

March 2, 2022

The Honorable Mariannette Miller-Meeks, M.D.
United States House of Representatives
1716 Longworth House Office Building
Washington, D.C. 20515

The Honorable Mike Kelly
United States House of Representatives
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The Honorable Morgan Griffith
United State House of Representatives
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Washington, D.C. 20515

Attn: Kendyl Willox

Dear Healthy Future Task Force Modernization Subcommittee members,

Thank you for this opportunity to provide input on behalf of members of The ERISA Industry Committee (ERIC) regarding your request for information on policy solutions to improve the use of technology and modernize the U.S. health care system. ERIC is the only national association advocating exclusively for large employer plan sponsors that provide health, retirement, paid leave, and other benefits to their nationwide workforces on the federal, state, and local levels. With member companies that are leaders in every economic sector, ERIC advocates for policies that promote quality and affordable health benefits for employees, their families, and retirees.

Americans engage with ERIC member companies many times a day, such as when they drive a car or fill it with gas, use a cell phone or a computer, watch TV, dine out or at home, enjoy a beverage, fly on an airplane, visit a bank or hotel, benefit from our national defense, receive or send a package, go shopping, or use cosmetics. ERIC supports efforts to utilize improved technology and to modernize the U.S. health care system thereby offering improved access to health care, affordability and quality of coverage, transparency, safety, and support better health care outcomes for all Americans. Our ardent belief is that employers can be an important partner in this effort.

Below, we will highlight key policy proposals ERIC urges you to consider in upcoming legislation. Many of these policies address questions outlined in the RFI.

I. Wearable Technologies

Digital health technologies like wearable devices provide an opportunity for individuals to become more aware of health factors, track progress toward health goals, and live healthier lives. They can help improve the treatment and prevention of chronic conditions and empower individuals with information they need to advocate for health care services.

Digital health care technology solutions also give payers and providers the opportunity to operate more efficiently and effectively.¹ Health care technology companies offer innovative services for employers to provide them with a global view of the activity trends in their populations and additional tools to help implement wearable devices as a part of their wellness programs. Others have offered a collection of services and applications to help understand their sleep habits and stress levels. Some have even enabled cellphones as a wearable device to track movement or help with social distancing. The Department of Defense also explored wearable devices with Philips Healthcare to detect COVID-19 with 11,000 participants from June 2020 to September 2021. A digital watch and ring were used to predict COVID-19 infection up to 72 hours before symptoms showed.² As of February 2021, the algorithm has performed well and gave 2.3 days of advance notice prior to individuals becoming symptomatic for COVID-19 and subsequently receiving a diagnostic test. Employers are increasingly utilizing wearables, and policies should be updated to promote innovation.

Employers strive to promote participation in employee wellness programs. They offer a wearable device to employees free of charge, to improve health outcomes and connect health data to electronic medical records, providing an attractive option for many employers and employees. Any employer that currently wants to arm its employee population with a wearable device has to impute income to the employee equal to the value of the device, because the device itself is not a health benefit that can be excluded from income. **ERIC supports the PHIT Act of 2021 (H.R. 3109 - S. 844), which would broadly allow a medical care tax deduction for the employee for up to \$1,000 of qualified sports and fitness expenses per year. Additionally, we encourage Congress to consider legislation that allows employers to supply employees with wearable or other medical devices as part of a wellness program or health plan, without imputing income to the employee, or jeopardizing the employee's ability to contribute to a Health Savings Account (HSA).** These changes will enable more participation in wellness programs and significantly improve patient health outcomes for the entire health care system. They also would provide for a more complete medical record for providers in setting up care plans.

Wearables in the Medicare program should also be covered to ensure uniformity in the markets.

Many aspects of private insurance follow the lead of Medicare, including reimbursement codes and definitions of care. We understand that Medicare limits reimbursement for certain medical devices such as wearables, and that reimbursement is very slow and antiquated. Currently, Medicare Advantage plans may choose to buy and give wearable devices to enrollees similar to extra benefits currently offered like gym memberships and Meals on Wheels that are treated as supplemental benefits.

Congress should allow the provision of wearable medical devices to be covered through the core medical benefit of both traditional Medicare and Medicare Advantage plans.

We urge Congress to pass legislation that would make wearable devices affordable for employees, including the following:

¹ Walmart, Safety Wearables Help Keep Associates Safe at Work. May 4, 2021,

<https://corporate.walmart.com/newsroom/2021/05/04/safety-wearables-help-keep-associates-safe-at-work>

² Philips, The U.S. Department of Defense, Philips Expand Research on Groundbreaking AI Technology, Opening New Front in Battle to Contain COVID-19, September 22, 2020 <https://www.usa.philips.com/a-w/about/news/archive/standard/news/press/2020/20200922-the-us-department-of-defense-philips-expand-research-on-groundbreaking-ai-technology-opening-new-front-in-battle-to-contain-covid-19.html>

1. Treat certain wearable devices, downloadable applications, and medical technology as preventive care medical expenses allowing first-dollar coverage under high-deductible health plan rules, and an allowable medical expense for Health Savings Account funds;
2. Implement comprehensive coverage of wearables in traditional Medicare and Medicare Advantage plans; and
3. End data blocking to promote coordination of care and encourage unification of electronic medical records.

Food and Drug Administration (FDA) Approvals

ERIC believes that FDA approval processes should not serve as a bottleneck to slow down innovation in the space of wearable medical technologies and mobile applications, but should instead encourage and promote an environment for wearable technology to be used widely. The FDA should review processes to ensure that developers and manufacturers are encouraged to seek approval of wearables and their corresponding apps as medical devices and technologies. Further, Congress should direct the FDA to minimize barriers to entry for mobile application developers and wearable medical device manufacturers.

II. Telemedicine Expansion

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

The Administration and Congress acted quickly and decisively:

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

These changes improved telehealth benefits for Medicare beneficiaries on a vast scale, instantly unleashing telehealth's tremendous potential to fill the voids created by the pandemic and paving the way for improvement. Unfortunately, very few changes in law have been made for individuals in the private sector not covered by Medicare, despite employer efforts to expand and improve telehealth benefits.

ERIC's member companies are pioneers in offering robust telehealth benefits. Telehealth enables individuals to obtain the care they need, when and where they need it, affordably and conveniently. Telehealth visits are generally less expensive than in-person visits and significantly less expensive than urgent care or emergency room visits. Telehealth visits allow individuals who may not have a primary care provider and are experiencing medical symptoms an affordable option of care rather than an emergency room visit. Access to telehealth benefits saves individuals significant money and reduces the cost to the plan which ultimately lowers health plan premiums. Telehealth benefits reduce the need to leave home or work and risk infection at a physician's office, provide a solution for individuals with limited mobility or access to transportation, and has the potential to address provider shortages, especially related to mental health, and improve choice and competition in health care. An analysis of data conducted by Mercer, which warehouses the claims of over one million health plan members, found that the portion of total outpatient behavioral healthcare encounters conducted via telebehavioral health jumped from one percent prior to Q1 2020 to more than 50 percent in Q2 2020 – where it has stayed for more than a year now (through Q3 2021).³ This change is a result of both a decrease in traditional office visits and an increase in telebehavioral health visits.⁴

Most ERIC member companies offer comprehensive telehealth benefits and did so long before the COVID-19 pandemic. As in most health insurance and value-driven plan design, self-insured employers have been the early adopters and drivers of telehealth expansion. Some employers also have value-based care and worksite health centers that have utilized clinic-based and specialty telehealth services during the pandemic, with the services rising to 78 percent in 2021 compared to 21 percent in 2018.⁵ With the onset of the pandemic, ERIC's member companies continued to lead the way in rolling out telehealth improvements – held back only by various federal and state government barriers. This includes provider licensing, unnecessary barriers, such as banning store and forward communications, or implementing specific technology requirements, and offering telehealth to certain sectors of the employer's workforce.

These impediments to provider licensing seriously impact telehealth coverage offered to employees from state to state. For example, primary care is available to employees regardless of age in all states, but offering behavioral health and mental health services to all in each state is a challenge because there are not enough licensed providers in each state. Each individual's telehealth care access is limited based on state rules and what can be covered through the medical plan or Employee Assistance Program (EAP).

We encourage Congress to pass the following pieces of legislation to permanently increase telehealth care for individuals:

³ Blondino C, Conrad J, Kuhn S, Telebehavioral Healthcare: A Post-Pandemic View – January 20, 2022.

<https://www.mercer.us/our-thinking/healthcare/telebehavioral-healthcare-a-post-pandemic-view.html>

⁴ Ibid.

⁵ Mercer, National Association for Worksite Health Centers, Worksite Health Centers 2021 Survey Report

<https://www.mercer.us/content/dam/mercer/attachments/north-america/us/us-2021-worksite-health-centers-survey-report.pdf>

1. **Telehealth Expansion Act (S. 1704 – H.R. 5981)**. The legislation would allow for individuals enrolled in a high-deductible health plan to have access to telehealth benefits at a low cost or free of charge before their deductible is met and continue to maintain Health Savings Account eligibility.
2. **Primary and Virtual Care Affordability Act (H.R. 5541)**. The legislation would allow for individuals with high-deductible health plans to use telehealth benefits, or to have an in-person primary care visit, at a low cost or free of charge before their deductible is met and continue to maintain Health Savings Account eligibility.
3. **Telehealth Benefit Expansion for Workers Act**. This bill would allow employers to offer standalone telehealth benefits to millions of individuals who are not enrolled on their full medical plan, such as part-time workers, interns, seasonal workers, persons on a waiting period, and more by removing barriers currently presented under current law, such as the Affordable Care Act.
4. **A permanent solution to interstate licensure that could be addressed by either:**
 - National reciprocity for medical provider licenses;
 - A new national license specifically for telehealth;
 - One comprehensive interstate compact with financial incentives for states; or
 - Update and pass the TELE-MED Act and TREAT Act.

National Telehealth Standard

Telehealth is currently regulated only at the state level. As a result, individuals in national, ERISA governed self-insured health plans, face many barriers to care and other limitations, which vary state by state. This kind of regulation may be appropriate for individuals enrolled in (and providers contracting with) fully-insured plans, which are regulated at the state level. However, it creates uneven care for workers, families, and retirees who get their health insurance through self-insured health plans, which are regulated at the federal level. This unfairness is exactly what ERISA preemption was intended to prevent.

Congress could fix this inequity by creating a new national standard for telehealth benefits offered under an ERISA governed self-insured health plan. Such a standard should consider the following tenets (which are the key areas in which state laws currently conflict and disadvantage telehealth patients):

- **Specifically allow telehealth to establish a patient-provider relationship:** In some states, provider lobbies have passed laws that ban telehealth visits if the individual does not have a pre-existing doctor-patient relationship with the particular doctor providing telehealth. This makes it impossible to use telehealth services like the ones large employers provide, making telehealth useless for connecting individuals in areas with doctor shortages to out-of-state providers (especially important in mental health), and

reduces telehealth in the state to a slight convenience (Zoom with your doctor) instead of a game-changing improvement for mental health access.

- **Apply the same standard of care to in-person visits and telehealth visits:** One of the major arguments against telehealth is that individuals will receive different or a lesser standard of care. For instance, the patient-doctor interaction will be more rushed, patients will not be offered certain treatment options, or providers will not follow the same steps or protocols for a given indication or diagnosis. By explicitly requiring that the standard of care should not vary in person or via telehealth, this argument or risk is eliminated.
- **Do not require reimbursement for telehealth visits to be at the same rate as reimbursement for in-person visits:** In general, medical providers are opposed to the federal government “price setting” in the health care system. Instead, they want to negotiate directly with payers to determine network status, in-network reimbursement rates, and out-of-network payments. However, certain provider groups have lobbied on the state and federal level to mandate that telehealth service prices NOT be negotiated, and instead be mandated by law to be equal to the same reimbursement for a given product or service delivered via in-person care. This requirement is not only a vast government overreach, but also eliminates any and all savings that can be achieved via telehealth (due to efficiencies, lower infrastructure costs, ability of providers to accommodate more patients and services, etc.). It also undermines innovative providers who are focused on maximizing their practices by focusing on telehealth.

Encourage interstate practice among providers: One of the biggest advantages of telehealth for patients is access to a wider pool of providers than those who are nearby. However, this access is significantly restricted due to state licensure of medical professionals. Even when states do participate in interstate licensure compacts, they tend to erect barriers that significantly reduce the effectiveness of those compacts (such as significant fees, continuing education requirements, in-person registration requirements, and more). A national standard for telehealth could potentially include a limited interstate license for providers practicing telehealth under the auspices of an ERISA plan. This does not allow a provider to move into another state and set up an in-person location without approval by the state medical board, rather it allows patients and providers to connect over the telephone or internet and removes barriers restricting access to needed mental health care.

- **Coordinate between the patient’s telemedicine provider and primary care provider is encouraged:** The best care is coordinated care that keeps a patient’s entire care team in the loop and on the same page. Some telehealth critics worry that telehealth providers, especially those affiliated with telehealth specialty services or vendors, will be less likely to coordinate with a patient’s medical home or existing care team. A national standard can alleviate this concern by requiring participating providers to coordinate with a patient’s existing care team, preferably via the use of an interoperable, patient-owned, unified electronic medical record that allows for collaboration and information sharing among all of a patient’s providers.

- **Simply define “telehealth” and “telemedicine” and apply the terms to broadly include all types of care that use technology to connect a provider in one location and a patient in a different location:** Telehealth comes in many forms – while the most popular at this time is two-way video, some telehealth takes place via telephone, email, or “store-and-forward” technology such as sending a photo or using a patient web portal. It is likely that telehealth platforms will continually evolve based on advancing science and technology, as well as patient preferences. However, some states attempt to define telehealth narrowly, often with the effect of outlawing certain technologies such as audio-only. This serves as a major barrier to care for patients (for example, patients who lack broadband internet are highly unlikely to be able to do video conferencing). A national standard should broadly define telehealth in order to be “future proof” as the technology advances, and to ensure that rural Americans or those without smart phones are not barred from care.
- **Do not require or encourage patients to travel to specific “originating sites” to access telehealth services:** There are still several states that continue the arcane practice of requiring individuals to travel to a “designated telehealth facility” before they can connect with a telehealth provider. Medicare traditionally has similar restrictions, although they were suspended during the Public Health Emergency. If these restrictions return, individuals lose the ability to conveniently access care, which is the overarching purpose of telehealth benefits, and will have to take time off work to access care. This type of restriction critically impacts individuals most in need of telehealth services, including those who care for small children at home or for an elderly parent or loved ones with special needs. These restrictions have not kept up with the advancement of medicine or technology, which now enables individuals anywhere to connect via wireless data. A national standard should specify that these originating site restrictions do not apply, so that individuals can use telehealth to its fullest and most convenient potential.
- **Apply the same informed consent requirements to in-person visits and telehealth visits:** Privacy and consent are taken seriously in health care settings, and should be taken equally seriously when patients and providers connect via telehealth. However, some states have attempted to apply more restrictive or burdensome privacy and consent procedures to telehealth than to in-person care. This serves only to disincentivize both providers and patients from using telehealth. Instead, a national standard should specify that providers abide by the same privacy and consent rules that apply to in-patient visits.
- **Allow prescribing via telemedicine:** A small number of states have sought to discourage the use of telehealth by banning providers who see a patient via telehealth from prescribing medication to the patient. Access to medication is an integral part of health care, and many patients would eschew telehealth if any diagnosis would then require an additional (and costly, unnecessary) in-person follow-up visit before they could be prescribed a medication. A national standard should clarify that no special limitations are placed on providers utilizing telehealth. Since they are operating under the same standard of care, they should have the same discretion to develop a care plan, and if need be, to prescribe medication to the patient.

Allow the Free Market to Determine Telehealth Reimbursement

Some stakeholders are asking Congress to implement telehealth changes that would eliminate competitive markets, promote low-value care, and reduce the potential for telehealth to be transformational for the medical system. Large employers that offer health coverage through ERISA governed group health plans make plan design decisions based on clinical guidelines, evidence, and best practices. Plan sponsors use experience, advice from medical professional societies, bodies that evaluate quality and efficiency in health care, and other sources, and then use this information to develop and deliver benefits that drive the most value for their employee populations. This allows a plan sponsor to deliver the quality of care that is specific to its employee population and should not be mandated by legislation. It should be the responsibility of plan sponsors, not the government, to determine what care is appropriate to cover via telehealth settings.

Under current law, providers are free to negotiate telemedicine rates with payers – which has given rise to a thriving market in which competition drives cost efficiency, value, quality, and innovation. So, it should come as no surprise that certain provider groups are eager to destroy this market and instead set reimbursement by government fiat. It is wholly inappropriate and unprecedented for the federal government to mandate payment rates between two private parties.

There are often low overhead costs for telehealth compared to in-person visits. For example, there is no patient waiting room and shuffling patients into exam rooms since the provider does not have to lease space. Patients also do not need to go through the hassle of filling out paper forms. Patients do not have high out-of-pocket costs compared to brick-and-mortar facilities that must inflate their prices to manage all their equipment and space. Solutions combining remote patient monitoring with real-time telehealth management have been proven to reduce use and spending for office-based services. A recent study in the *Journal of Medical Economics* showed that at 12 months, people active in a remote patient monitoring program demonstrated a statistically significant 25 percent reduction in office-based visits (which translated in a reduction of an average of 2.5 visits per year) compared to people with diabetes not on a remote patient monitoring program.⁶ Based on the study, telehealth has proven to reduce costs.

Oftentimes, telehealth platform vendors receive capitated payments, so overhead costs are incorporated into that pricing structure. The platform provider must then manage their overhead costs to be profitable over the per member per month rate.

Artificial Intelligence (AI) and Telehealth

AI can play a role in the triage of a telemedicine patient and is currently used to do so today. It allows the provider to work more effectively and spend their time only on the delivery of care. If telehealth providers leverage AI, they should be able to bring down the costs of their services. At this point, live clinicians will still play a critical role in every visit. AI can assist in offering more efficient and personalized delivery of care, but not fully replace a live clinician.

⁶ Whaley CM, Bollyky JB, Lu W, et al. Reduced Medical Spending Associated With Increased Use of a Remote Diabetes Management Program and Lower Mean Blood Glucose Values. *Journal of Medical Economics*. 2019;0(0):1-9. doi:10.1080/13696998.2019.1609483 <https://pubmed.ncbi.nlm.nih.gov/31012392/>

AI is also being utilized to navigate the patient through the health care system and find suitable sites of care. It allows for clinical decision support and real-time benefits tools, both of which assist providers in serving patients with the most up-to-date and efficient care, and the most affordable prescription drugs. AI can help calculate expected costs and help algorithms be more tailored for quality, which would impact price and quality transparency and care continuity. AI would better help manage chronic care patients and improve outcomes to innovate for AI engines to support the telehealth program system more broadly.

Every effort should be made to integrate AI (and other modern analytic tools and techniques such as machine learning, predictive analytics, and big data) into the health care system.

Conclusion

Thank you for the opportunity to share our views with the Subcommittee. The ERISA Industry Committee and our member companies are committed to working with you to meaningfully help improve health outcomes for workers, their families, and retirees. We are confident that our policy recommendations can provide meaningful changes to our health care system and patient lives. We look forward to working with the subcommittee to further help in policy development and enact legislation.



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