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

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November 5, 2021

The Honorable Chris Murphy
United States Senate
136 Hart Senate Office Building
Washington, D.C. 20510

The Honorable Bill Cassidy
United States Senate
520 Hart Senate Office Building
Washington, D.C. 20510

Dear Senators Murphy and Cassidy,

Thank you for this opportunity to provide our input on behalf of The ERISA Industry Committee (ERIC) regarding your request for information on the effectiveness of certain mental health and substance use disorder programs and new policy solutions that Congress can enact to enhance mental and behavioral health care as well as substance use disorder care for all Americans. ERIC is a national nonprofit organization exclusively representing large employers that provide health, retirement, paid leave, and other benefits to their nationwide workforces. With member companies that are leaders in every sector of the economy, ERIC advocates on the federal, state, and local levels for policies that promote flexibility and uniformity in administering their employee benefit plans.

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

Below, we will highlight the topline policy proposals ERIC hopes you will consider in upcoming legislation and how it relates to programs from the *Mental Health Reform Act of 2016* that were included in the *21st Century Cures Act*. Many of these policies are within the jurisdiction of the Senate Health, Education, Labor, and Pensions Committee, while others would fit in a complementary effort from the Senate Finance Committee. It is our ardent belief that employers can be an important partner in this effort, helping to forge solutions that result in improved access, affordability, quality, and safety in mental and behavioral health care all Americans.

ERIC's *Prioritizing Employee Mental Health* Report

ERIC's large employer member companies, seeing a rise in mental health and substance use disorder cases during the COVID-19 pandemic, worked quickly to expand access to mental and behavioral health services for employees. ERIC member companies shared with us the challenges they experienced in providing mental and behavioral health benefits for their employees. We developed with them potential policy changes that would enable them to offer better benefits. These policy proposals are contained in our report, *Prioritizing Employee Mental Health: Solutions for Congress*. We appreciate being able to share our top ten recommendations and how it relates to programs from the Mental Health Reform Act of 2016 that were included in the 21st Century Cures Act. We look forward to working with you and your staff to advance them in this Congress.

1. **Allow mental health providers to practice across state lines to improve access to care through reciprocity of state-provided licenses**. In the short term, no other solution comes close to the impact this will have on improving access to providers. While this policy will expand telehealth to areas that have a provider shortage, programs such as the *Increasing Access to Pediatric Mental Health* (42 U.S.C. §254c-19) can truly benefit from interstate practice. *Community Mental Health Services Block Grant* (42 U.S.C. §300x-9) will also allow states to provide funding to facilities that are utilizing telehealth to better serve their patient population.

2. **Expand telehealth benefits for all employees to improve access to providers**. This includes making permanent 1st-dollar coverage for telehealth in high-deductible health plans and making permanent the ability to offer telehealth-only plans to all employees. Many large employers have implemented telehealth-only plans during the public health emergency to part-time workers, seasonal workers, those on an ACA-regulated three-month waiting period for health insurance benefits, and more. However, it will expire at the end of the public health emergency. T*he National Mental Health and Substance Use Policy Laboratory* (42 U.S.C. §290aa-0) can help evaluate and promote this innovative model that can benefit from further development and scaling.

3. **Incentivize more practitioners to enter the mental health field by increasing education funding and tuition reimbursement**. This includes realigning existing funds to prioritize mental health specialties. Many of the programs you have listed such as the *Minority Fellowship Program* (42 U.S.C. §290ll) and the *Mental and Behavioral Health Education and Training Grants* (42 U.S.C. §294e-1) align with our policy proposals that encourage more diverse health care workers and students to train and be familiar with mental and behavioral health treatments.

4. **Require provider transparency around the ability to accept new patients, reducing patient uncertainty and frustration**. Prior to implementation of the requirement for accurate provider directories next year, Congress should clarify that providers must indicate whether or not they are open to new patients. This is certainly an area where the *National Mental Health and Substance Use Policy Laboratory* can identify, coordinate, and facilitate if this policy change is likely to have a significant effect on accessing mental health appointments.

5. **Integrate multiple health care disciplines through collaboration to provide patients with higher quality care**. This includes improving funding to existing programs, incentivizing improvements in scope of practice laws, and requiring interoperable electronic medical records. The health care system is siloed and difficult for some patients to navigate in getting the appropriate care they need. Programs such as the *Promoting Integration of Primary Care and Behavioral Health* (42 U.S.C. §290bb-42), *Grants for Jail Diversion Programs* (42 U.S.C. §290bb-38), *Projects for Assistance in Transition from Homelessness* (42 U.S.C. §290cc-35) can benefit from our policy recommendations.

6. **Ensure patients and plan sponsors have access to meaningful provider quality and safety information**. Congress should require the federal agencies to make information available to the public, information should be specific to providers and facilities, and agencies like PCORI and CMMI should prioritize improving mental health. Once Congress does this, the *National Mental Health and Substance Use Policy Laboratory* or another government agency can evaluate the effectiveness of sharing such data.

7. **Modernize health care account rules to increase flexibility for employees and improve access to mental and behavioral health**. While this is in direct jurisdiction of the Finance Committee, this Committee should make several changes to rules for high-deductible health plans, health savings accounts, and flexible spending arrangements, in order to allow employers to improve benefit offerings for working families. Once Congress does make these changes, grants for *Priority Mental Health Needs of Regional and National Significance* (42 U.S.C. §290bb32) can be initiated and help more than half of the workforce that have a high-deductible health plan get care in these high-risk areas.

8. **Reduce regulatory barriers to encourage employer innovation**. This should include allowing standalone mental health benefits, eliminating red tape and paperwork, creating a certification process for mental health parity compliance, and allowing employers to offer benefits to independent contractors without creating an employment relationship. Employers want to do more for their employees' mental health, but are stymied by outdated regulations. Allowing for different policy solutions in coordination with government agencies can expand mental health access as well as allow for the federal government to focus on providing grants for mental health programs that keep up with the private sector.

9. **Apply lessons learned from COVID-19 to advance health equity and better prepare for the future**. ERIC applauds ongoing Congressional efforts related to pandemic preparedness and urges that mental and behavioral health be included as major tenets in these efforts. Once a report has been complete, Congress can then use *Community Mental Health Services Block Grants* (42 U.S.C. §300x-9), evaluate the priority mental health needs of regions and states, and provide other grants so that those impacted by the public health emergency can have access to mental and behavioral health services.

10. **Encourage the transition to value-based payments to better manage the costs of mental and behavioral health**. While the federal government is slowly transitioning to alternative payment models, it is imperative that employers be included in demonstration projects, and that mental health be taken into account when designing options such as capitation programs. Our policy recommendation fits perfectly with the National Mental Health and Substance Use Policy Laboratory's goals and we hope to work with them and other federal agencies on this.

Many of these policy proposals are already drafted into legislative language, and some have been introduced in a bipartisan manner. Others will need to be fleshed out and drafted. All of these ideas come to you from the large employers who sponsor benefits for tens of millions of Americans. They want to provide better benefits and access to mental and behavioral health care, and are stymied by federal and state rules that prevent them from doing more.

Prioritize Patient Safety in Mental Health

Prior to COVID-19, medical errors were the third leading cause of death in the United States, contributing to about 250,000 deaths per year.[1] The stress on the health care system from COVID-19 may have further exacerbated these harms due to staffing shortages and burnout.[2] Staffing shortages will also likely continue with nearly 23,000 physicians permanently leaving the medical profession by 2026.[3] Many organizations have worked to reduce adverse events for over two decades since the IOM report, *To Err is Human*, was published in 1999, but the country still fails to apply its extraordinary technology and information systems to effectively protect its patients and their health care workers from harm and stress.

[1] Makary, M, et al. (2016). Medial Error—The Third Leading Cause of Death in the US. BMJ, 353 (i2139). Available at https://www.bmj.com/content/353/bmj.i2139

[2] Office of the Inspector General. (March 2021). Hospitals Reported That the COVID-19 Pandemic Has Significantly Strained Health Care Delivery. OEI-09-21-00140. Available at https://www.oig.hhs.gov/oei/reports/OEI-09-21-00140.asp.
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[3] Mercer (2021) US Healthcare Labor Market Report. https://www.mercer.us/content/dam/mercer/assets/content-images/north-america/united-states/us-healthcare-news/us-2021-healthcare-labor-market-whitepaper.pdf

There is currently a lack of patient safety measures for mental health facilities. For example, the Joint Commission only has four safety goals for behavioral health care: accurately identifying people served, medication safety, health care-associated infections, and suicide risk.[4] This supports that a majority of patient safety recommendations and best practices are designed for hospitals and doctor's offices, not for mental health care settings. However, some patient safety indicators such as medication errors, diagnostic errors, restrain and seclusion, suicide, falls, assault, and self-harm, among others, have been proposed as indicators in mental health settings, but there has been no other recent action.[5]

The United States is behind in protecting patients in mental health settings and can learn from other countries in identifying the best patient safety indicators. Outside of the United States, the United Kingdom's National Learning and Reporting System found that omission of medication, wrong frequency, and wrong or unclear dosage were the most frequently reported medication incidents at mental health hospitals from 2010 to 2017.[6]

We encourage Congress to consider legislation that would create a National Patient Safety Board (NPSB), modelled on the well-established and successful National Transportation Safety Board (NTSB), so that patient safety events in health care settings, including inpatient and outpatient mental health facilities, can be diminished or completely eliminated. The NPSB would be a central independent federal agency focused solely on patient and provider safety and guarantee a data-driven, non-punitive, collaborative approach to reducing adverse events. It would interface with Health and Human Services (HHS) agencies and offices similar to how the NTSB interfaces with the Department of Transportation (DOT) and its Federal Aviation Administration (FAA).

At its core, the NPSB would:

- Support agencies in monitoring and anticipating adverse events with AI and machine learning technology
- Identify significant harm and then conduct studies of the adverse events
- Create recommendations, including autonomous solutions, to prevent medical errors

[4] The Joint Commission. (2021). *Behavioral Health Care and Human Services: 2021 National Patient Safety Goals*. Retrieved from https://www.jointcommission.org/standards/national-patient-safety-goals/behavioral-health-care-national-patient-safety-goals/

[5] Marcus. S, et al. (2020) Defining Patient Safety Events in Inpatient Psychiatry https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6336525/ and Cuomo A, et al. (2021) Patient Safety and Risk Management in Mental Health. Textbook of Patient Safety and Clinical Risk Management. https://link.springer.com/chapter/10.1007/978-3-030-59403-9_20

[6] Alshehri, Ghadah H et al. Medication Safety in Mental Health Hospitals: A Mixed-Methods Analysis of Incidents Reported to the National Reporting and Learning System, Journal of Patient Safety: August 2021 - Volume 17 - Issue 5 - p 341-351 https://journals.lww.com/journalpatientsafety/Citation/2021/08000/Medication_Safety_in_Mental_Health_Hospitals__A.2.aspx

Establishing the NPSB would allow those on the interagency coordinating committee[7] to review, update, and prioritize patient safety indicators for mental health care settings. Once the patient safety indicators are established, it would work with the agencies and offices to help them adopt patient safety data surveillance technologies to autonomously collect the data from electronic health records (EHRs to track the patient safety events. Studies would then be conducted by considering the impact of the patient safety event, whether there is systemic risk, and if there is a lesson to be learned that can be shared with the entire health care system. The studies would be conducted by multidisciplinary experts, including a clinically informed Human Factors Engineer, to gather additional data onsite, establish the facts, probable causes, and recommendations. HHS agencies and the Department of Veterans Affairs would be required to respond to the NPSB's recommendations within 90 days in terms of whether and how agencies will use their existing authorities and policy levers to help implement the recommendations and improve patient safety in all facilities, including those focused on mental health.

ERIC understands that creating a new federal agency is a large undertaking, but the NPSB will benefit all patients and providers by drastically improving quality of life, lowering health care costs, and resolving potential and life-threatening medical errors. For far too long, there has not been drastic improvement in this area and the time is now to save more patient lives.

We also call on Congress to require robust patient safety reporting from all facilities so that patients can easily know what facilities are safe and can best address their health needs. The Centers for Disease Control and Prevention's National Health Safety Network (NHSN) currently collects data and calculates nationally standardized infection rates for many, but not all, health care facilities. NHSN has the capacity and protocols in place to collect and calculate data, and we urge Congress to require a wider variety of facilities such as long term care facilities, rehabilitation facilities, hospice facilities, ambulatory surgery centers (ASCs), hospital outpatient surgery departments, specialty hospitals, pediatric hospitals, critical access hospitals, dialysis centers, hospitals in Guam and Puerto Rico and other territories to systematically report key infection data to NHSN that should then be publicly available. This will then paint a true national picture of the burden of infections on patients and the health care system.

Having all facilities, including mental health facilities, report to the NHSN will allow federal officials to identify "hot spots" and concentrate strategies to reduce or eliminate infections quickly and efficiently. It also supports employers and other purchasers that want to protect their employees residing in different states across the country to best understand where they should receive care. Patients should not have to worry about contracting an infection while seeking mental health treatment, and enacting reporting requirements for all facilities to the NHSN will hold all facilities accountable.

[7] Substance Abuse and Mental Health Services Administration, Agency for Healthcare Research and Quality, Centers for Disease Control and Prevention, Veterans Affairs, Office of the National Coordinator for Health Information Technology, Indian Health Service, Office of Minority Health, Health Resources and Services Administration, Food and Drug Administration, National Institutes of Health, National Quality Forum, and the National Committee for Quality Assurance

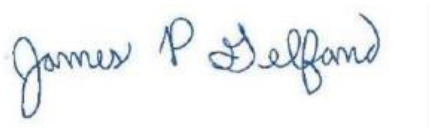
Eliminate Barriers to Worksite Health Centers to Facilitate Better Mental Health Care

Worksite health centers allow for convenient care for employees and can help manage chronic conditions and mental health treatment. Worksite health centers are a setting where an employer offers one or more medical and wellness services, delivered by licensed providers, to all or a designated portion of its active population and other eligible individuals. The clinics not only serve employees, but dependents, part-time and contract workers, retirees and even other employer groups and the local community. They can offer a broad array of services such as first aid, occupational health, acute, primary, specialty, condition management, mental and behavioral health, wellness and ancillary services, and more to their workers. Especially during the COVID-19 pandemic, patients increasingly relied on primary care doctors and nurse practitioners who oversee their "medical homes," to provide mental health care, including the prescribing of various medications because there was and still is difficulty in scheduling appointments with those that specialize in mental health, behavioral health, and substance use disorder.

Worksite health centers have proven to be the first point of access for all patients' health care needs, but for approximately half of the workforce that have a high -deductible health plan (HDHP) paired with a Health Savings Account (HSA), they must be charged the "fair market" rate for their health care services if they have not yet reached their deductible. This is especially problematic given that patients enrolled in other types of health plans (such as a PPO) are usually offered free or heavily discounted rates at worksite health centers. The high cost of market value services proves prohibitive for patients that may need immediate help managing their depression or anxiety, and are unable to see a mental health counselor, psychiatrist, or other mental health provider due to an overload of appointments. ***We encourage Congress to allow those with HSAs to access worksite clinics under the same cost structure as those not in a qualified HDHP, regardless of where they are in meeting their annual deductible.***

Conclusion

Thank you for this opportunity to share our views. The ERISA Industry Committee and our member companies are committed to working with Congress to meaningfully improve access to quality mental health care and substance use disorder care for our employees, their families, and retirees. We are confident that this can be done without costly new mandates and penalty regimes, by leveraging bipartisan solutions and encouraging innovation. We look forward to working with you to enact legislation to meet the mental and behavioral health needs of Americans.



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