



Prioritizing Employee Mental Health

Solutions for Congress

ERIC

THE ERISA
INDUSTRY COMMITTEE
*Shaping benefit policies
before they shape you.*

About ERIC

ERIC is a national advocacy organization that exclusively represents large employers that provide health, retirement, paid leave, and other benefits to their nationwide workforces.

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.

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 the administration of their employee benefit plans.

ERIC member companies are large, nationwide employers—generally companies with more than 10,000 employees—that provide comprehensive employee benefits to workers and families across the country. ERIC represents member companies exclusively in their capacity as large plan sponsors. By working to preserve the Employee Retirement Income Security Act of 1974, ERIC is helping to maintain national uniformity and fighting against taxes, mandates, and compliance burdens for large plan sponsors. ERIC advocates for policies that make it easier and more cost-effective for employers to provide benefits that support their workforce and families.

Only ERIC provides the combination of intel, expertise, collaboration, and lobbying that exclusively serves the interests of large employers who provide health, retirement, and compensation benefits to their nationwide workforce. Through this work, ERIC helps employers help their employees. ERIC has expanded the availability of telemedicine, improved retirement and health regulations, and reconciled conflicting state and local paid sick and family leave laws.

ERIC works with lawmakers on Capitol Hill and in the states to ensure they and their staff understand legislative policies that impact large employers whether it be policies related to prescription drugs, health insurance premiums, or even mental health benefits. ERIC also meets with regulatory agencies and Administration officials to advance benefit regulations through the political process. ERIC continues to push forward in representing large employers in employee benefit policies at the state and federal levels.

A blue-tinted photograph of two men in a meeting. One man is seated and looking towards the other, who is standing and gesturing with his hand. The background is slightly blurred, showing what appears to be a whiteboard or screen.

Table of Contents

Executive Summary	3
It's Time to Address Mental and Behavioral Health, and Substance Use	5
Employers Are Working To Improve Access to Mental and Behavioral Health.....	7
Policy Proposals for Congress to Adopt.....	9
Allow mental health providers to practice across state lines to improve access to care	9
Expand telehealth benefits for all employees to improve access to providers.....	11
Incentivize more practitioners to enter the mental health field by increasing education funding and tuition reimbursement	14
Require provider transparency around the ability to accept new patients, reducing patient uncertainty and frustration	15
Integrate multiple health care disciplines through collaboration to provide patients with higher quality care	16
Ensure patients and plan sponsors have access to meaningful provider quality and safety information	18
Modernize health care account rules to increase flexibility for employees and improve access to mental and behavioral health.....	19
Reduce regulatory barriers to encourage employer innovation	20
Apply lessons learned from COVID-19 to advance health equity and better prepare for the future	21
Encourage the transition to value-based payments to better manage the costs of mental and behavioral health	22
Conclusion	23



Executive Summary

COVID-19 launched an urgent mental health crisis that continues today. Unfortunately, existing provider shortages, affordability and access problems, and insurance coverage issues have complicated efforts to get Americans the help they desperately need.

In response to surging demand for mental and behavioral health treatment and the complications of care delivery under rapidly shifting pandemic conditions, the nation's largest employers rushed in to adjust and enhance their benefits and to meet the needs of employees and their families. A lack of suitable "off the shelf" solutions led many companies to experiment with their own programs. This first-of-its-kind report derives from their experiences innovating under pressure and reflects the policy and legal barriers and shortcomings they discovered along the way.

To understand the challenges employers are confronting as they reimagine mental and behavioral health coverage and services for the 21st century, ERIC convened discussions among member companies with nationwide workforces to offer their insights and share the regulatory barriers that prevent them from helping their employees more. From these extensive discussions, ten core recommendations emerged. The policy recommendations described in this document will help ensure that Americans are better able to access the mental health care they need, when and where they need it, without excessive financial burden.

We urge Congress to take up these policy proposals and enact meaningful legislation without delay.

It is our belief that in driving high value care, we cannot only help to improve mental health, but also save money for taxpayers and the federal government.

Top 10 Solutions for Congress to Consider

1. *Allow mental health providers to practice across state lines to improve access to care*

Permitting mental health practitioners to serve patients across the country will expand access to care, especially in under-served communities and rural areas facing critical provider shortages, as well as enhance competition to bring down costs.

2. *Expand telehealth benefits for all employees to improve access to providers*

Employers should be able to offer telehealth benefits to all employees and their families, not just those enrolled in the full company health plan.

3. *Incentivize more practitioners to enter the mental health field by increasing education funding and tuition reimbursement*

Increase funding for programs at medical and graduate schools, tuition reimbursement and loan forgiveness, and support for hospital fellowships can help expand the mental health provider ranks.

4. *Require provider transparency around the ability to accept new patients, reducing patient uncertainty and frustration*

Providers should be required to clearly indicate in online health plan directories whether they are accepting new patients so people seeking care are not repeatedly turned away.

5. *Integrate multiple health care disciplines through collaboration to provide patients with higher quality care*

Interdisciplinary team care should be encouraged and coordination improved between primary care physicians and other supports, such as group meetings and therapy sessions.

6. *Ensure patients and plan sponsors have access to meaningful provider quality and safety information*

The government should collect and publish meaningful provider data so that patients can avoid ineffective or even dangerous treatments, providers, and facilities.

7. *Modernize health care account rules to increase flexibility for employees and improve access to mental and behavioral health*

Congress should allow employers to cover the cost of telehealth and offer subsidized care at worksite health centers for all employees. Policymakers should also modernize rules on how dependent care flexible savings accounts may be spent on caregiving needs.

8. *Reduce regulatory barriers to encourage employer innovation*

Reducing red tape and restrictive rules will unleash employers to try new and innovative mental health care models and address unique workforces.

9. *Apply lessons learned from COVID-19 to advance health equity and better prepare for the future*

The U.S. must study the long-term consequences of COVID-19, including the mental health ramifications, and create a pandemic-preparedness roadmap.

10. *Encourage the transition to value-based payments to better manage the costs of mental and behavioral health*

Value-based care models would encourage providers to manage patients' mental health, rather than waiting to intercede only when crises arise—leading to more efficient care and better outcomes.

It's Time to Address Mental and Behavioral Health, and Substance Use

The number of Americans needing mental and behavioral health care services has significantly risen since 2019, impacting the overall health care system, patients, and providers. The Centers for Disease Control (CDC) and Prevention concluded that 40 percent of adults in the United States struggled with mental health or substance use issues and that rates of depression and anxiety had skyrocketed since 2019.¹ Leading into late 2020, nearly 190 million people visited emergency departments for mental health conditions, suicide attempts, drug overdoses, and child abuse and neglect.² Today, the mental health crisis continues with few solutions to solve for mental health provider access, treatment affordability, and insurance coverage of mental health and substance use disorder services.

Unless you live in certain high-population urban centers, the likelihood is high that you have a shortage of mental and behavioral health providers. The National Institute of Mental Health (NIMH) found that nearly 90 percent of all psychologists and psychiatrists work exclusively in metropolitan areas while 60 percent of rural Americans live in mental health professional shortage areas.³ This discrepancy leads to a myriad of problems, which patients assuredly 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.

On average, patients pay roughly \$65 to \$250 for an hour-long traditional therapy session if not using insurance.⁴ For those patients who do stay in-network, significant wait times can exacerbate mental health issues.

Patient therapy costs



1 Centers for Disease Control and Prevention. "Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020". <https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm>

2 JAMA Psychiatry. "Trends in US Emergency Department Visits for Mental Health, Overdose, and Violence Outcomes Before and During the COVID-19 Pandemic." February 3, 2021. <https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2775991>

3 National Institute of Mental Health. "Mental Health and Rural America: Challenges and Opportunities." May 30, 2018. <https://www.nimh.nih.gov/news/media/2018/mental-health-and-rural-america-challenges-and-opportunities#:~:text=The%20cold%20hard%20facts%20about,work%20exclusively%20in%20metropolitan%20areas.>

4 GoodTherapy. "How Much Does Therapy Cost?" <https://www.goodtherapy.org/blog/faq/how-much-does-therapy-cost>

But the problem is much greater than simply, “not enough providers,” or “pay providers more.” Based upon previous efforts by employers and policymakers, ERIC believes that this is a problem that goes beyond simply applying more financial resources. Many mental health providers report they would not be willing to relocate for moderately higher compensation – meaning that the financial cost of enticing them to do so would fall heavily on plan sponsors and participants.

Now is the time to not only increase the supply of providers, but also to improve quality. Large employers are deeply troubled by the lack of quality and efficacy data in the mental and behavioral health space. During the worst of the opioid epidemic, for example, our member companies were frustrated that beneficiaries often received 90 days’ worth of OxyContin, when a three-day fill would have been more than enough. In response, employers directed their medical and dental providers to limit fills, divert employees to other medications and treatments, and implement more protections such as prior authorization. Employers were aghast to learn that their plans were reimbursing certain substance use disorder recovery facilities that may 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.

Employers are part of the solution, innovating and generating new ideas to improve access, quality, and affordability. They recognize that mental and behavioral health access needs improvement and are being proactive in providing real solutions to benefit their employees.

In a February 2021 New York Times article, psychotherapists discussed struggling to take on new patients, how long wait lists are causing patients to desperately seek out a psychotherapist who is available when they need one, and how many patients have resorted to seeking mental health care from a primary care physician.⁵

Not to mention, many patients struggle to find providers who are sympathetic and match the patient’s culture, religion, race, or values, which leads to the rise in health inequity in all aspects of health care. 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.



American mental health care services impact



40%
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Population & Access

90%

of all psychologists and psychiatrists work exclusively in metropolitan areas while

60%

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Employers are part of the solution, innovating and generating new ideas to improve access, quality, and affordability.

⁵ Caron, Christina. New York Times. “Nobody Has Openings”: Mental Health Providers Struggle to Meet Demand.” February 17, 2021. <https://www.nytimes.com/2021/02/17/well/mind/therapy-appointments-shortages-pandemic.html>



Employers Are Working To Improve Access to Mental and Behavioral Health

As measures to address the pandemic led to isolation and other consequences for many employees and their families, employers worked to adjust and improve benefits to meet the growing need for more access to affordable mental and behavioral health services. Many ERIC member companies reported they did not find these solutions “off the shelf” from existing vendors, and often had to design programs on their own or work with new innovators and disruptors to develop and roll out programs. ERIC discussed changes in benefits implemented by member companies, analyzed how these changes fit into existing offerings, and considered the policy and legal barriers that arose or applied.

Many large employers set up new virtual 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 resources and free mobile apps to build emotional resilience, improve sleep, and manage stress. While these platforms are user-friendly and individual-based, employers have also set 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. Many employers that offer one-on-one counseling with a 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.

Employers are continually evaluating available support resources and want to do more to help their workforce, including addressing substance use 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 who initiated the change has shown that fewer than one in ten employees seek 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 an employee tests positive, the company then finds the appropriate treatment for the employee. Employers that have onsite wellness centers are also promoting alternative pain treatment such as physical therapy, acupuncture, and even massages rather than prescribing pain medication.

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Another example includes insurance and health systems utilizing a model that focuses on opioid use disorders, specifically helping practitioners treat more patients with medication-assisted treatment. Through videoconferencing, expert teams conduct virtual clinics with non-specialist community providers to educate them about various health conditions. The goal of this model is to ensure broad knowledge sharing among providers so more patients have access to care in the local area. Moreover, innovative virtual peer support groups have also been utilized. These groups are co-facilitated with two peers and designed to reduce loneliness scores and provide case-specific assistance. 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
and well-being**



**Online
meditation
sessions or
yoga classes**



**Crisis hotline
for emergency
mental health
episodes**

While these are only a few highlights of what benefits employers are offering to their employees, a one-size-fits-all approach when addressing the crisis does not exist. 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.”

As large nationwide employers, ERIC member companies 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 their plans.

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– President's Commission on Combating Drug Addiction and the Opioid Crisis

Policy Proposals for Congress to Adopt

As a public policy organization, ERIC analyzes current rules and government programs with an eye toward employers' flexibility to innovate, as well as the current supply of providers. ERIC proposes the following policy recommendations to efficiently and effectively get patients better access to mental health and behavioral health services. Each proposal is aimed at addressing a different aspect of the current environment and ERIC urges Congress to implement them.

1. *Allow mental health providers to practice across state lines to improve access to care*

At a minimum, Congress must act to improve access to mental and behavioral health professionals. There are long- and short-term measures that are needed for this and many will require significant time and resources. ERIC recommends easy and efficient ways to provide patients with greater provider access almost immediately.

First, Congress should advance legislation to allow any surplus volume of available professional providers in a given area to treat patients in other areas. This will allow providers to practice in remote and rural areas where there are provider shortages.

Second, Congress should facilitate reciprocity of state-provided licenses. ERIC believes that all patients and providers can benefit from state licensing reciprocity for licensed and certified practitioners or professionals (those that treat physical and mental health conditions) in all states, and for all types of services, especially to link patients with providers of their choice based on nationality, race, gender, or other perspective. Specifically, Congress should consider legislation that would allow:

- ▶ A provider who holds a valid license in good standing in any state and is not barred in another state, should be permitted to practice in every state; and
- ▶ A provider who has achieved a medical license and accreditation 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.

ERIC's Top 10 Solutions

1. *Allow mental health providers to practice across state lines to improve access to care*
2. *Expand telehealth benefits for all employees to improve access to providers*
3. *Incentivize more practitioners to enter the mental health field by increasing education funding and tuition reimbursement*
4. *Require provider transparency around the ability to accept new patients, reducing patient uncertainty and frustration*
5. *Integrate multiple health care disciplines through collaboration to provide patients with higher quality care*
6. *Ensure patients and plan sponsors have access to meaningful provider quality and safety information*
7. *Modernize health care account rules to increase flexibility for employees and improve access to mental and behavioral health*
8. *Reduce regulatory barriers to encourage employer innovation*
9. *Apply lessons learned from COVID-19 to advance health equity and better prepare for the future*
10. *Encourage the transition to value-based payments to better manage the costs of mental and behavioral health*

Congress should advance legislation to allow any surplus of available professionals in a given area to treat patients in other areas.

Immediate action should be taken to ensure that patients who use telehealth for physical, mental, and behavioral health services will have the best chance of finding a provider that is ready and willing to see them. Remote access to providers can serve to address the immediate need for an increase in mental health providers in many parts of the country. 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 pandemic. Congress' immediate action will enable more competition and access in telehealth, creating incentives for providers to improve quality and affordable access for patients.

ERIC believes telehealth can serve an integral role in supporting patients' cultural and linguistic needs. Many patients may live in areas where, if any providers are available, those providers may not be culturally competent, or may not speak their language. The patient may also prefer a provider with a background like their own. For any of these patients, telehealth can vastly increase their ability to find a provider with whom they are comfortable – if providers are free to practice telehealth across state lines.

Congress has worked on cross-state practice before regarding sports medicine and should continue to do so in telehealth.

While there are different possible paths forward such as national reciprocity, a national license, or one comprehensive interstate compact with financial incentives for states, employers urge Congress to work through this challenge and come to consensus on a solution. Congress appears to be willing to solve the problem of state barriers to care for Medicare patients, and ERIC wants to ensure that private sector patients are not left behind.

ERIC believes telehealth can serve an integral role in supporting patients' cultural and linguistic needs.

While Congress delves through the difficult issues necessary to fully open up interstate practices (such as licensing fees, provider scope of practice, and the like), ERIC urges Congress to pass the **TREAT Act** (H.R. 708, S. 168). This legislation would allow full cross-state practice for the duration of the COVID-19 pandemic. While this is only a temporary measure, it can help stem the immediate needs of patients, lay groundwork for a long-term solution, and give Congress time (with a deadline!) to develop and pass a permanent solution.

ERIC does commend the 18 states⁶ that have signed on to the Psychology Interjurisdictional Compact (PSYPACT), as well as the 16 states⁷ that are currently considering legislation to do so for taking matters into their own hands to support their residents seeking access to mental and behavioral health providers. However, federal leadership is needed to ensure that patients in all states can see the providers and specialists they need. ERIC member companies stressed that even if states engage in an interstate compact, a given provider may still need to invest substantial amounts of time, and significant financial capital, to be allowed to practice in the participating states. As such, while states continue to pursue PSYPACT, ERIC urges the federal government to consider alternative methods of encouraging interstate license reciprocity.



⁶ 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.

⁷ 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.

2. Expand telehealth benefits for all employees to improve access to providers

Telehealth use has been growing over the past decade and skyrocketed as a result of the COVID-19 pandemic. Through technology advancement, telehealth enables patients to see their providers from their home or a safe setting without risking contracting deadly viruses and diseases.⁸ Telehealth enables 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, provides a solution for individuals with limited mobility or access to transportation, and has the potential to address provider shortages in the short-term, especially related to mental health, all while improving choice and competition in health care. However, some state licensing restrictions continue to disrupt patient care.

Most importantly, employers need legislation to ensure that they can offer telehealth as a benefit to their workforce, as part of, in addition to, or separate from the employer's health benefit plan.

Allow employers to offer standalone telehealth benefits

Currently, outside of temporary emergency measures, telehealth cannot be offered as a standalone benefit to anyone not enrolled in the full medical plan due to Affordable Care Act (ACA) rules. These rules require any "group health plan" to meet a host of requirements, many of which require paying for in-person care, prohibit cost-sharing or coverage limitations, and include other rules that are incompatible with the current model employers use to offer telehealth. Employers contract with a host of vendors and services to create a suite of benefits for employees, and increasingly this includes a telehealth-only vendor. Examples include services such as Doctors on Demand, Teladoc, Amazon Care, 98point6, and the like. Because of these group health plan requirements, employers who offer benefits provided by telehealth-only vendors can only offer telehealth services to individuals who are enrolled in a broader comprehensive medical/surgical benefit that meets all ACA rules.

There are many employees who opt out of their employer's medical benefits, for a variety reasons. Those individuals are ineligible to receive a telehealth benefit. However, there are also many employee cohorts who are generally not eligible for employer-sponsored medical benefits. Examples include:



If telehealth-only benefits were designated as an excepted benefit, telehealth-only plans 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.

The Department of Labor (DOL) recognized the importance of standalone telehealth benefits. On June 23, 2020, DOL 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:

- ▶ 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.

8 SYKES. "How Americans Feel About Telehealth: One Year Later." March 2021. <https://www.sykes.com/resources/reports/how-americans-feel-about-telehealth-now>

While this FAQ was a step in the right direction, it unfortunately leaves several important groups of potential beneficiaries behind. This includes younger workers and those with less economic means. The temporary nature also 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 those who are ineligible.**

If Congress chooses to act, standalone telehealth could be offered to additional groups of employees and their dependents, including but not limited to:

- ▶ Employees who are eligible but chose to remain uninsured rather than to enroll in the full medical benefit;
- ▶ Employees with other coverage – including those enrolled in a spouse’s plan, young adults on their parents’ plan, or individuals eligible for government programs; and
- ▶ Retirees or others who currently receive supplemental or “wrap-around” coverage.

Many ERIC member companies rolled out expanded telehealth-only benefits to their workforce soon after the Administration took action in 2020. However, due to the temporary nature of the allowance, many employers opted not to expand coverage. ERIC encourages Congress to make this measure permanent so more employees can have access to telehealth – and thus, to mental and behavioral health providers.

Allow employers to pay for telehealth with 1st-dollar coverage

Congress has made a considerable improvement in telehealth 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 – which allows employers to cover these services before an employee’s annual deductible is met – thanks to the enactment of the “*Telehealth Expansion Act*” (S. 3539), which was passed into law as part of the “*Coronavirus Aid, Relief, and Economic Security*” (CARES) Act (H.R.748). ERIC member companies reported nearly universal adoption of 1st-dollar coverage for telehealth within HDHPs in response to the CARES Act provision.

ERIC believes that statutory restrictions for HDHPs, while a critical tool in empowering patients to be cost-conscious “smart shoppers” for health care, can present barriers to care. The original design of HSA-qualified HDHPs (nearly 20 years ago) put an emphasis on reducing utilization. The prevailing belief among plan sponsors today is that while low-value care utilization should be decreased, high-value care should be made easier and less costly to use and that barriers to that care should be eliminated. The HSA and HDHP rules have not kept up with this evolution of thinking, and Congress must reevaluate and modernize them.

Many aspects of mental and behavioral health, primary care, and low-cost but high-impact care like telemedicine should be considered high-value care, and as such, employers should have the ability to offer that care at a subsidized or zero-cost rate to plan participants, prior to the participant hitting their deductible. Oftentimes, a deductible will serve as a significant disincentive to obtaining needed care, with many beneficiaries never meeting their annual deductible in a given plan year. This may be an especially serious barrier for low-income employees and persons of color that are statistically more likely to be in this socio-economic stratum. For these employees and their families, the CARES Act provision has been critical in improving their access to care.



Unfortunately, this telehealth improvement is time-limited and set to expire at the end of 2021. More than half of the U.S. workforce is enrolled in an HDHP, and 1st-dollar coverage of telehealth could be a significant incentive to help ensure these beneficiaries get the care they need. In a sign of bipartisan support and progress, Senators Steve Daines (R-MT) and Catherine Cortez Masto (D-NV) recently introduced a new version of the "Telehealth Expansion Act," or S.1704, which would make the CARES Act provision permanent.

National telehealth standards

One of the major challenges employers face in leveraging telehealth to expand mental and behavioral health services is the state variations in rules and regulations surrounding telehealth. These state rules tend to limit access to care in ways beneficial to entrenched interests, but harmful to patients. ERIC's Model Telehealth Legislation⁹ was developed in order to eliminate some of these artificial and unnecessary barriers to care.



Because telehealth is regulated at the state level, major barriers arise 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 (forcing patients to leave their homes to go to a telehealth location), mandates that telehealth cannot establish a doctor-patient relationship (in effect prohibiting national telehealth services), or even bans on the use of telehealth for prescribing or provision of mental health services. There are also states that prohibit telehealth that uses audio-only or “store-and-forward” portals (such as sending a photo of a suspicious condition), even though this might be the only viable way an individual who lacks broadband internet or a smartphone could have access to telehealth.

The practical implications for patients are devastating. In states where a doctor-patient relationship cannot be established via telehealth, telehealth services are virtually useless for those who need mental health care. A patient may obtain a telehealth visit, but the provider may not be able to prescribe needed medication. Or a patient may have the app installed on their phone, and have a relationship with a mental health provider, but because of an originating site requirement, be unable to attend the visit when they need it (from home, for example, or from a break room at work). All of these restrictions need to be viewed through an understanding that every barrier erected, every extra step a patient must take to obtain care, serves to dissuade patients from receiving needed care.

Interstate telehealth provider

A provider who has achieved a medical license and accreditation in their own state



should be permitted to practice on the internet, without states blocking them



⁹ ERIC Telehealth Model Legislation: <https://www.eric.org/wp-content/uploads/2019/08/Updated-Telehealth-Model-Legislation-Handout.pdf>

ERIC believes Congress should step in and establish that telehealth delivered under the auspices of ERISA plans should have one consistent set of rules throughout the country, including:

- ▶ Allow telehealth to establish a patient-provider relationship through an initial telehealth visit;
- ▶ Apply the same medical standard of care used for in-person visits 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 other interdisciplinary team members;
- ▶ Support and acknowledge patient's cultural and linguistic needs during a telehealth visit;
- ▶ 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.

ERIC can think of no better example of interstate commerce than a willing doctor and willing patient connecting either by a phone call or electronically via the internet to conduct 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.

By establishing a consistent set of rules, Congress can encourage the use of telehealth, thereby making mental and behavioral health more accessible and affordable to patients who need it.

3. Incentivize more practitioners to enter the mental health field by increasing education funding and tuition reimbursement

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 interdisciplinary care teams. There are many ways Congress can do this, including:

- ▶ Increase funding for graduate medical education (GME) programs that is specifically earmarked for mental and behavioral health providers. This could also include funding for programs such as perinatal or reproductive psychiatry fellowships, and other programs aimed at assisting providers to enter into the mental health field;
- ▶ Condition government funding to hospitals and other health facilities on their waiving fees for provider training and residency programs. ERIC member companies shared that while in the past hospitals offered providers free training in exchange for essentially free labor, these facilities now often charge students (via the programs in which they are enrolled) thousands of dollars for the privilege of learning to be a doctor or medical provider. ERIC finds this unacceptable and urges the government to evolve policies to stamp out this behavior;

By establishing a consistent set of rules, Congress can encourage the use of telehealth, thereby making mental and behavioral health more accessible and affordable to patients who need it.

- ▶ Provide funding for programs that empower frontline health providers to address mental health. A good example is funding for perinatal psychiatry access programs¹⁰, which was included in the *21st Century Cures Act*. It is our understanding that due to a shortage of funds allocated, while at least 30 states applied for funding to create and operate these programs, only seven states were able to receive funding. This is completely unacceptable – Congress should allocate sufficient funds such that every U.S. state and territory can establish and operate these programs;
- ▶ Encourage medical schools to include a greater emphasis on mental and behavioral health, including programming specifically aimed at future providers who do not intend to specialize in the field, but could potentially fill unmet needs;
- ▶ Incentivize non-mental health providers and systems to include coordination with mental and behavioral health professionals as part of serving as a medical home for patients;
- ▶ Similar to advanced primary care medical homes,¹¹ incentivize providers to keep a sufficient number of open appointments available to see patients with immediate and sudden needs;
- ▶ Encourage states, foundations, and others to establish a tuition reimbursement program for psychiatrists that will help improve mental health care access in the areas and states that have the most acute provider shortages. The government could also consider expanding student loan forgiveness programs for providers who practice in certain fields for a sufficient amount of time. The Obama Administration established loan forgiveness for individuals who work for government or nonprofit entities – perhaps it is time to consider what other callings we want to proactively encourage medical students to consider; and
- ▶ Ensure that the National Health Service Corps and Nurse Corps are adequately funded to recruit and retain diverse health care workers and students, especially their programs related to opioids and rural communities.

Health care workers have gone above and beyond during the COVID-19 pandemic and are feeling the effects of burnout. Also, many health care workers experience debt in pursuing their studies and careers. Such assistance in paying for providers' student loans will decrease stress, anxiety, and potential burn-out, while hopefully encouraging more students to consider entering into the mental and behavioral health field. ERIC encourages other stakeholders, not just federal and state governments, to be a part of the solution to ensure that medical students and providers are well-trained to address mental and behavioral health concerns.



4. *Require provider transparency around the ability to accept new patients, reducing patient uncertainty and frustration*

Employers have heard many complaints from both patients and members of Congress about so-called “ghost networks,”¹² in which a patient’s insurance provider directory may include providers who no longer are in the network, are not accepting new patients, or the like. ERIC supported efforts by Congress to address this issue. 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. As far as knowing whether a provider is in-network, the new rule should solve part of the “ghost network” problem for patients.

10 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>

11 Advanced primary care medical homes ensure patients are provided with high quality care based upon value-based payments instead of fee-for-service models. These arrangements allow providers to spend more time with patients and treat a lower patient volume.

12 Turban, Jack. STAT. “Ghost networks of psychiatrists hinder patients’ access to care.” June 17, 2019. <https://www.statnews.com/2019/06/17/ghost-networks-psychiatrists-hinder-patient-care/>

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 – the worst of which could be a patient actually foregoing care due to frustration with getting turned away by providers. ERIC member companies recounted patient stories about going down the list of providers on an insurer’s network, calling each one on the telephone, and being repeatedly told that although the provider does accept this insurance, he or she is not taking new patients at this time. This situation can cause patients to give up on finding a provider, and thus their mental health needs to go unmet. ERIC believes that 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 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 and saving time for both the patient and the provider.

It is our understanding that a provider at any time may choose to start or stop accepting new patients; as such, it is important that the responsibility for indicating this status rests with providers. But insurance carriers would also bear some responsibility, in that they would need to include real-time updates to their directories, to ensure that a patient will always see accurate information when they pull up the website.

ERIC member companies believe that virtually every employee and their families will be using websites to find this information, not making phone calls or writing letters to seek printed information via snail mail. As such, ERIC opposes requirements relating to paper or mailed information. ERIC is seeking 21st century solutions, which we believe will not levy an undue cost on carriers or providers but will produce tangible benefits for beneficiaries.

5. Integrate multiple health care disciplines through collaboration to provide patients with higher quality care

As access to psychologists and psychiatrists in particular has proven a challenge to plan beneficiaries, employers have learned that patients responded by seeking mental health care elsewhere. Patients increasingly rely on primary care providers, who oversee their “medical homes,” to provide mental health care, including the prescribing of various medications. But this is by no means the only place our employees are going. COVID-19 has revealed several things that Congress can do to facilitate the transition of some mental and behavioral health services to nontraditional providers, including:

- ▶ Continue to pursue efforts to ease a transition for coordinated care between interdisciplinary teams.

Employers are encouraged by the strengthening of relationships between primary care providers and plan beneficiaries. For example, programs like Beacon’s Massachusetts Child Psychiatry Program (MCPAP) were designed to create access by delivering telephone child psychiatry consultations and specialized care coordination support to over 95 percent of the pediatric primary care providers in Massachusetts. The federal government should provide funding to states to enhance and expand programs like this.



Employers are encouraged by the strengthening of relationships between primary care providers and plan beneficiaries, but more needs to be done.

However, there are still barriers to the transition to coordinated care between interdisciplinary teams. Both Congress and the Administration have made significant advances in this issue area, and ERIC encourages them to continue on this path. Possible next steps include directing CMS to pursue new opportunities for mental and behavioral health to be included in accountable care organization (ACO) type arrangements, eliminating regulatory barriers to creating capitated models that include mental health professionals, and conditioning some portion of public program reimbursement on participation in these types of models for mental health professionals and facilities.

It is important to note that provider reimbursement payment models for medical and surgical providers are substantially different than for mental health and substance use disorder providers, which are largely systemic in nature. While Diagnostic Related Group (DRG) reimbursement methodologies exist on the medical/surgical side and serve to act as a treatment limitation for inpatient stays, DRGs do not exist as frequently for mental health/substance use disorder treatments. Payers remain committed to offering innovative value-based payment arrangements as well as reimbursement based on DRGs. CMS should similarly look to expand these kinds of arrangements and include more value-based and episodic payments;

- ▶ Create incentives for states to broaden “scope of practice” laws that currently hinder the ability of various medical providers (a prime example being nurse practitioners) from meeting unmet mental and behavioral health needs.

In some jurisdictions, requirements that these providers be directly supervised by doctors, or prohibitions on their ability to prescribe medication, constrain their ability to alleviate significant provider shortages. Congress can and should explore ways to free up these professionals to care for more patients. Similar to our calls for interstate practice, ERIC believes Congress should take action to encourage the best and highest use for the supply of providers the country currently has available, while working to expand that supply over time. One option would be to condition the receipt of certain federal funds on certification that a state has eliminated barriers to effectively provide mental and behavioral health services by these professionals;

- ▶ Mandate fully interoperable electronic medical records (EMRs), and redesign the Meaningful Use program to ensure that every provider or facility participating in CMS programs transitions to a fully interoperable system so that a patient’s entire interdisciplinary care team can access and contribute to the same EMR. The federal government must ensure that these requirements apply to every patient a provider sees; and
- ▶ Explore 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. As such, changes may be appropriate to rules governing use of the CMS trust funds, and potentially to rules governing health insurance and group health plans, to facilitate plan sponsors who wish to fund travel or attendance.

There is a link between having a primary care provider and improved patient health outcomes.¹³ Having a primary care provider helps control chronic conditions, reduces unnecessary visits to the emergency room, and allows patients to form a relationship in addressing different health needs. While not every provider is able to address all health care matters, ensuring that medical teams have proper systems and relationships is crucial in making sure that patients receive the best care. Several ERIC member companies expressed frustration that in 2021 EMRs are still not interoperable, more than 15 years after the creation of the Office of the National Coordinator for Health Information Technology. And while ERIC is encouraged by changes made in the last several years to CMS rules, which have expanded the types of services that can be paid for out of the Trust Funds, more needs to be done.



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. ERIC suggests important steps Congress can take to alleviate the information gap, which is especially pertinent in the mental and behavioral health space:

- ▶ Require the Centers for Medicare and Medicaid Services (CMS) to expand the availability of quality ratings for mental and behavioral health providers and facilities. Participation in CMS programs should be conditioned on reporting outcomes-based data, and data should be specific to an individual provider or facility (not to a larger medical group or hospital system/company);
- ▶ Require all medical facilities, including in-patient treatment centers for eating disorders, substance use disorders, and mental health generally, to regularly report patient safety information to the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network. As called for last year by dozens of thought leaders and interest groups, led by The Leapfrog Group and AARP,¹⁴ this data should be collected uniformly from different sites of care, and publicly reported for use by patients and plans so they can avoid predatory facilities;
- ▶ Direct the Patient-Centered Outcomes Research Institute (PCORI) to prioritize funding research on mental health, including the efficacy of experimental treatments and various prescription drugs, the success rates of inpatient care, and the comparative effectiveness of different treatments and sites of care. This research should be focused on findings that would be useful for the design of health benefits, in order to ensure that patients receive the best possible care;
- ▶ Empower CMS' Center for Medicare and Medicaid Innovation (CMMI) to experiment with Centers of Excellence (COE) programs, modeled off successful efforts in employer-sponsored coverage, to encourage better outcomes, specifically in the area of mental and behavioral health. These demonstration projects have the potential to transform care, advance the U.S. health care system beyond outmoded fee-for-service models, and encourage provider competition based on quality and improved outcomes. Further, CMMI should be directed to partner with employers and carriers in these demonstrations, in order to cross-pollinate innovations and learn from successes and failures in the private market.

¹³ Pourat N, Davis AC, Chen X, Vrungos S, Kominski GF. In California, Primary Care Continuity Was Associated With Reduced Emergency Department Use And Fewer Hospitalizations. Health Affairs. 2015. <https://pubmed.ncbi.nlm.nih.gov/26153305/>

¹⁴ AARP and The Leapfrog Group. "Stakeholders urge Congress to empower CDC to protect patient safety in legislation to help address the COVID emergency." July 15, 2020. <https://www.eric.org/wp-content/uploads/2020/07/Infection-Reporting-Expansion-Letter.pdf>

There is much more that can and should be done to enhance access to better information for patients and plan sponsors, but these initial steps would be meaningful and demonstrate a commitment from Congress. Employers are especially interested in investing in high-value networks for their plan beneficiaries but doing so is very challenging without the necessary quality reporting and outcomes data. More participation and engagement from mental and behavioral health providers and facilities in federal programs will enable more transparency and understanding in accessing quality care.

7. Modernize health care account rules to increase flexibility for employees and 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. Many of these plan designs were created with a mind to reduce health care utilization, and they have proven effective in doing so. However, as plan sponsors have evolved to seek higher utilization of high-value services and lower utilization of low-value services, the rules surrounding these benefits have not kept up. It is our contention that mental and behavioral health services often constitute a high-value service that plan sponsors should have discretion to promote. Therefore, ERIC explored ways to modernize account-based plans.



ERIC suggests Congress make the following changes, in order to maximize the ability, and the likelihood, that patients will seek out and obtain the care they need:

- ▶ Update HDHP rules to allow plan beneficiaries to access subsidized care at worksite health centers. Under current rules, an employer may subsidize or even offer free care to employees, if those employees are enrolled in any non-HDHP type of group health plan (such as a PPO, POS, or HMO). However, employees enrolled in HDHPs must be charged the “fair market value,” out-of-pocket cost, for any services received at worksite clinics, unless and until the employee has paid their entire plan deductible. In 2021, that means the patient must have spent \$1,400 in self-only coverage, or \$2,800 on a family plan. This serves as a huge disincentive for HDHP beneficiaries to utilize worksite health centers, which are a critical access point for both primary care and mental health care;
- ▶ Give HDHP sponsors flexibility to provide a limited amount of 1st-dollar coverage for high-value services of their choosing. HDHPs still operate under the philosophy that drove the 2003 rules in the wake of the *Medicare Modernization Act* (P.L. 108-173), which seek to encourage patients’ “skin in the game” by barring them from coverage of most needed and high-value medical services until they have satisfied a deductible. However, in the intervening decades, employers have learned that outcomes can be significantly improved when barriers are removed from high-value care, whether or not this care is currently considered “preventive” by the Internal Revenue Service (IRS). As such, Congress should consider allowing employers to experiment with new models that allow 1st-dollar coverage in HDHP plans, including coverage of mental and behavioral health;
- ▶ Allow the coordination of capitated benefit models with HDHPs. Currently, participating in a capitated benefit, even if that plan is strictly limited like a Direct Primary Care arrangement, is considered “disqualifying coverage” that will prevent an HDHP beneficiary from contributing to an HSA. Congress should consider legislation such as the *Primary Care Enhancement Act* (H.R. 3708 in the 117th Congress) to allow these capitated benefits to be paired with HDHPs. Further, Congress should consider a broader approach, allowing any limited benefit that provides capitated high-value services – such as potentially an arrangement to cover mental and behavioral health services in certain cases – to be enjoyed by HDHP beneficiaries;

- ▶ Eliminate discrimination in HSA participation. Currently, working seniors who have enrolled in Medicare, veterans who have access to TRICARE or the Veterans Health system, and Native Americans eligible for care at the Indian Health Service are deemed ineligible to contribute to HSAs. As a result, employers who contribute money to employees' HSAs as a way of shielding them from part of the costs of paying their deductible, are legally required to discriminate against these individuals. The result is that these individuals are less likely than other plan beneficiaries to obtain needed care – including mental and behavioral health. ERIC and other employer groups are working with Congress to develop legislation to correct this inequity; and
- ▶ Permit funds in dependent care flexible savings arrangements (DCFSAs) to be used to pay a broader definition of “caregivers,” including family and friends. During the COVID-19 pandemic, employers learned that plan beneficiaries often sought help from those closest to them. Their inability to use their own money, trapped in IRS-regulated accounts, to reimburse these nontraditional caregivers, caused a large amount of consternation and distress, compounding an already challenging time for many employees and dependents.

While it may not seem like HDHP and DCFSA rules would play a large part in mental health access, these rules hamstringing employers who want to innovate, experiment, and try out new benefit models and options to support their workforce and families. These rules also create “winners and losers” among our plan beneficiaries, making it much harder for some patients to access needed care than others. Congress should consider taking a fresh look at these rules and allow employers to innovate, develop new best practices, and work to address the gaps in access and care experienced by beneficiaries.

8. Reduce regulatory barriers to encourage employer innovation

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. Undeniably there are benefits to the rules spawned by laws such as *The Mental Health Parity and Addiction Equity Act (MHPAEA)*, *Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)*, and the *Affordable Care Act (ACA)*. But with the current dire need for improved access to mental health, it is time for Congress to consider providing employers with flexibility to innovate in this space.

ERIC member companies discussed innovations they implemented, as well as ideas they considered but decided against pursuing. Several themes emerged, the most prominent being a worry that new benefit structures might run afoul of existing rules, thus threatening the employer with heavy fines or penalties. As such, ERIC suggests that Congress consider the following options to encourage employers to experiment with novel approaches that could increase access and affordability for patients:

- ▶ Allow employers to create mental health benefit programs, in addition to and outside of the current benefits offered (which would themselves be subject to ACA, COBRA, MHPAEA), and specify that these “mental/behavioral health-only” programs are not group health plans – as such, employers could create new options for beneficiaries, without worrying about a host of rules that might not be possible to adhere to;
- ▶ Reduce reporting requirements for ERISA plan sponsors, including reducing or streamlining notices and disclosures, and move into the 21st century by allowing all disclosures to be delivered electronically unless a beneficiary has mitigating circumstances. A simple solution would be a postcard that is mailed to participants and tells individuals where this information can be found on a company's intranet and that the materials can be provided free of charge and upon request in paper by calling a phone number. This is becoming increasingly important, as various reporting and disclosure requirements pile up within the United States Postal Service mailing system and unread mounds of paper have a negative impact on the environment. Plan beneficiaries are overloaded with disclosures that may or may not be of value to them, and sometimes important notices go unnoticed;

- ▶ Reduce concerns about MHPAEA compliance by creating a system by which DOL can designate third party organizations to “certify” MHP compliance by a plan. Employers generally do not have the detailed information necessary to demonstrate compliance with the non-quantitative treatment limit (NQTL) provisions and need to rely on third party administrators and pharmacy benefit managers for support in verifying the appropriateness of an NQTL. ERISA fiduciaries should then be able to rely upon this certification, so attention may be focused on improving benefits, rather than on regulatory compliance; and
- ▶ Create a regulatory regime through which benefits can be offered to independent contractors without creating an employment relationship. Many employers have a large workforce of contractors who are not (and do not wish to be) employees, but the employer would be interested in offering some degree of benefits to them – no doubt including programs that could facilitate access to mental and behavioral health.

ERIC is aware that some members of Congress are concerned that these proposals would lower employers’ responsibility in providing comprehensive health care to their employees and cheat the reporting requirement system. This is not the case and ERIC member companies are committed to continuing to provide comprehensive benefits. However, if large employers have the flexibility to expand their benefits offerings, then more employees, families, retirees, independent contractors, and others in the workforce would be able to benefit from new health programs and offerings.

9. *Apply lessons learned from COVID-19 to advance health equity and better prepare for the future*

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 ERIC learns more about the consequences of the policy decisions made to combat the COVID-19 pandemic. It is imperative that the federal government develop a comprehensive categorization of “lessons learned” and determine what could be done better.

This is especially important in the area of mental health. ERIC member companies have reported many findings in this area, including challenges getting beneficiaries access to the care they needed as it wasn’t traditionally defined as care under medical benefits: for example, mental health consequences related to isolation and loneliness; familial challenges related to job changes or losses; challenges obtaining needed prescriptions or counseling, and cancellation of in-person support groups, and more.

But recognizing the challenges and problems is only half of what is needed;

Congress should direct an objective body to suggest a roadmap to better prepare and eliminate said problems, should such a disaster ever befall the country again.

Emergency Medical visits leading into late 2020

NEARLY

190 million people visited emergency departments

for mental health conditions, suicide attempts, drug overdoses and child abuse and neglect.

Recent data from the Substance Abuse and Mental Health Services Administration (SAMHSA)

NEARLY

20 million people have a substance use disorder

caused by dependence on or abuse of illicit drugs, with

NEARLY

18 million people not receiving treatment.

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 people not receiving treatment.¹⁵ More needs to be done to improve access to outpatient, residential, and hospital inpatient service treatments.

While Congress has held hearings on lessons learned from the COVID-19 pandemic, a comprehensive strategy must be designed to address not only mental and physical health of Americans, but health equity to ensure that all patients receive the care they need. Learning from the past will allow the country to better prepare for the future.

10. Encourage the transition to value-based payments to better manage the costs of mental and behavioral health

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 CMHI, there is more work to do, and a huge opportunity as it pertains to mental and behavioral health. Employers urge Congress to:

- ▶ Launch demonstrations or nationwide programs to transition away from fee-for-service in the area of mental health, including an emphasis on care coordination and capitation payments;
- ▶ Give employers the opportunity to partner with CMS in regional or national demonstrations with the potential to largely eliminate fee-for-service in a given region;
- ▶ Increase the speed of the transition by requiring a greater proportion of CMS payments to be value-based, and a greater percentage of those payments as well;
- ▶ Extend the five percent payment bonus under the Quality Payment Program for Advance Alternative Payment Models (APMs);
- ▶ Consider realigning payments to encourage the highest-value treatments, medications, and services; and
- ▶ Ensure that patient-reported outcomes measures are central to these efforts.

In order to control health care costs within the health care system, we must move much more quickly to emphasize and better promote value-based payments rather than relying on fee-for-service. The private sector is working to help promote this transformation, and ERIC urges Congress to consider our proposals.

¹⁵ 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>



Conclusion

Employees and their families understand the value that employers bring to the table in offering excellent benefits, including mental health benefits. ERIC member companies offer benefits like health care and see them as a value for employees, paying a majority of their health care costs. ERIC member companies pay on average 85 percent of the cost of employer-sponsored health coverage. Employers contribute expertise, foster innovation, and serve as trusted intermediaries on behalf of our plan participants. ERIC leaned in on formulating policy solutions with our member companies, giving them the opportunity to share the successes, setbacks, and barriers they are experiencing in working toward a more comprehensive, accessible, and affordable mental and behavioral health system for employees and their families.

The policy proposals contained in this report are designed to ensure that patients can access the care they need, when and where they need it, without excessive financial barriers. ERIC believes these are the best, most comprehensive solutions proposed to date, which would have the greatest probability of actually making meaningful improvements for patients sooner rather than later. In a world of limited resources and political capital, ERIC knows our solutions are worth the cost and can provide immediate benefits.

ERIC believes policymakers can make meaningful improvements in patients' access to mental health, behavioral health, and substance use disorder services.

ERIC, with input from our member companies, focused exclusively on solutions that we believe would positively impact patients' access to affordable substance use disorder, mental and behavioral health care. It is important to remind ourselves that real, thoughtful, and comprehensive solutions, can only come with help from the nation's largest employers. Listening and learning through our collective voice and real-world experience can help ensure the offering of employer-sponsored insurance remains intact and continues to be a viable option for all who choose it.

Large employers can make meaningful improvements in patients' access to mental health, behavioral health, and substance use disorder services if Congress allows them. These employers are working to address gaps in access to mental and behavioral health by innovating new and improved benefit designs and practices and advocating for policies that will empower both plan sponsors and beneficiaries to offer and obtain high-quality care.

ERIC hopes that this report will foster meaningful discussion with Congress, the Administration, and stakeholders who can work together to adopt and implement policy changes to bridge the gap and produce real results for patients.



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