THE ERISA INDUSTRY COMMITTEE
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STATEMENT FOR THE RECORD BY

THE ERISA INDUSTRY COMMITTEE (ERIC)

TO THE

U.S. SENATE
COMMITTEE ON FINANCE

HEARING ON

"BEHAVIORAL HEALTH CARE WHEN AMERICANS NEED IT: ENSURING PARITY AND CARE INTEGRATION"

March 30, 2022

Chairman Wyden, Ranking Member Crapo, and Members of the Committee, thank you for the opportunity to submit a statement for the record on behalf of The ERISA Industry Committee (ERIC) for the hearing entitled *"Behavioral Health Care When Americans Need It: Ensuring Parity and Care Integration,"* providing specific recommendations to improve mental and behavioral health access and quality.

ERIC is a national nonprofit organization exclusively representing the largest employers in the United States in their capacity as sponsors of employee benefit plans for their nationwide workforces. With member companies that are leaders in every economic sector, ERIC is the voice of large employer plan sponsors on federal, state, and local public policies impacting their ability to sponsor benefit plans and to lawfully operate under ERISA's protection from a patchwork of different and conflicting state and local laws, in addition to federal law.

Americans engage with an ERIC member company 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 or snack, use cosmetics, fly on an airplane, visit a bank or hotel, benefit from our national defense, receive or send a package, or go shopping.

ERIC member companies voluntarily offer comprehensive health benefits to millions of active and retired workers and their families across the country. Our members offer great health benefits to attract and retain employees, be competitive for human capital, and improve health and provide peace of mind. On average, large employers pay around 75 percent of health care costs on behalf of 181 million beneficiaries.

Employers like ERIC member companies roll up their sleeves to improve how physical, mental, behavioral health care is delivered in communities across the country. They do this by developing value-driven and coordinated care programs, implementing employee wellness programs, providing transparency tools, and adopting a myriad of other innovations that improve quality and value to drive down costs. These efforts often use networks to guide our employees and their family members to providers that offer high-value care.

ERIC member companies understand the shortage of mental and behavioral health providers and offered policy solutions to address the crisis and long wait times. This included the following policy recommendations that will help ensure that Americans are better able to access the mental and behavioral health services they need, when and where they need them, without excess financial burden:

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

Our policy recommendations require a collaborative approach from Congress, employers, and providers, but many providers eschew insurance networks[1]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. We urge the Committee to develop legislation that will:

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

- Require that mental health facilities accept private insurance

- Increase telehealth access for employers' workforces and address unnecessary state and federal government barriers such as licensure and specific technology requirements

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

We also request that Congress steer clear of policies that establish counterproductive mandates that are likely to increase costs without improving access or care. We specifically request that the Committee refrain from advancing policies that use civil monetary penalties (CMPs) for mental health parity violations in favor of clear-cut policies that promote access and affordability of care.

Avoid Mandating a One-Sided Network Adequacy Requirement

Some have proposed that the way to provide more access to providers is to mandate a network adequacy requirement on health plans. We oppose this approach in favor of policies that allow more providers to reach patients in need such as through telehealth and cross-border licensing. ERISA plans do not profit from denying care to beneficiaries, and they do not seek to limit access to needed care. In fact, to do so would be completely counterproductive. Employers strive to ensure that beneficiaries have access to the type and volume of care they need, when they need it, as they want their employees and families healthy physically and mentally. This is why we have continually worked to improve access and quality in all aspects of the health care system.

As mentioned before, many mental and behavioral health providers choose not to participate in any insurance network. This could be for a variety of reasons – perhaps they prefer to accept out-of-network rates and balance bill patients. Perhaps they choose to take cash only. Or perhaps they simply recognize that due to provider shortages, they wield such market power that agreeing to anything other than the price they want, is unnecessary. In a 2017 Milliman report, 17.2 percent of behavioral health office visits were to an out-of-network provider showing that more patients are paying higher costs to get the care they need.[2] Regardless, many mental and behavioral health providers are charging high rates as payment in full, and as such, do not participate in networks. Enabling more providers to practice such as across state lines will give patients more affordable choices.

Simply requiring insurers to include these providers in-network will necessarily lead to price increases for patients. If providers know an insurer has to bring them in-network, they have an incentive to demand prices higher than what the market would otherwise bear, thus leading to higher costs for all insured beneficiaries due to premium increases. This approach hits patients in self-insured plans especially hard. After all, with half the workforce in high-deductible health

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

plans, and a significant portion of other beneficiaries whose cost-sharing is based on the cost of care, these price increases will serve to increase out-of-pocket costs for those who need the care most.

Any effort to implement a requirement that insurance networks include more mental and behavioral health providers must be a fair, two-sided requirement: it must be paired with a requirement that providers themselves participate in networks and show their willingness to be a part of the solution for mental and behavioral health care access and affordability. If not, Congress must take action by requiring that providers go in-network in at least a few plans. If Congress does this, it will show lawmakers are addressing the patient needs and should encourage good faith negotiations between providers and health plans. If providers are going to demand that a mandate be placed on health plans, providers should be prepared to also participate in this mandate, for the benefit of their patients, not providers' pockets.

Telehealth Innovation Can Improve Behavioral Health Care Access

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 time, and reduces the cost to the plan which ultimately lowers health plan premiums.

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.[3] 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.

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

- Telehealth Expansion Act (S. 1704). 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

[3] 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-centerssurvey-report.pdf

eligibility

- 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.

- 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.

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

- Apply the same standard of care to in-person visits and telehealth visits

- Do not require reimbursement for telehealth visits to be at the same rate as reimbursement for in-person visits

- Encourage interstate practice among providers

- Coordinate between the patient's telemedicine provider and primary care provider is encouraged

- 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

- Do not require or encourage patients to travel to specific "originating sites" to access telehealth services
- Apply the same informed consent requirements to in-person visits and telehealth visits
- Allow prescribing via telemedicine

Congress can develop a set of rules that protect patients while maximizing flexibility and care, rather than some of the current protectionist rules that serve to block patients from care on the state level. These simple, streamlined set of rules will provide clarity to providers and maximize access for patients.

Improving Care Integration for All Patients

As the access to psychologists and psychiatrists, in particular, has proven a challenge to plan beneficiaries, many have utilized other health care providers, such as those in primary care, to take care of their mental and behavioral needs. Congress can facilitate the transition of some mental and behavioral health services to nontraditional providers, such as to:

- Pursue efforts to ease a transition for coordinated care between interdisciplinary teams
- Direct CMS to pursue new opportunities for mental and behavioral health to be included in accountable care organization (ACO) type arrangements
- Eliminate regulatory barriers to creating capitated models that include mental and behavioral health professionals and condition some portion of public program reimbursement on participation in these types of models for mental health professionals and facilities
- 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
- 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
- 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 not every provider can 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.

Do Not Implement Civil Monetary Penalties (CMPs) for Mental Health Parity (MHP) Violations

One oft-repeated idea to improve access to mental health providers and treatments for beneficiaries of employer-sponsored health insurance has been to implement a monetary penalty regime to punish insurance companies and employers who are found to have fallen short of parity requirement.

We are deeply troubled by the Department of Labor's (DOL) recommendation encouraging Congress to authorize the agency to assess civil monetary penalties for parity violations, as mentioned in their 2022 Mental Health Parity and Addiction Equity Act (MHPAEA) Report. Penalties are not the answer. Rather, what is needed is clearcut, comprehensive guidance that helps employers support their workforce and mental health providers that support patients over their bottom line.

It is our understanding that problems in the large-group market among self-insured plans are primarily a result of non-quantitative treatment limitations (NQTLs), a requirement that was never contemplated in the original MHP legislation, but instead developed by the federal agencies.

Employers looking for a firm understanding of what is allowed, and what is not, have to resort to third-party publications, consultants, and outside vendors. In the large-group market, employers who are found to have parity violations inevitably have relied on outside counsel.

Large employers have continually made available the newly required comparative analyses upon request from DOL. However, despite extensive good faith efforts to comply, our member companies have reported that upon submitting analyses, DOL staff sent back dozens of questions and requests for substantially more documentation without explanation of what changes employers can make to comply with parity rules.

As such, penalizing employers for these violations are unlikely to prevent them in the future. Rather than implementing CMPs, if the goal is to reduce MHP violations through NQTLs, Congress should consider mandating that DOL provide much clearer, simpler guidance, that includes examples of what is actually allowed – rather than just citing various impermissible plan design elements.

Conclusion

Thank you for this opportunity to share our views with the Committee. The ERISA Industry Committee and our member companies are committed to working with Congress to meaningfully improve access to quality behavioral health care for our employees, their families, and retirees. We look forward to working with the Committee to enact legislation to meet the behavioral health needs of Americans.