do, with the goal of expanding the points of access to care for mental and behavioral health – but it starts with recognizing that there is capacity available.

(8) ***Modernize HDHP and DCFSA Rules to Improve Access to Mental and Behavioral Health***.

Rules related to account-based health benefits are currently far from optimized to encourage and empower patients to access mental and behavioral health when they need it. ERIC member companies have suggested several changes Congress should consider to maximize the ability and the likelihood that patients will seek out and obtain the care they need.

One option is to update HDHP rules to allow plan beneficiaries to access subsidized care at worksite health centers, which are a critical access point for primary care. Congress could also give HDHP sponsors flexibility to provide a limited amount of 1st-dollar coverage for high-value services, since employers have learned that outcomes can be significantly improved when barriers are removed from high-value care. Similarly, policy could be updated to allow the coordination of capitated benefit (like Direct Primary Care) models with HDHPs[14]. Or Congress could consider permitting funds in dependent care flexible spending arrangements (DCFSAs) to be used to pay a broader definition of "caregivers," including family and friends, as the COVID-19 pandemic has shown employers that plan beneficiaries often sought help from those closest to them.

While it may not seem like HDHP and DCFSA rules would play a large part in mental health access, these rules hamstring employers who want to innovate, experiment, and try out new benefit models and options – while frustrating patients by serving as barriers to access the care they need. Congress should consider taking a fresh look at these rules, and allowing employers to try new things, develop best practices, and address the gaps in access and care experienced by their beneficiaries.

(9) Target Funding, Education, and Reimbursement at Mental Health.

ERIC member companies continue to believe that some of the most important steps Congress can take to address access to mental and behavioral health include facilitating more providers in the field, equipping more providers in other fields (such as primary care doctors or nurse practitioners) to take on mental health roles, and encouraging more coordination between care teams. Our task force has explored a number of options Congress could consider in this space.

One option would be to specifically target programs like Graduate Medical Education at mental and behavioral health providers, and to promote programs aimed at assisting providers entering into the mental health field (such as perinatal or reproductive psychiatry fellowships).

[14] See: Primary Care Enhancement Act (H.R. 3708 in the 117th Congress)

Congress should consider programs that empower frontline health providers to address mental health such as perinatal psychiatry access programs[15], which were included in the *21st Century Cures Act.* Medical schools should include a greater emphasis on mental and behavioral health, and non- mental health providers and systems should be incentivized to include coordination with mental and behavioral health professionals as part of serving as a medical home for patients.

Employers defer to Congress on the best way to achieve these aims, however, the point cannot be escaped: America needs more mental health providers, and it needs to equip other providers to engage in mental and behavioral health care.

(10) ***Spur Greater Adoption of Value-Based Payments***.

The federal government has an unparalleled ability to transform the entire health care system by leveraging the tens of millions of covered lives enrolled in federal health programs. Various employers, in concert or individually, have worked for decades to end fee-for-service and transition to a value-driven system. However, it will be impossible to fully make that transition without federal leadership. While good work has already been done by CMS and CMMI, there is more work to do, and a huge opportunity as it pertains to mental and behavioral health.

Demonstrations or nationwide programs could be launched to transition away from fee-for-service in the area of mental health, potentially in partnership with employers and private-sector initiatives. We hope that such efforts could include realigning payments to encourage the highest-value treatments, medications, and services, and ensuring that patient-reported outcomes measures are central to these efforts.

As you can see, employers are working to address gaps in access to mental and behavioral health, not only by innovating new and improved benefit designs and practices, but also by developing policy that we believe will empower plan sponsors and beneficiaries to offer and obtain high quality care. We look forward to working with members of the Committee to develop legislation based upon these and other ideas, and hope that the 117th Congress will act on meaningful solutions for patients.

Counterproductive Mandates Likely to Increase Costs Without Improving Access or Care

ERIC recognizes that many members of Congress are working in good faith to develop solutions to the mental and behavioral health access challenges Americans are facing. While many of these proposed solutions are innovative ideas worthy of further exploration, some of them are unlikely to help beneficiaries, instead serving only to increase costs in the health system, expose patients to improper or dangerous care, or penalize good actors who are trying to be part of the solution. ERIC's concerns with some of these proposals include:

[15] Fact Sheet on Perinatal Psychiatry Access Programs by the Maternal Mental Health Leadership Alliance: https://www.mmhla.org/wp-content/uploads/2020/07/MMHLA-Psychiatry-Fact-Sheet.pdf

(1) ***Do Not Implement Civil Monetary Penalties (CMPs) for Mental Health Parity Violations***.

One oft-repeated idea to improve access to mental health providers and treatments for beneficiaries of employer-sponsored health insurance has been to implement a monetary penalty regime to punish insurance companies and employers who are found to have fallen short of parity requirements. For instance, see the *Parity Enforcement Act* (H.R. 1364). We believe that this idea would increase costs without meaningfully improving care.

It is our understanding that problems in the large-group market among self-insured plans are primarily a result of non-quantitative treatment limitations (NQTLs), a requirement that was never contemplated in the original MHP legislation, but instead developed by the federal agencies. Congress has repeatedly pressed the agencies to give better guidance on NQTLs, including examples, and the agencies have repeatedly refused to do so, even though they recognize the difficulties in discerning the violations.[16] Employers looking for a firm understanding of what is allowed, and what is not, have to resort to third-party publications, consultants, and outside vendors. In the large-group market, employers who are found to have parity violations inevitably have relied on outside counsel. As such, penalizing employers for these violations is unlikely to prevent them in the future.

The current process of remediating parity violations is sufficient not only to help solve these problems, but also to help consultants, vendors, and plan sponsors learn more about what DOL considers to be acceptable or unacceptable medical management practices. According to a Government Accountability Office (GAO) 2019 report, GAO recommended that the DOL and HHS evaluate whether relying on targeted oversight is effective for ensuring compliance with mental health/substance use parity requirements or whether alternative approaches are needed.[17] Rather than implementing CMPs, if the goal is to reduce MHP violations through NQTLs, **Congress should consider mandating that DOL provide much clearer, simpler guidance, that includes examples of what is actually allowed** – rather than just citing various impermissible plan design elements.

(2) ***Avoid Mandating a One-Sided Network Adequacy Requirement***.

ERISA plans do not profit from denying care to beneficiaries, and they do not seek to limit access to needed care. In fact, to do so would be completely counter-productive. The entire purpose of an employer-sponsored ERISA plan is to ensure that beneficiaries have access to the type and volume of care they need, when they need it. This is why we have continually worked to improve access and quality, including working with this Committee to crack down on abusive surprise medical bills.

[16] Department of Labor. "DOL 2018 Report to Congress: Pathway to Full Parity". 2018.
[17] Mental Health and Substance Use: State and Federal Oversight of Compliance with Parity Requirements Varies, Government Accountability Office, GAO-20-150, December 13, 2019

Currently, many mental and behavioral health providers choose not to participate in any insurance network.[18] This could be for a variety of reasons – perhaps they prefer to accept the out-of-network rates and balance bill patients. Perhaps they choose to take cash only, thus obviating the need to engage in the bureaucratic processes necessary to obtain reimbursement from insurance carriers. Or perhaps they simply recognize that due to provider shortages, they wield such market power that agreeing to anything other than the price they want, is unnecessary. In a 2017 Milliman report, 17.2 percent of behavioral health office visits were to an out-of-network provider showing that more patients are paying higher costs to get the care they need.[19] Regardless, the end result is that many mental health providers are unwilling to accept market rates as payment in full, and as such, do not participate in networks.

As such, simply requiring insurers to include these providers in network must necessarily lead to price increases for patients. If providers know an insurer has to bring them in network, they have an incentive to demand prices higher than what the market would otherwise bear, thus leading to higher costs for all insured beneficiaries due to premium increases, but hitting patients in self-insured plans especially hard. After all, with half the workforce in high-deductible health plans, and a significant portion of other beneficiaries whose cost-sharing is based on the cost of care, these price increases will serve to increase out-of-pocket costs for those who need the care most.

Instead, any effort to implement a requirement that insurance networks include more mental and behavioral health providers **must be a fair, two-sided requirement**: it must be paired with a requirement that providers themselves participate in networks. By requiring that providers go in-network in at least a few plans, Congress will be leveling the playing field, encouraging good-faith negotiations. If providers are going to demand that a mandate be placed on health plans, they should be prepared to also participate in this mandate, for the benefit of their patients.

(3) ***Protect Medical Management***.

ERIC member companies know that Congress is under pressure to address what patients see as "gatekeeping" within their health benefits. Employers believe that medical management is critical to controlling cost and improving quality for our plan beneficiaries. As ERISA fiduciaries, it is incumbent upon the employer to ensure that money is not wasted, that the network is not bloated with low-value or high-cost providers, and that plans are designed in such a way as to be good stewards of beneficiaries' funds. Medical management techniques such as prior authorization, "try-first" requirements, step-therapy, and the like, while sometimes unpopular with patients, are absolutely integral to performing our fiduciary duties.

[18] Bishop, Tara F et al. "Acceptance of insurance by psychiatrists and the implications for access to mental health care." JAMA psychiatry vol. 71,2 (2014): 176-81. doi:10.1001/jamapsychiatry.2013.2862. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3967759/

[19] Melek, Steve. Davenport Stoddard and T.J. Gray. "Addiction and Mental Health vs. Physicial Health: Widening Disparities in Network Use and Provider Reimbursement". Milliman. November 19, 2019. https://www.milliman.com//media/milliman/importedfiles/ektron/addictionandmentalhealthvsphysicalhealthwideningdisparitiesinnet workuseandproviderreimbursement.ashx

Medical management processes – and the processes to make exceptions to them – are designed by medical experts not only to protect all beneficiaries from higher costs, but also to drive quality, limit patient exposure to riskier treatments, improve utilization of best practices, and often to encourage the use of safer and less invasive interventions. Employers know that beneficiaries would prefer to have immediate access to any treatment, medication, or care that they would like instantly – and that providers may prefer to develop a care plan without the input of the plan fiduciaries. However, this is not in the best interest of the beneficiaries or the plan. We hope that Congress will take a balanced approach when considering medical management, and include the input of employers in any legislation.

(4) ***Do Not Mandate Coverage of Unproven, Experimental Treatments***.

There are numerous treatments some patients are seeking, but data is lacking to affirm the efficiency and effectiveness of the treatments, including (but not limited to) certain residential substance abuse programs, so-called "wilderness therapy," autism applied behavior analysis (ABA) therapy, and some treatments considered experimental. Employers and insurers may be criticized for taking time to evaluate new therapies before deciding whether to include them in coverage, but this is imperative to protect beneficiaries. And sometimes, the right decision is indeed not to cover a treatment.

Congress should instruct the federal agencies to clarify that MHP requirements do not force plans to cover treatments of unproven value or medical efficacy. Right now, this is often left to litigation to decide. Plan sponsors want to offer high-quality care, but we cannot expend plan assets on care that is ineffective or dangerous. And not everything that might be beneficial to a patient is actually medical care. Mandating that plans cover these treatments – or placing burdensome rules or financially destructive consequences on plans that make a mistake – would only serve to increase costs for beneficiaries, while leading some plan participants to obtain care that does not actually help them.

(5) ***Avoid Creating a New "Reimbursement Parity" Regime***.

Some advocates are asking Congress or the DOL to impose a requirement that group health plans reimburse mental and behavioral health providers at the same rate paid to providers on the medical/surgical side of the plan. Employers believe that government should not mandate the methodology used to determine and negotiate rates paid to providers.

Under current practices, provider reimbursement is based on a series of factors that are built into medical coding and plan administration. It often takes into account provider education (and how long it takes to develop a specialty or obtain a license or certification), complexity of the services provided, risks to the provider and patient pursuant to the care provided, availability of the specialty, and more. Employers largely rely on insurance carriers to help design reimbursement structures for a plan's providers, and it is not done with any intent to discriminate.

If providers feel that they should be reimbursed at a higher rate, this should be worked out via negotiations between providers and plans, not by government fiat.

And mandating the same payments for different kinds of providers and services is sure to have significant unintended consequences and potentially negative externalities. **Congress should resist calls to get in the middle of negotiations between providers and plans, and should instruct DOL to do the same**.

Conclusion

In conclusion, employers are acutely aware of the challenges patients face in accessing quality, affordable mental and behavioral health. We are committed to helping improve this dynamic for patients, and have demonstrated through innovation and investment that employers can be part of the solution. ERIC's Mental Health Task Force has developed a comprehensive set of policy recommendations that could help Congress to forge legislation that will efficiently and effectively get patients better access to these services. And while employers do not support some of the legislative efforts that have been considered in this space, employers believe we can work with Congress to develop solutions that will meet your constituents' needs.

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 meaningfully improve access to mental health for our employees, their families, and retirees. We are confident that this can be done without costly new mandates and penalty regimes, by leveraging bipartisan solutions and encouraging innovation. We look forward to working with the Committee to enact legislation to meet the mental and behavioral health needs of Americans.