STATEMENT FOR THE U.S. SENATE, FINANCE COMMITTEE HEARING ON

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

MARCH 30, 2022

The HR Policy Association (Association) and the American Health Policy Institute (Institute) appreciate the Committee holding this important hearing on behavioral and mental health care issues.

The Association is the leading organization representing chief human resource officers of 400 of the largest employers in the United States. Collectively, their companies provide health care coverage to over 20 million employees and dependents in the United States. The Institute, a part of the Association, examines the challenges employers face in providing health care to their employees and recommends policy solutions to promote affordable, high-quality, employer-based health care. The Institute serves to provide thought leadership grounded in the practical experience of America's largest employers.

Congress should enact the following policy recommendations to improve access to behavioral and mental health care services.

More Guidance Will Achieve Mental Health Parity, Not Civil Monetary Penalties

HR Policy strongly opposes enacting civil monetary penalties for mental health parity violations before the Department of Labor (DOL) publishes and implements its parity rulemaking and the additional guidance that is required by the Consolidated Appropriations Act of 2021 (CAA).

Congress recognized that employers needed substantially more guidance to implement the complicated mental health parity requirements for nonquantitative treatment limitations (NQTLs) when it enacted the CAA. Specifically, Congress required DOL to publish a "compliance program guidance document" that provides "illustrative, de-identified examples" of previous findings of compliance and noncompliance, including:

- Examples illustrating requirements for information disclosures and nonquantitative treatment limitations; and
- Descriptions of the violations uncovered during the course of such investigations.[1]

[1] 29 U.S.C. 1185a(a)(6)(B)(i).

Importantly, the CAA requires the examples to "provide sufficient detail to fully explain such finding, including a full description of the criteria involved for approving medical and surgical benefits and the criteria involved for approving mental health and substance use disorder benefits."[2]

Congress also required DOL to publish "additional guidance" that "shall include clarifying information and illustrative examples of methods that group health plans and health insurance issuers … may use for disclosing information to ensure compliance" with their parity requirements.[3] Specifically, "[s]uch guidance shall include information that is comparative in nature with respect to —

> (I) nonquantitative treatment limitations for both medical and surgical benefits and mental health and substance use disorder benefits;
>
> (II) the processes, strategies, evidentiary standards, and other factors used to apply the limitations described in subclause (I); and
>
> (III) the application of the limitations described in subclause (I) to ensure that such limitations are applied in parity with respect to both medical and surgical benefits and mental health and substance use disorder benefits."[4]

Regarding nonquantitative treatment limitations, the CAA also requires DOL to publish guidance that provides clarifying information and illustrative examples of methods, processes, strategies, evidentiary standards, and other factors that group health plans and health insurance issuers may use regarding the development and application of nonquantitative treatment limitations to ensure compliance with their parity requirements, "including —

> (i) examples of methods of determining appropriate types of nonquantitative treatment limitations with respect to both medical and surgical benefits and mental health and substance use disorder benefits, including nonquantitative treatment limitations pertaining to —
>
> > (I) medical management standards based on medical necessity or appropriateness, or whether a treatment is experimental or investigative;
> >
> > (II) limitations with respect to prescription drug formulary design; and
> >
> > (III) use of fail-first or step therapy protocols;
>
> (ii) examples of methods of determining —
>
> > (I) network admission standards (such as credentialing); and
> >
> > (II) factors used in provider reimbursement methodologies (such as service type, geographic market, demand for services, and provider supply, practice size, training, experience, and licensure) as such factors apply to network adequacy;

---

[2] 29 U.S.C. 1185a(a)(6)(B)(ii).

[3] 29 U.S.C. 1185a(a)(7)(B)(i).

[4] 29 U.S.C. 1185a(a)(7)(B)(ii).

(iii) examples of sources of information that may serve as evidentiary standards for the purposes of making determinations regarding the development and application of nonquantitative treatment limitations;

(iv) examples of specific factors, and the evidentiary standards used to evaluate such factors, used by such plans or issuers in performing a nonquantitative treatment limitation analysis;

(v) examples of how specific evidentiary standards may be used to determine whether treatments are considered experimental or investigative;

(vi) examples of how specific evidentiary standards may be applied to each service category or classification of benefits;

(vii) examples of methods of reaching appropriate coverage determinations for new mental health or substance use disorder treatments, such as evidence-based early intervention programs for individuals with a serious mental illness and types of medical management techniques;

(viii) examples of methods of reaching appropriate coverage determinations for which there is an indirect relationship between the covered mental health or substance use disorder benefit and a traditional covered medical and surgical benefit, such as residential treatment or hospitalizations involving voluntary or involuntary commitment; and

(ix) additional illustrative examples of methods, processes, strategies, evidentiary standards, and other factors for which the Secretary determines that additional guidance is necessary to improve compliance…"[5]

Under the CAA, DOL is supposed to publish this guidance 18 months after the CAA was enacted (July 2022) and is required to provide at least a 60-day public comment period before issuing any final guidance. DOL is also required to update this guidance every two years. According to DOL's latest regulatory agenda, the Department is currently scheduled to publish a proposed mental health parity rule that incorporates examples and modifications to account for the CAA in July 2022.

The need for this guidance before imposing any civil monetary penalties is abundantly clear from DOL's 2022 MHPAEA Report to Congress. The report shows none of the 134 self-funded employer plans' NQTL comparative analyses "contained sufficient information" despite the nine sets of FAQs, draft and final Disclosure Templates, and several enforcement fact-sheets DOL has published. When not one employer plan has a sufficient comparative analysis, it is not because none of them want to comply. It is because they do not know how to comply.

Moreover, imposing civil monetary penalties on plan sponsors will not solve the serious problem of provider shortages. According to HHS, 129.6 million Americans live in areas designated as Mental Health Professional Shortage Areas,[6] and 6,559 additional behavioral

[5] 29 U.S.C. 1185a(a)(7)(C).

[6] Bureau of Health Workforce Health Resources and Services Administration, U.S. Department of Health & Human Services, "Designated Health Professional Shortage Areas Statistics," September 30, 2021, available at: https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport.

health providers[7] are needed to fill these provider gaps.[8] Addressing this long-term problem will require significant investments by the federal government.

Employers have innovated and invested in significant new behavioral health benefits during the COVID pandemic. Addressing the current mental health care crisis and achieving mental health parity compliance will require significant efforts in partnership between employers, providers, government, patient groups and other stakeholders. We believe that enacting punitive legislative provisions like civil monetary penalties at this point will poison these efforts and serve only to hurt patients.

To achieve mental health parity compliance, Congress should:

- Encourage DOL to publish the guidance required by the CAA and additional de-identified examples of comparative parity analyses that are compliant under a final determination letter; and
- Focus on fostering partnerships between employers, providers, and carriers rather than punitive legislative provisions which further push stakeholders into their respective corners.

Expand the Collaborative Care Model (CoCM)

To increase access to behavioral health services the Association urges Congress to enact the bipartisan Collaborate in an Orderly and Cohesive Manner Act (H.R. 5218) to promote the uptake of the collaborative care model by providing grant funding to remove the barriers that primary care practices face when trying to implement the model. The collaborative care model increases access by creating a care team comprised of a primary care provider, a psychiatric consultant and care manager working together in a coordinated fashion. Over 90 randomized controlled trials have demonstrated collaborative care models are more effective and cost efficient than usual care.[9]

Behavioral health conditions often initially appear in a primary care setting and primary care clinicians provide mental health and substance use care to most people with behavioral disorders, as well as prescribe the majority of psychotropic medications. An integrative model that joins behavioral health and primary care would significantly improve behavioral health services, reduce the burden of other illness, lower medical costs, and reduce disparities in the identification and effectiveness of treatment for behavioral health issues.

---

[7] Behavioral health providers are health care practitioners or social and human services providers who offer services for the purpose of treating mental disorders including: psychiatrists, clinical social workers, psychologists, counselors, credentialed substance use specialists, peer support providers, and psychiatric nurse providers.

[8] Bureau of Health Workforce Health Resources and Services Administration, U.S. Department of Health & Human Services, “Designated Health Professional Shortage Areas Statistics,” September 30, 2021

[9] Jürgen Unützer, et.al., The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes, Health Home Information Resource Center, May 2013, available at: https://www.chcs.org/media/HH_IRC_Collaborative_Care_Model__052113_2.pdf.

The stigma surrounding mental health and substance use disorders results in patients not seeking treatment and even when they do, it can be difficult to find a provider in a timely manner. The collaborative care model provides a strong building block to address these problems by ensuring that patients can receive expeditious behavioral health treatment within the office of their primary care physician. Importantly, the team members also use measurement-based care to ensure that patients are progressing, and when they are not, treatment is adjusted.

In addition to increasing access, the collaborative care model has tremendous cost savings potential. For example, cost/benefit analysis demonstrates that this model has a 12:1 benefit to cost ratio for the treatment of depression in adults.[10] Furthermore, the model greatly increases the number of patients being treated for mental health and substance use disorders when compared to traditional 1:1 treatment. Lastly but no less important, the model has been shown to increase physician and patient satisfaction and reduce stress among primary care physicians.

Despite its strong evidence base and availability of reimbursement, uptake of the collaborative care model by primary care physicians and practices remains low due to the up-front costs associated with implementing the model. Additionally, many primary care physicians and practices may be interested in adopting the model but are unsure of next steps. The Collaborate in an Orderly and Cohesive Manner Act addresses both potential roadblocks by providing grants to primary care practices to cover start-up costs and by establishing technical assistance centers to provide support as practices implement the model. Moreover, the bill promotes research to identify additional evidence-based models of integrated care.

Remove Barriers to Providing and Expanding Telebehavioral Health

To help improve access to behavioral health care when Americans need it Congress should eliminate restrictions that impede an employer's ability to provide employees with telehealth services. During the COVID pandemic, telehealth became the preferred way for patients to see providers and liberalized telehealth rules resulted in an exponential growth in the use of telehealth, particularly telebehavioral health.[11] It allowed access to needed care while meeting patients' needs of convenience and safety as the virus spread.

A survey of HR Policy members showed that 79 percent of respondents offered mental health virtual care and telebehavioral health services to their employees to address access challenges.[12] Telebehavioral health has the potential to overcome patient stigma and improve access and efficiency of care for behavioral health services. Since the public health emergency, there has been a significant increase in patients keeping their behavioral health appointments. When patients keep their first appointment, they are more likely to keep subsequent appointments and patients satisfied with their treatment are more likely to continue with their course of therapy.

---

[10] Washington State Institute for Public Policy Benefit-Cost Results for Adult Mental Health. Retrieved from: https://www.wsipp.wa.gov/BenefitCost?topicId=8.

[11] Bestsennyy, O., Gilbert, G., Harris, A., & Rost, J. (2021). Telehealth: A quarter-trillion-dollar-post-COVID-19 reality? McKinsey & Company. https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/telehealth-a-quarter-trillion-dollar-post-covid-19-reality.

[12] HR Policy Association, CHRO Survey 2021.

Research also suggests that telebehavioral health results in better medication compliance, fewer visits to the emergency department, fewer patient admissions to inpatient units, and fewer subsequent readmissions.[13]

Despite the positive impact of expanded telebehavioral health, state and federal barriers continue to limit employers' ability to innovate in the telehealth space. While many positive steps were taken to increase flexibility around telehealth offerings during the public health emergency, several permanent changes are needed so employers can expand the scope of their telehealth offerings. Our recommendations for changes to expand access to affordable coverage and care through telehealth are below.

Pass the Primary and Virtual Care Affordability Act (H.R. 5541): Under the CARES Act, employees with a high-deductible health plan (HDHP) were able to access first-dollar coverage of telehealth visits through December 31, 2021. Its expiration left many employees without the ability to seek care through telehealth without first meeting their deductible. While an extension was included in the Omnibus package, it was only extended through the end of 2022. For behavioral health services, permanent change is especially important as provider shortages, in conjunction with limited in-network providers, makes it difficult for patients to find affordable in-network providers.

Allow telehealth services to be treated as an excepted benefit. Currently, stand-alone telehealth programs are considered excepted benefits and can only be provided to full-time employees enrolled in the employer health plan. Part-time, seasonal, and full-time employees that declined the employer medical plan cannot access these telehealth programs because it violates coverage rules under the ACA employer mandate. This was removed temporarily during the COVID-19 pandemic, but a permanent solution would allow employers to expand access to telehealth services to more employees, specifically younger workers and economically disadvantaged workers.

Allow providers in good standing with a valid license in at least one state provide telehealth services to patients in other states. While states should remain able to determine licensure requirements around prescribing ability or scope of practice, a state should not be able to prohibit a provider that is deemed qualified in another state from operating according to their licensure. Telehealth increases patients' ability to get adequate care from a qualified provider in another state. Additionally, cumbersome and expensive credentialing and licensing processes disincentivize many providers from obtaining licenses in multiple states. Congress should encourage states to join interstate medical licensure compacts to expedite the process for providers that want to practice in multiple states and expand the accessibility of providers for patients in need.

Enact the Telemental Health Care Access Act (S. 2061, H.R. 4058). This legislation will ensure Medicare beneficiaries can access telemental health services post-pandemic without satisfying the unnecessary and restrictive in-person requirement that was passed into law at the

[13] Hilty, D.M., Ferrer, D.C., Parish, M.B., Johnston, B., Callahan, E.J. & Yellowlees, P.M. (2013). The effectiveness of telemental health: A 2013 review. https://www.liebertpub.com/doi/10.1089/tmj.2013.0075.

end of 2020 that requires physicians to see their patients in-person at least six months prior to their telemental visit before a Medicare will reimburse for the telehealth visit. Congress should also ensure similar restrictions are not imposed on employer plans and individual coverage.

Enact the Telehealth Response for E-prescribing Addiction Therapy Services Act or TREATS Act (S.340, H.R. 1647). This legislation would allow certain controlled substances specifically schedules III and IV to be prescribed via telehealth without an in-person requirement. It also allows telehealth services to be provided via audio-only technology, if a physician has already conducted a video or in-person visit.

Enable ERISA plans to offer a uniform set of telehealth benefits. Congress passed the Employee Retirement Income Security Act (ERISA) to enable employers to provide uniform health care benefits to their employees. While health care reforms should offer states greater flexibility regarding their individual and small group health insurance markets, creating a uniform set to telehealth rules will enable multi-state employers to create and expand valuable telehealth benefits for their plan participants.

Expand the Use of Measurement-Based Care

It is estimated that only 18% and 11% of psychiatrists and psychologists, respectively, use assessment tools regularly.[14] When such tools are used in initial assessments, earlier diagnosis is more likely and can prevent conditions from becoming more severe. Outcomes improve 20-60% when such tools are used over the course of treatment because the provider has additional evidence on the effectiveness of the course of treatment.[15] Measurement-based care provides an objective tool for providers, mitigating inherent biases and resulting disparities in treatment. Measurement based care is also a critical component of the collaborative care model above.

Policy Recommendations

- Establish incentives with carriers (*e.g.*, star ratings) and providers (*e.g.*, pay for performance) to increase the use of appropriate measurement tools when providing care.
- Allocate funds to support a change effort to educate and implement measurement-based care across the country. A portion of such funds should be allocated to virtual programs such as telebehavioral interventions and digital behavioral apps to facilitate behavioral health integration models to add measurement-based care for small and rural practices in addition to larger practices.
- Instruct the CMS Office of the National Coordinator for Health Information Technology (ONC) Health IT Certification Program to mandate that certified electronic health record (EHR) vendors must include screening and symptom follow up tools using standardized

[14] Wood, J. & Gupta, S. Using Rating Scales in a Clinical Setting. *Current Psychiatry* 2017; 16[2]: 21-25. Retrieved on January 14 from https://mdedge-files-live.s3.us-east-2.amazonaws.com/files/s3fs-public/Document/August-2017/CR02709028.PDF.

[15] Fortney, J., et al. A Tipping Point for Measurement-Based Care. Psychiatry Serv. 2017 Feb 1;68(2):179-188. doi: 10.1176/appi.ps.201500439. Epub 2016 Sep 1. PMID: 27582237.

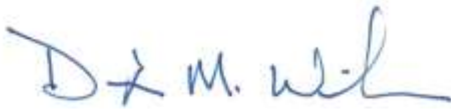
measures (PHQ-9, GAD-7) for major mental health and substance use disorders, including depression, suicide, anxiety, PTSD, mania, addiction, and psychotic disorders at no cost to providers. Supports for documentation, billing, panel management, and tracking measure scores over time should also be included.

- Increase incentives for using existing CPT Codes such as GO444, 96127, 96160, 96161, 96130, 96139.
- Include measurement-based care as a standard of care regardless of the modality.

* * * *

The HR Policy Association and the American Health Policy Institute welcome any opportunity to provide input and speak in further detail about improving access to behavioral and mental health care services. We look forward to working with you on this important topic.

Sincerely,



D. Mark Wilson
President and CEO, American Health Policy Institute
Vice President, Health & Employment Policy
HR Policy Association

Margaret Faso
Director, Health Care Research and Policy
HR Policy Association, American Health Policy Institute