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Employers' "Lessons Learned" on Telehealth: Give Us the Tools to Expand Benefits

Statement for the Record by
The ERISA Industry Committee (ERIC) to the
U.S. Senate
Committee on Finance

Hearing:
"COVID-19 Health Care Flexibilities: Perspectives, Experiences, and Lessons Learned"

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Introduction and About ERIC

Chairman Wyden, Ranking Member Crapo, 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 "*COVID-19 Health Care Flexibilities: Perspectives, Experiences, and Lessons Learned*." ***This is a critical hearing, because the Senate Finance Committee's jurisdiction far exceeds Medicare – policies determined by this Committee govern the benefits provided by employers***, especially as they affect the rules regarding high deductible health plans (HDHPs) and the Affordable Care Act (ACA). Our statement details ways that the Committee and Congress can take decisive action to consolidate the telehealth gains made by private sector employers during COVID and consider expanding telehealth policies to the private sector so that employees and their families can access virtual care.

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 and with stores, factories, offices, warehouses, and other operations in every state, 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, 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 state and local 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 plan beneficiaries. Large employers have been essential in connecting employees and their families to programs and care such as through telehealth benefits. ERIC's member companies have been pioneers in offering robust access to telehealth. Telehealth enables our beneficiaries to obtain the care they need, when and where they need it, affordably and conveniently. 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, especially related to mental health, and improve choice and competition in health care. And telehealth is an important tool to help minority communities connect with doctors who share identity and culture, thus helping these individuals feel comfortable accessing the health care system, no matter where they may be.

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. ***Congress should take decisive action to consolidate the telehealth gains made by private sector employees during COVID and consider expanding telehealth policies to the private sector so that employees and their families can access virtual care***.

Federal Actions Greatly Improve Telehealth for Medicare Beneficiaries… but Leave the Private Sector Behind

Early on in the pandemic, the Administration and Congress quickly realized that unnecessary barriers to telehealth care would be a significant 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 (e.g., 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 December 4, 2020 letter, 49 Congressional leaders called for making these changes permanent. While ERIC member companies are primarily outside of the Medicare system, we support making these Medicare improvements permanent. We have endorsed Senator Schatz's *CONNECT for Health Act* (S. 1512) to do just this. Medicare's embrace of telehealth is a boon to private sector patients, because it advances the creation of infrastructure, the adoption of telehealth by more providers, and provides proof that telehealth expansion can produce better access to care and savings.

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. Below we detail how private-sector patients are harmed by the current situation and what the Committee and Congress can do about it:

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 practice. 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.

Restrictive licensure rules help some providers by essentially outlawing competition from out-of-state, but it hinders other providers 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.), 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 setting a standard of care or protecting patients, these requirements really serve to stymie telehealth, driving more care to (more expensive) in-person settings -- or preventing patients from obtaining care at all - and hampering wider telehealth adoption.

These restrictions also have significant equity impact creating barriers that disproportionately affect low-income populations, persons of color, or those with disabilities. At the same time, they serve to protect profits for high-income professions.

Rules imposed by the federal government prevent employers from offering telehealth to many beneficiaries. Employers generally cannot offer telehealth as an employee benefit, separate from health coverage, because, under Department of Labor regulations, telehealth benefits are deemed to be "a plan" for the purposes of 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, essential health benefits 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.

To be clear, telehealth is not a “modality” of care. For employers, it is often an entirely different benefit, part of a suite of programs that are offered to employees and their families. 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 services their full medical plan. But the result of treating this separate benefit as a “group health plan” is that telehealth cannot be offered as a 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.***

Administrative action has provided limited relief. On June 23rd, 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 debilitating restrictions:

(1) Standalone telehealth may ***only*** be offered to individuals ***ineligible for the full medical/surgical benefit***; and

(2) Standalone telehealth may be offered to these individuals ***only until the end of the public health emergency***.

While this FAQ was a step in the right direction, it unfortunately leaves a number of potential beneficiary cohorts behind (again, younger workers and those of less economic means are hardest hit), while the temporary nature served as a significant disincentive for large employers to implement a major benefit change. **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*.** If not, millions of people will lose this benefit that has enabled them to access providers, especially mental health providers, in a timely manner.

We will note one considerable improvement in telehealth that Congress has made for private sector workers: individuals enrolled in a 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), 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.

Senators Daines (R-MT) and Cortez Masto (D-NV) have introduced a new version of the *Telehealth Expansion Act*, which would make the CARES Act policy permanent. ERIC strongly supports this legislation. **We urge Congress to swiftly pass the Daines-Cortez Masto bill, and make 1st-dollar coverage of telehealth permanent, so that workers in these plans can receive the care they need.**

Key Steps the Finance Committee Should Consider to Improve Telehealth

The solutions to many of these problems are within the Committee's jurisdiction, and employers look forward to continuing to provide technical assistance to Congress to implement solutions. We urge the Committee to advance provisions to address each of these barriers to care for private sector workers and put them on equal footing with Medicare beneficiaries.

First, Congress should pass the Temporary Reciprocity to Ensure Access to Treatment (TREAT) Act (S. 168) and enable providers to practice telehealth across state lines during the COVID-19 pandemic. Telehealth use has drastically increased over the past year, and some state

licensing restrictions continue to disrupt patients' care. The TREAT Act would provide temporary state licensing reciprocity for all licensed and certified practitioners or professionals (those who treat physical and mental health conditions) in all states for all types of services (in-person and telehealth) during the COVID-19 Public Health Emergency. 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 to the fullest extent of their license in that interaction. For example, not allowing a qualified provider to prescribe medication during a medical visit or discuss treatment options during a mental health visit.

Congress should act immediately to ensure that patients who use telehealth for physical and mental health services will have the best chance of finding a provider ready and willing to see them on the other end during the public health emergency. Mental health care providers prior to the pandemic were difficult to access, especially for those not living in urban areas. 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. At a time when anxiety and depressive disorders are at an ultimate high, access for patients is sorely needed in offering mental health care services through telehealth.

In the longer term, ***we urge Congress to enact a permanent solution to interstate licensure***. While this will require addressing some thorny questions, we have seen significant leadership in the past with respect to the issue. For instance, in a previous Congress, Congressmen Pallone and Nunes introduced the TELE-MED Act to permanently allow interstate practice for Medicare providers. Congress previously fixed this issue in the realm of sports medicine as well. While there are different possible paths forward (national reciprocity, a national 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.

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 sets of 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.

Congress can also develop a set of rules that protect 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 cross state practice among providers;
- Promote continuity of care by encouraging telehealth providers to coordinate with a patient's primary care provider and interdisciplinary care team;
- 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 or the sophistication to operate video, forward information, etc.;
- 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 Internal Revenue Code (IRC), the Public Health Service Act (PHSA), and the Employee Retirement Income Security Act (ERISA).

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 employers' ability 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 immediately 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. Many ERIC member companies are currently taking advantage of the DOL FAQ allowing limited telehealth expansion, but action by Congress could greatly increase these numbers, and thus, greatly increase patients' access to care.

While the Committee considers telehealth advancements for the private sector, more can be done for the millions of workers (approximately half the workforce) with HDHP plans. ***Congress should allow patients with a HDHP paired with a HSA to access worksite health centers via 1st-dollar coverage as well.*** Worksite health and wellness centers are more critical today than ever before, as employers provide their employees with more widespread and easy access to preventive and primary care services, including vaccination and diagnostic testing services at the workplace. And during COVID, many of these health centers have gone virtual, providing care to workers throughout a given region, not just confined to a specific worksite. However, under current law, individual taxpayers may not contribute pre-tax dollars to an HSA if they also receive certain supplemental health benefits, which currently includes access to care at a worksite health center. The resulting policy is that individuals with an HDHP are required to pay the full price, no discounts, until they have paid through their full deductible. It's unfair and counterproductive, when employers want our beneficiaries to use the clinics. ERIC encourages Congress to address the inequity by permitting individuals to both benefit from discounted services offered at worksite employee centers and still be eligible to participate in and provide pre-tax contributions to HSAs.

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*" 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.

Further, telehealth is cheaper than in-person care. Telehealth enables providers to treat more patients more efficiently, with less overhead cost, fewer staff, and lower 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 passed in Congress and signed into law by President Biden.