MEETING THE MOMENT: IMPROVING ACCESS TO BEHAVIORAL AND MENTAL HEALTH CARE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH, EMPLOYMENT, LABOR, AND PENSIONS

OF THE

COMMITTEE ON EDUCATION AND LABOR U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTEENTH CONGRESS

FIRST SESSION

HEARING HELD IN WASHINGTON, DC, APRIL 15, 2021

Serial No. 117–6

Printed for the use of the Committee on Education and Labor

Available via: edlabor.house.gov or www.govinfo.gov

U.S. GOVERNMENT PUBLISHING OFFICE

44–330 PDF WASHINGTON : 2022

COMMITTEE ON EDUCATION AND LABOR

ROBERT C. "BOBBY" SCOTT, Virginia, *Chairman*

RAÚL M. GRIJALVA, Arizona
JOE COURTNEY, Connecticut
GREGORIO KILILI CAMACHO SABLAN, Northern Mariana Islands
FREDERICA S. WILSON, Florida
SUZANNE BONAMICI, Oregon
MARK TAKANO, California
ALMA S. ADAMS, North Carolina
MARK DE SAULNIER, California
DONALD NORCROSS, New Jersey
PRAMILA JAYAPAL, Washington
JOSEPH D. MORELLE, New York
SUSAN WILD, Pennsylvania
LUCY MC BATH, Georgia
JAHANA HAYES, Connecticut
ANDY LEVIN, Michigan
ILHAN OMAR, Minnesota
HALEY M. STEVENS, Michigan
TERESA LEGER FERNÁNDEZ, New Mexico
MONDAIRE JONES, New York
KATHY E. MANNING, North Carolina
FRANK J. MRVAN, Indiana
JAMAAL BOWMAN, New York, *Vice-Chair*
MARK POCAN, Wisconsin
JOAQUIN CASTRO, Texas
MIKIE SHERRILL, New Jersey
JOHN A. YARMUTH, Kentucky
ADRIANO ESPAILLAT, New York
KWEISI MFUME, Maryland

VIRGINIA FOXX, North Carolina, *Ranking Member*
JOE WILSON, South Carolina
GLENN THOMPSON, Pennsylvania
TIM WALBERG, Michigan
GLENN GROTHMAN, Wisconsin
ELISE M. STEFANIK, New York
RICK W. ALLEN, Georgia
JIM BANKS, Indiana
JAMES COMER, Kentucky
RUSS FULCHER, Idaho
FRED KELLER, Pennsylvania
GREGORY F. MURPHY, North Carolina
MARIANNETTE MILLER-MEEKS, Iowa
BURGESS OWENS, Utah
BOB GOOD, Virginia
LISA C. MC CLAIN, Michigan
DIANA HARSHBARGER, Tennessee
MARY E. MILLER, Illinois
VICTORIA SPARTZ, Indiana
SCOTT FITZGERALD, Wisconsin
MADISON CAWTHORN, North Carolina
MICHELLE STEEL, California
Vacancy
Vacancy

VÉRONIQUE PLUVIOSE, *Staff Director*
CYRUS ARTZ, *Minority Staff Director*

SUBCOMMITTEE ON HEALTH, EMPLOYMENT, LABOR, AND PENSIONS

MARK DE SAULNIER, California, *Chairman*

JOE COURTNEY, Connecticut
DONALD NORCROSS, New Jersey
JOSEPH D. MORELLE, New York
SUSAN WILD, Pennsylvania
LUCY MC BATH, Georgia
ANDY LEVIN, Michigan
HALEY M. STEVENS, Michigan
FRANK J. MRVAN, Indiana
ROBERT C. "BOBBY" SCOTT, Virginia *(ex officio)*

RICK W. ALLEN, Georgia *Ranking Member*
JOE WILSON, South Carolina
TIM WALBERG, Michigan
JIM BANKS, Indiana
DIANA HARSHBARGER, Tennessee
MARY E. MILLER, Illinois
SCOTT FITZGERALD, Wisconsin
VIRGINIA FOXX, North Carolina *(ex officio)*

CONTENTS

MEETING THE MOMENT: IMPROVING ACCESS TO BEHAVIORAL AND MENTAL HEALTH CARE

Thursday, April 15, 2021

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH, EMPLOYMENT,
LABOR, AND PENSIONS,
COMMITTEE ON EDUCATION AND LABOR,
Washington, DC.

The committee met, pursuant to notice, at 10:15 a.m., via Zoom, Hon. Mark DeSaulnier (Chairman of the subcommittee) presiding.

Present: Representatives DeSaulnier, Courtney, Norcross, Morelle, Wild, McBath, Stevens, Levin, Scott (Ex Officio), Allen, Walberg, Harshberger, Miller, Fitzgerald, and Foxx (Ex Officio.)

Staff present: Phoebe Ball, Disability Counsel; Ilana Brunner, General Counsel; Ijeoma Egekeze, Professional Staff; Daniel Foster, Health and Labor Counsel; Christian Haines, General Counsel; Sheila Havenner, Director of Information Technology; Carrie Hughes, Director of Health and Human Services; Ariel Jona, Policy Associate; Andre Lindsay, Policy Associate; Max Moore, Staff Assistant; Mariah Mowbray, Clerk/Special Assistant to the Staff Director; Kayla Pennebecker, Staff Assistant; Véronique Pluviose, Staff Director; Banyon Vassar, Deputy Director of Information Technology; Joshua Weisz, Communications Director; Cyrus Artz, Minority Staff Director; Courtney Butcher, Minority Director of Member Services and Coalitions; Rob Green, Minority Director of Workforce Policy; Georgie Littlefair, Minority Legislative Assistant; John Martin, Minority Workforce Policy Counsel; Hannah Matesic, Minority Director of Operations; Audra McGeorge, Minority Communications Director; Carlton Norwood, Minority Press Secretary; Ben Ridder, Minority Professional Staff Member; and Taylor Hittle, Minority Professional Staff Member.

Chairman DESAULNIER. The Subcommittee on Health, Employment, Labor and Pensions will come to order. Welcome everyone. I note that a quorum is present. The Subcommittee is meeting today to hear testimony on Meeting the Moment: Improving Access to Behavioral and Mental Health Care.

This is an entirely remote hearing. All microphones will be kept muted as a general rule to avoid unnecessary background noise. Members and witnesses will be responsible for unmuting themselves when they are recognized to speak, or when they wish to seek recognition. I also ask that Members please identify themselves before they speak.

Members should keep their cameras on while in the proceeding. Members shall be considered present in the proceeding when they

are visible on camera, and they will be considered not present when they are not visible on camera. The only exception to this is if they are experiencing technical difficulty and inform Committee staff of such difficulty.

If any Member experiences technical difficulties during the hearing, you should stay connected on this platform, make sure you are muted, and use your phone to immediately call the committee's IT Director, whose number was provided in advance.

Should the Chair experience technical difficulty, or need to step away to vote on the floor, Mr. Levin, as a Member of this subcommittee, or another majority Member if I am not available, or if he is not available, is hereby authorized to assume the gavel in the Chair's absence.

Again, this is an entirely remote hearing and as such, the committee's hearing room is officially closed. Members who choose to sit with their individual devices in the hearing room must wear headphones to avoid feedback, echoes and distortion resulting from more than one person on the software platform sitting in the same room.

Members are also expected to adhere to social distancing and safe health care guidelines, including the use of masks, hand sanitizer, and wiping down their areas both before and after their presence in the hearing room.

In order to ensure that the committee's five-minute rule is adhered to, staff will be keeping track of time using the committee's field timer. The field timer will appear in its own thumbnail picture and will be named 001__timer. There will be no one-minute remaining warning. The field timer will sound its audio alarm when time is up. Members and witnesses are asked to wrap up promptly when their time has expired.

While a roll call is not necessary to establish a quorum in official proceedings conducted remotely, or with remote participation, the Committee has made it a practice whenever there is an official proceeding with remote participation for the Clerk to call the roll, and to help make clear who is present at the start of the proceeding.

Members should say their name before announcing they are present. This helps the Clerk, and also helps those watching the platform and the livestream who may experience a few second's delay.

At this time I'd like to ask the Clerk to call the role.

The CLERK. Chairman DeSaulnier?

Chairman DESAULNIER. Here.

The CLERK. Mr. Courtney?

Mr. COURTNEY. Courtney present.

The CLERK. Mr. Norcross?

Mr. NORCROSS. Here.

The CLERK. Mr. Morelle?

Mr. MORELLE. Morelle present.

The CLERK. Ms. Wild?

Ms. WILD. Present.

The CLERK. Mrs. McBath?

Mrs. MCBATH. McBath present.

The CLERK. Ms. Stevens?

Ms. STEVENS. Stevens is present.

The CLERK. Mr. Levin?
[No response]
The CLERK. Mr. Mrvan?
[No response]
The CLERK. Mr. Scott?
Mr. SCOTT. Chairman Scott is present.
The CLERK. Ranking Member Allen?
Mr. ALLEN. I was on mute, OK. All right. I'm present. I think I'm unmuted.
The CLERK. Mr. Wilson?
[No response]
The CLERK. Mr. Walberg?
Mr. WALBERG. Walberg present.
The CLERK. Mr. Banks?
[No response.]
The CLERK. Mrs. Harshbarger?
Mrs. HARSHBARGER. Harshbarger is present.
The CLERK. Mrs. Miller?
[No response.]
The CLERK. Mr. Fitzgerald, excuse me? Mr. Fitzgerald I think I see you.
VOICE. Yes we're still working on the audio.
The CLERK. Understood. Mrs. Foxx?
[No response.]
The CLERK. Chairman DeSaulnier that concludes the roll call.
Chairman DESAULNIER. Thank you. Pursuant to Committee Rule 8(c), opening statements are limited to the Chair and the Ranking Member. This allows us to hear from our witnesses sooner, and provides all Members with adequate time to ask questions.

I recognize myself now for the purpose of making an opening statement.

I want to thank you all. I want to thank Chairman Scott and Ranking Member Allen. I'm very excited and enthusiastic about this subcommittee and the work we're going to pursue, and particularly the subject matter that we will discuss today. And I want to thank all the panelists and the staff for the terrific job they've done putting this meeting together.

I want to thank Ranking Member Allen for the time we had the last few days to catch up, and to talk about how we can collaborate. And again I want to thank Chairman Scott. So with that, one thing about this issue is in our conversations with other Members and with our staff, this is an issue that is of importance personally and professionally to many of us.

And it's my hope that we work aggressively on the subcommittee and with the Chairman and the Ranking Member of the full committee to make sure that we're doing everything we can to be knowledgeable and to help get valuable behavioral health and mental health services to Americans.

Today in this meeting we are here to discuss the importance of improving access to behavioral health and mental health services. This morning's hearing comes amid a pandemic-driven surge in the demand for mental health services. Across this country essential workers are grappling with the trauma of working through the pandemic.

Millions of workers are struggling with the loss of their livelihoods, and countless people have been unable to appropriately grieve the deaths of their loved ones. Overall, the number of individuals reporting symptoms of depression or anxiety has increased from 11 percent before the pandemic to 41 percent now. I'm going to repeat that: 11 percent before the pandemic, 41 percent now.

As with nearly all consequences of this pandemic, the mental health and behavioral health challenges, some communities have it harder than others. This is particularly true for people of color who entered the pandemic with disproportionately limited access to affordable health care and stable employment.

Regrettably, individuals seeking affordable mental health services are facing significant barriers for far too long that have kept quality mental health care out of reach for far too many people, and unfortunately make their individual situations more challenging and much more difficult to overcome.

And, with the addition of the pandemic, have made them more isolated. In fact, even before the pandemic, less than half of individuals with mental illness, and only 11 percent of individuals with a substance abuse disorder received services and treatment. And those services and treatment the quality was varied to say the least.

This is due in part to the high cost of care and nationwide shortage of mental health providers. However, the most glaring barrier to these critical services is a health insurance system that still does not provide true and equal coverage for both mental health services and medical health services, known as mental health parity.

This barrier is particularly frustrating given the significant steps Congress has taken to get insurers to cover both behavioral and medical health services. In 2008, for example, Congress passed the Mental Health Parity and Addiction Equity Act, which prohibited employer-sponsored health plans from placing restrictions on benefits for mental health and substance abuse disorder than are greater than those applied to medical and surgical benefits.

And in 2010 of course, Congress passed the landmark Affordable Care Act to extend this protection to the individual insurance market. Despite these efforts, our Federal agencies still do not have the resources they need to protect and oversee millions of people's health benefits.

The Employee Benefits Security Administration investigates workplace benefits issues on behalf of more than 150 million Americans, yet its enforcement and consumer assistance budget has been frozen at less than $150 million dollars for several years now, meaning that the agency has only about one dollar to protect the health benefits of each person.

Even when they do find wrongdoing, the agency lacks the authority to penalize insurers who restrict coverage for mental health services. In other words, our communities, particularly underserved communities, have been left to deal with the lasting and potentially fatal mental health consequences on this pandemic on their own.

This in spite of exponential research and knowledge about behavioral health and substance abuse, and evidence-based research that would help Americans if we provide these services. I'm going to

have to pause for a second because I told by staff that we've got some livestream issues.

Mr. VASSAR. Mr. Chairman, I believe we're good to go sir. Thank you everyone for your patience.

Mr. DESAULNIER. Thank you. Sorry for that interruption. Oh, I left off about the difficulty in getting these services. This is unacceptable. One of our basic responsibilities as elected officials is to care for the well-being of our constituents, and that means providing—means ensuring people have sufficient access to affordable behavioral and mental health care.

The first step is enforcing the laws we have already passed. We should all be able to agree that this is a step worth taking to ensure that all Americans have access to the care that they need, and we all benefit from. And we must take additional steps to build upon these laws to ensure that they more fully protect consumers and are as efficient in delivering services as is possible.

I also know that many employers, unions, health plans and providers are rising to the challenge to meet the unique needs of workers and families during this time, and we look forward to the benefit of what they are doing after the pandemic.

I also look forward to hearing from our expert witnesses about solutions to securing access to equitable mental and behavioral health care for all of our constituents, all Americans.

I now would like to recognize the distinguished Ranking Member for the purpose of making an opening statement. Congressman Allen.

[The statement of Chairman DeSaulnier follows:]

STATEMENT OF HON. MARK DESAULNIER, CHAIRMAN,
SUBCOMMITTEE ON HEALTH, EMPLOYMENT, LABOR, AND PENSIONS

Today, we are meeting to discuss the importance of improving access to behavioral and mental health care.

This morning's hearing comes amid a pandemic-driven surge in the demand for mental health services. Across the country, essential workers are grappling with the trauma of working through the pandemic; millions of workers are struggling with the loss of their livelihoods; and countless people have been unable to appropriately grieve the deaths of their loved ones. Overall, the number of individuals reporting symptoms of depression or anxiety has increased from 11 percent before the pandemic to 41 percent this year.

As with nearly all consequences of the coronavirus pandemic, the mental and behavioral health challenges have hit some communities harder than others. This is particularly true for people of color who entered the pandemic with disproportionately limited access to affordable health care and stable employment.

Regrettably, individuals seeking affordable mental health services are facing significant barriers that—for far too long—have kept quality mental health care out of reach for far too many people.

In fact, even before the pandemic, less than half of individuals with mental illness—and only 11 percent of individuals with a substance use disorder—received services and treatment.

This is due, in part, to the high cost of care and the nationwide shortage of mental health providers.

However, the most glaring barrier to these critical services is a health insurance system that still does not provide true, equal coverage for both mental health services and medical health services—known as mental health parity.

This barrier is particularly frustrating given the significant steps Congress has taken to get insurers to cover both behavioral and medical health services.

In 2008, for example, Congress passed the Mental Health Parity and Addiction Equity Act, which prohibited large employer-sponsored health plans from placing restrictions on benefits for mental health and substance use disorder that are greater than those applied to medical and surgical benefits. And, in 2010, Congress passed

the landmark Affordable Care Act to extend this protection to the individual insurance market.

Despite these efforts, our Federal agencies still do not have the resources they need to protect and oversee millions of people's health benefits.

The Employee Benefits Security Administration investigates workplace benefits issues on behalf of more than 150 million people. Yet, its enforcement and consumer assistance budget has been frozen at less than $150 million for several years, meaning that the agency has about one dollar to protect the health benefits of each person.

Even when they do find wrongdoing, the agency lacks the authority to penalize insurers who restrict coverage for mental health services.

In other words, our communities—particularly underserved communities—have been left to deal with the lasting and potentially fatal mental health consequences of this pandemic on their own.

This is unacceptable. One of our most basic responsibilities as elected officials is to care for the well-being of our constituents—and that means ensuring people have sufficient access to affordable behavioral and mental health care.

The first step is enforcing the laws we have already passed. We should all be able to agree that this is a step worth taking to ensure that all Americans have access to the care they need and we all benefit from. And we must take additional steps to build upon these laws to ensure that they more fully protect consumers and are as efficient at delivering services as possible. I also know that many employers, unions, health plans, and providers are rising to the challenge to meet the unique needs of workers and families during this time and we look forward to the benefit of what they are doing after the pandemic.

I look forward to hearing from our expert witnesses about solutions to securing access to equitable mental and behavioral health care for all of our constituents and all Americans.

I now recognize the distinguished Ranking Member for the purpose of making an opening Statement.

Mr. ALLEN. Thank you Chairman. We're having a little anxiety and behavioral problems with technology today. It makes us all a little anxious doesn't it. But I want to thank everybody for joining us here today for this important discussion about the quality and accessibility of mental health and behavioral health services for American workers.

The well-being of America's workers have always been a priority for committee republicans, that's why Congress is engaged in ongoing efforts to address worker's mental and behavioral health needs, including efforts to improve access to high-quality and innovative treatment and services.

Sadly, due to the COVID–19 pandemic and related lockdowns, this past year has been very trying for families across the country. Almost overnight schools and workplaces closed upending American's lives, and creating barriers to key mental health services.

While upsetting, but perhaps not surprising, these events triggered an increase in symptoms of anxiety and depression in the United States. In 2020 four in 10 adults reported symptoms of anxiety or depression up from one in 10 in 2019. More Americans are struggling with substance abuse disorder leading to rising overhead death rates.

In response to growing mental health needs Congress in a bipartisan manner, increased funding to the Substance Abuse and Mental Health Services Administration through the Care's Act in 2021 appropriations, which include additional money for emergency grants for behavioral health services to states and other grantees.

The COVID–19 pandemic also accelerated the use of telehealth services, and in response to the increased need, Congress provided

additional temporary flexibility for employers to provide telehealth benefits to more workers.

Congress should strongly consider permanent expansions of telehealth coverage that may improve access to quality care, including behavioral health care. As a committee of jurisdiction over employer sponsored healthcare, republicans understand that employers want what is best for their employees, which means having the flexibility to provide quality healthcare and addressing workers' mental and behavioral health needs.

Ensuring workers have access to high-quality treatment services is key to maintaining a healthy and successful workplace. And I add that that is what employers want. Thank you very much and that concludes—I yield my time.

[The statement of Ranking Member Allen follows:]

STATEMENT OF HON. RICK W. ALLEN, RANKING MEMBER,
SUBCOMMITTEE ON HEALTH, EMPLOYMENT, LABOR, AND PENSIONS

Thank you all for joining us here today for an important discussion about the quality and accessibility of mental and behavioral health services for American workers.

The well-being of America's workers has always been a priority for Committee Republicans. That's why Congress is engaged in on-going efforts to address workers' mental and behavioral health needs, including efforts to improve access to high-quality and innovative treatments and services.

Sadly, due to the COVID–19 pandemic and related lockdowns, this past year has been a very trying one for families across the country. Almost overnight, schools and workplaces closed, upending Americans? lives and creating barriers to key mental health services.

While upsetting, but perhaps not surprising, these events triggered an increase in symptoms of anxiety and depression in the United States. In 2020, four in 10 adults reported symptoms of anxiety or depression, up from one in 10 in 2019. More Americans are struggling with substance use disorder leading to rising overdose death rates.

In response to growing mental health needs, Congress, in a bipartisan manner, increased funding to the Substance Abuse and Mental Health Services Administration through the CARES Act and 2021 appropriations, which included additional money for emergency grants for behavioral health services to States and other grantees.

The COVID–19 pandemic also accelerated the use of telehealth services, and in response to the increased need, Congress provided additional temporary flexibilities for employers to provide telehealth benefits to more workers. Congress should strongly consider if permanent expansions of telehealth coverage may improve access to quality care, including behavioral health care.

As the Committee of jurisdiction over employer-sponsored health care, Republicans understand that employers want what is best for their employees, which means having the flexibility to provide quality health care and addressing workers? mental and behavioral health needs. Ensuring workers have access to high-quality treatment services is key to maintaining a healthy and successful work force.

According to a 2020 Congressional Budget Office estimate, 151 million Americans receive health insurance through employer-provided plans which is the largest single source of coverage. Yet, Democrats are seeking to eliminate employer-sponsored health care through their socialist Medicare-for-All scheme, which would force millions of Americans into a one-size-fits-all, government-run system and cost more than $30 trillion dollars over the next decade.

A 2018 survey by American's Health Insurance Plans reveals that 71 percent of Americans are satisfied with their current employer-provided health coverage. By all metrics, satisfaction with employer health coverage outpaces public support for the Democrat's Medicare-for-All scheme.

Employers around the country continue to make concerted efforts to meet the mental and behavioral health needs of workers through implementation of coordinated care programs, employee wellness programs, use of telehealth services, and additional employee assistance programs, though Democrats will ignore this fact and unjustifiably assume that employers are short-changing their employees.

House Republicans want to empower America's job creators to expand access to quality care and mental health services for workers and their families. While the system can be improved, we also recognize employers are attuned to the needs of their employees, as I know firsthand. For 37 years, I ran a construction business where we provided staff benefits. I knew my employees? needs and what benefits and services were best suited to meet them. That is why I believe employers play a critical role in enhancing the system moving forward, which will benefit workers by ensuring that effective mental and behavioral health services are offered.

Chairman DESAULNIER. Thank you, Mr. Allen. Without objection all other Members who wish to insert written statements into the record may do so by submitting them to the Committee Clerk electronically in Microsoft Word format by 5 p.m. on April 28, 2021.

And now I'd like to welcome and again thank our witnesses. We are just delighted that you would take the time to share your experience and your expertise with the committee. It's a really important endeavor that we are about to embark on.

Dr. Brian Smedley is Chief of Psychology in the Public Interest at the American Psychological Association. He is a psychologist by training, and an expert in the field of healthy equity. Thank you Doctor for being here.

Dr. Christine Yu Moutier, and if I mispronounce your name please forgive me. It's happened to me many times in my life, and correct us all—correct me I should say, when you start your comments. Dr. Moutier is Chief Medical Officer at the American Foundation for Suicide Prevention. She is a psychiatrist by training and a leader in the field of suicide prevention.

James Gelfand is Senior Vice president for Health Policy at the ERISA Industry Committee. He works on the development of policies that support employer-sponsored health plans.

Dr. Meiram Bendat is the founder of Psych-Appeal. He is a licensed psychotherapist as well as an attorney who has litigated numerous cases on behalf of consumers and behavioral health providers. Welcome to all of you.

Instructions—we appreciate the witnesses for participating again today and look forward to your testimony. Let me remind the witnesses that we have read your statements, and they will appear in full in the hearing record.

Pursuant to Committee Rule 8(d) and the committee practice, each of you is asked to limit your oral presentation to a five-minute summary of your written statement. Before you begin your testimony, excuse me, please remember to unmute your microphone.

During your testimony, staff will be keeping track of time and a timer will sound when time is up. Please be attentive to the time, wrap up when your time is over, and re-mute your microphone.

If any of you experience technical difficulties during your testimony or later in the hearing, you should stay connected on the platform, make sure you are muted, and use your phone to immediately call the committee's IT Director whose number was provided to you in advance.

We will let all of the witnesses make their presentations before we move to Member questions. When answering a question please remember to unmute your microphone.

The witnesses are aware of their responsibility to provide accurate information to the committee and therefore we will proceed with their testimony.

I will first recognize Dr. Smedley. Dr. Smedley please go ahead.

STATEMENT OF DR. BRIAN D. SMEDLEY, CHIEF OF PSYCHOLOGY IN THE PUBLIC INTEREST OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION

Dr. SMEDLEY. Thank you Chairman DeSaulnier. Chairman DeSaulnier, Ranking Member Allen, and Members of the subcommittee, thank you for the opportunity to testify today. I'm Dr. Brian Smedley and I'm the American Psychological Association's Chief of Psychology in the Public Interest.

APA's public interest directorate, which I lead, fulfills APA's commitment to apply the science and practice of psychology to the fundamental problems of human welfare and the promotion of equitable and just treatment of all segments of society through education, training and public policy.

The COVID–19 pandemic has contributed to what we have called a mental health tsunami in this country. APA's Stress in America survey series shows that over the past year COVID–19 consistently exacted a higher emotional toll than other common stressors.

We also know that patient's coping mechanisms for the public health and economic impacts of the pandemic are serious, and highly individualized, including undesired weight changes, increased use of alcohol and other drugs, or even suicidal behaviors and ideation.

Our Member clinicians continue to see an increase inpatient demand for treatment of anxiety disorders, depressive disorders, and stress or trauma disorders than before COVID–19. Research suggests that we may be grappling with the mental health impact of this pandemic long after the pandemic itself ends.

However, we also know that not all Americans are equally affected. The mental health impact of COVID–19 is especially prominent in black, indigenous and other people of color communities, which are more likely to report anxiety about contracting the virus, in addition to other stresses related to the virus like economic instability, social and economic inequality, racism, discrimination and stigma are at the root of mental and behavioral health inequities experienced by BIPOC communities.

I'd like to mention two other highly impacted groups. First, children and younger adults are experiencing higher rates of stress, anxiety and fear than older generations. School closures and social activity suspensions are a factor, but we're particularly concerned about the potential for increased rates of abuse, neglect, or other household trauma occurring in the home.

Second, frontline health care providers, including psychologists, are also exhibiting more frequent symptoms of post-traumatic stress disorder, depression, anxiety, sleep disorders and burnout due to the workplace stress occasioned by the pandemic.

APA urges action in two key areas in response. First, the 2008 Mental Health Parity Law has in some ways fallen short of its promise. Congress can do more to ensure adequate oversight and enforcement of insurers' compliance with the law, and close gaps

permitting states to exempt their own employees, including essential frontline workers such as police officers and firefighters from the law's provisions.

The second area is telehealth, which has been a rare silver lining of the pandemic. Congress and CMS have greatly expanded access to telehealth services, including audio only telehealth under Medicare. We urge the subcommittee to support measures that would ensure that ERISA plans equally cover and reimburse for these services.

We also believe Medicare's telemental health coverage flexibilities should extend beyond the pandemic. Specifically, we urge Members of the subcommittee to support the bipartisan Parity Enforcement Act of 2021, H.R. 1364, introduced by Congressman Norcross to strengthen the Department of Labor's ability to enforce the parity law by giving it the authority to levy civil fines.

We also urge that we close the loophole in the Federal Parity Law that allows states to opt out of parity requirements for State employees. We also urge that we support increased funding to enable better oversight and stronger enforcement of insurers' compliance with the Federal Parity Law.

And we urge you to support measures such as the bipartisan Tele-Mental Health Improvement Act, H.R. 2264, that would increase private coverage of telebehavioral services, including audio-only services, and establish permanent Medicare coverage of essential mental and behavioral health services by audio-only telehealth.

I applaud the committee for examining the long-term behavioral health effects of the pandemic and urge you to support an approach to this crisis that provides equitable access to care and preventive interventions to avert worse patient outcomes further downstream.

APA would welcome an opportunity to collaborate with the subcommittee on efforts to address inequitable access to care, and the ongoing mental health impact of his pandemic. Thank you for the opportunity to testify today, and I look forward to answering any questions you have.

[The prepared statement of Dr. Brian Smedley follows:]

PREPARED STATEMENT OF DR. BRIAN SMEDLEY

AMERICAN PSYCHOLOGICAL ASSOCIATION SERVICES, INC.

Written Testimony
Of
Brian Smedley, PhD
American Psychological Association

Before the U.S. House of Representatives

"Meeting the Moment: Improving Access to Behavioral and Mental Health Care"

April 15, 2021

Chairman DeSaulnier, Ranking Member Allen, and members of the Health, Employment, Labor, and Pensions Subcommittee, thank you for the opportunity to testify today on the vital topic of our nation's deepening behavioral and mental health crisis. I am Dr. Brian Smedley, and I am the Chief of Psychology in the Public Interest at the American Psychological Association (APA). APA is the nation's largest scientific and professional nonprofit membership organization representing the discipline and profession of psychology. APA has more than 122,000 members and associates who are clinicians, researchers, educators, consultants, and students. Through the application of psychological science and practice, our association's mission is to make a positive impact on critical societal issues.

In earlier testimony before Congress this year, APA described what we are facing as a "syndemic," wherein the COVID-19 pandemic is both fueled by and worsening pre-existing socioeconomic inequality. In other words, this pandemic spreads more rapidly because of social inequality and injustice, which contributes to disease clustering among those already at higher risk for poor health, which in turn multiplies the disease burden on these already-disadvantaged populations.

The mental and behavioral health toll of the pandemic is showing a similar pattern: greater impacts and higher levels of risk for certain populations, within a broader context of population-wide effects

APA.ORG
APASERVICES.ORG
Advocating for APA members and psychology
750 First Street, NE
Washington, DC 20002-4242
202.336.5800
202.336.6123 TDD

illustrating the need for a much stronger mental health and substance use disorder treatment system that everyone can depend on. With both mental health and substance use disorders and with COVID, the risks, burdens, experiences, and outcomes have proven to vary widely across different communities. Survey data from the Centers for Disease Control and Prevention (CDC) from last June found that Black, Hispanic, and American Indian or Alaska native, Native Hawaiian or Pacific Islander respondents were significantly more likely than White respondents to report experiencing one or more adverse mental or behavioral health symptoms.[i] Although suicide rates appear to have fallen over the past year,[ii] that same survey found that Black and Hispanic respondents reported having seriously considered suicide in the previous month at roughly twice the rate of White respondents. This illustrates the need to address not just the disease itself, but also the social determinants of health. Members of racial and ethnic minorities are substantially more likely to report stress and worry about housing instability or inability to pay rent, and about having enough food to put on the table.[iii]

It must also be emphasized that because of the stress, fear, anxiety, and treatment disruptions caused by COVID-19, we are falling further behind in addressing the public health emergency that was getting much attention before the COVID-19 pandemic—the drug overdose epidemic. The CDC projects that there were more than 88,000 drug overdose deaths over the previous 12 months ending in August of 2020, an astounding 26.8% increase over the August 2019 figure.[iv] The nation will likely have experienced a drug overdose death toll of more than 100,000 Americans over the course of 2020. The CDC's data also shows that while opioids, and especially fentanyl, continue to account for the bulk of overdose deaths, overdose deaths associated with the use of psychostimulants such as methamphetamine increased by 46% over the previous year. Even before COVID-19, data showed that methamphetamine and other psychostimulant overdose deaths were occurring in the American Indian/Alaska Native population at more than twice the rate of other racial groups.[v]

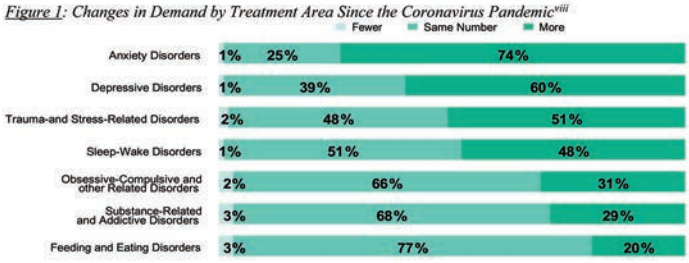
A population health approach addressing the needs of the entire population, including at-risk subgroups, is integral to addressing the mental health and substance use treatment needs heightened by the COVID-19 pandemic. My testimony today will focus on both the broader mental health impact of the COVID-19 pandemic, as well as how it is highlighting and exacerbating long-standing mental health disparities amongst disproportionately affected communities.

Overall Mental and Behavioral Health Impact of the COVID-19 Pandemic

Ample research demonstrates that the pandemic caused greater levels of stress, anxiety, depression, and trauma. According to APA's latest *Stress in America Survey*, 84% of U.S. adults reported feeling at least one emotion—such as anxiety, sadness, and anger—associated with prolonged stress within the previous two weeks. The COVID-19 pandemic was reported among the top sources of this stress.[vi] These survey results track other research showing sharp increases in reported symptoms of mental disorders[vii] and damage to social determinants of health.

Today, most of our member-clinicians continue to see an increase in patient demand for treatment of anxiety disorders (74%), depressive disorders (60%), and stress or trauma disorders (48%) than before COVID-19 (Fig. 1).

Figure 1: Changes in Demand by Treatment Area Since the Coronavirus Pandemic[viii]



APA.ORG
APASERVICES.ORG
Advocating for APA members and psychology
750 First Street, NE
Washington, DC 20002-4242
202.336.5800
202.336.6123 TDD

The impact of the pandemic on Americans' collective mental health is highly individualized, particularly as COVID-19 has affected many communities in different ways. As an example, unpaid adult caregivers reported one or more adverse mental or behavioral health impacts at twice the rate as non-caregivers, were five times as likely to have started or increased substance use in an effort to cope with the pandemic, and were almost nine times as likely to have seriously considered suicide in the last month as non-caregivers. [i] This illustrates that there are several ways the pandemic can negatively affect an individual's mental health. The financial and economic impact of COVID-19 is a primary source of stress, with over a third of adults reporting difficulty paying for a basic living expense—such as housing, food, or utilities—within the past three months, and more than four in ten adults reporting a decrease in income or a job loss.[ix]

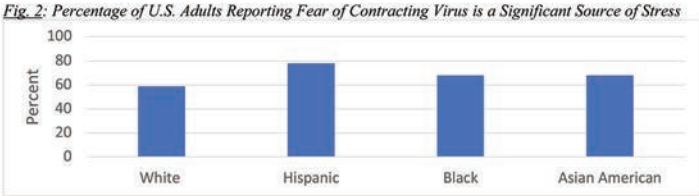
Another contributing factor is the social isolation and loneliness resulting from compliance with the public health measures, including social distancing and "stay at home" orders, necessary to control the spread of the virus. Psychologists led research on the effects of social isolation and loneliness, which were gaining recognition as a critical public health issue even before the spread of COVID-19. While physical distancing, mask-wearing, and "stay at home" orders are, and continue to be, vital tools to combat the spread of the virus, research demonstrates a link between prolonged social isolation and loneliness to both poor mental and physical health.[x] A recent tracking poll conducted shortly after many states issued COVID-related stay-at-home orders shows that individuals were more likely to report negative mental health effects from the pandemic.[xi]

COVID-19, Mental Health, and Health Equity

The impact of COVID-19 on mental health has been especially prominent in BIPOC communities of color that are also experiencing disproportionately high rates of COVID-19 cases and deaths, as well

as many of the underlying sources of stress and trauma identified above.[xii] Black and Hispanic adults are more likely than White adults to report symptoms of anxiety and/or depressive disorder during the pandemic.[xiii] BIPOC communities are also experiencing an adverse financial impact due to the pandemic.[xiv] Even in the early months of the pandemic, over 40% of Americans reported at least one adverse mental or behavioral health condition, including symptoms of anxiety disorder, depressive disorder, stressor-related disorder, or substance use disorder, with significantly higher rates amongst Black and Latino communities.[xv] Black, Hispanic, and Asian-American communities are also more likely to report fear of contracting the virus itself as a source of stress (Fig. 2).[xvi] According to data collected from Mental Health America's Online Screening Program, between January and September of 2020 Native American screeners reported the highest increases in rates of depression and suicidal ideation.[xvii]

Fig. 2: Percentage of U.S. Adults Reporting Fear of Contracting Virus is a Significant Source of Stress



The pandemic did not create these disparate impacts. Instead, it exacerbated preexisting inequities in the social determinants of health that affect these groups, which in turn influence a broad array of health and quality-of-life outcomes and risks. In particular, the pandemic has highlighted long-standing systemic health and social inequities that put many racial and ethnic minorities at increased risk of contracting COVID-19 and lessening the likelihood of recovery from the virus.[xviii] Social and economic inequality, racism, discrimination, and stigma are at the root of the differences we continue to see among racial and

ethnic minorities. Even when these groups can access care, factors such as providers' implicit bias may result in inequitable health outcomes.

People with disabilities are another group facing unique stressors and challenges during the COVID-19 pandemic that can affect their mental health. Research on past pandemics shows that individuals with disabilities find it difficult to access critical medical supplies as resources become scarce.[xix] Furthermore, policies around rationing medical care can intensify discriminatory attitudes towards disabled individuals during times of crisis, which can increase anxiety about getting sick and requiring medical care.[xx]

Although research on the effect of the COVID-19 pandemic and public health responses on patients with pre-existing mental disorders is scarce, some patients are reporting increased symptoms or manifestations of mental or behavioral health disorders.[xxi] One study of patients with eating disorders found that 37.5% reported a worsening of their symptoms during the pandemic, with 56.2% reporting increased anxiety.[xxii] The study's authors suggest that limitations on fitness activities during quarantine, isolation and loneliness, and increased use of social media could be contributing factors. Notably, APA's most recent *Stress in America* report found that more than 60% of Americans surveyed reported undesired weight gain or loss.[vi] Another survey of patients with preexisting mental disorders receiving outpatient treatment found that roughly one in five reported a deterioration of their mental health related to the pandemic, with a similar proportion reporting being unable to receive routine care due to suspension of hospital visits, and of reducing or stopping their use of prescribed medications because of difficulty accessing prescriptions. [xxiii]

Children and Young Adults

APA's October 2020 *Stress in America* report found that Generation Z (defined as those between the ages of 18 and 23) reported the highest stress level of any demographic group, and that reported stress level generally declined from younger to older age groups. Children remain particularly vulnerable to the mental health impact of the crisis, as the proportion of children's emergency department visits attributable to mental health continues to rise throughout the pandemic and significantly outpaces its proportion in 2019.[xxiv] There is some evidence showing higher rates of distraction, irritability, and fear among children, with younger children being more likely to exhibit these behaviors.[xxv] In a June 2020 survey, nearly a third of parents reported that their child had experienced some degree of harm to their emotional or mental health.[xxvi] As with adults, substance use among adolescents remains a concern, as there is some evidence of rising rates of solitary substance use amongst adolescents.[xxvii]

This population is of concern not only because of their higher vulnerability to stress, but also because of the increased risk they will be impacted by adverse childhood experiences (ACEs), including various forms of abuse, neglect, and household dysfunction. More than three-quarters of child abuse and neglect is perpetrated by parents, who as a group are increasingly socially isolated, economically stressed, and engaging in substance use during the pandemic.[xxviii]

Frontline health care workers

Our nation must invest in programs that support critical essential workers who have been on the frontlines of the pandemic and in many cases are suffering from PTSD, depression, anxiety, sleep disorders and burnout. The mental health impact of this pandemic on frontline healthcare workers is well-documented, with significantly higher levels of depression, anxiety, and stress noted among many professions.[xxix] According to a Kaiser Family Foundation/Washington Post Survey, 62% of frontline

healthcare workers say that worry or stress related to COVID-19 has a negative impact on their mental health. In addition, 13% of health care workers said they have received mental health services or medication specifically due to worry or stress related to COVID-19, and an additional one in five (18%) said they thought they might need such services but did not get them.[xxx] [xxxi] Roughly 80% of graduate-level psychology trainees and early-career psychologists were also highly likely to report stress from either the financial or career impact of COVID-19 (such as greater levels of student loan debt, limited employment, or extending the time needed to complete in graduate school due to disruptions in training), or the psychological stress or workload of COVID-19 and expectations regarding maintaining quality of the services they provide. [xxxii]

Strengthening Enforcement of Mental Health Parity

APA believes that an essential policy response to help meet the increased demand for mental health services is to provide more robust enforcement of federal mental health parity law. Mental health patients and providers had high hopes that the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) would effectively address inequities in access to mental health and substance use disorder treatment.

Although the law has helped improve access to behavioral health services somewhat, pervasive parity oversight and compliance issues remain, as shown by a major analysis by the Milliman consulting agency,[xxxiii] and as described by complaints APA receives regularly from its members. MHPAEA's requirements on health plan coverage of behavioral healthcare fall into two categories: quantitative limits (such as the number of outpatient visits or days of inpatient treatment covered, copayment requirements, and deductibles) on coverage, and non-quantitative (NQTL) treatment limits (such as the medical management standards used, pre-authorization requirements for coverage of services, and the adequacy

and accessibility of the plan's network of providers). MHPAEA prohibits plans from applying either quantitative or non-quantitative treatment limits on coverage of mental health and substance use disorder services that are more restrictive than the predominant corresponding limits it uses for substantially all medical/surgical benefits. Milliman's analysis found that patients were five times more likely to seek office visits to out-of-network behavioral healthcare providers than visits to out-of-network primary care providers, strongly suggesting that health plans did not have adequate networks of behavioral healthcare providers. Milliman also found that medical/surgical providers received in-network reimbursement rates that were 18-21% higher than reimbursement rates for in-network behavioral health providers, relative to Medicare reimbursement rates for their services.

Three key factors hamper the effectiveness of MHPAEA in establishing adequate access to necessary services: (1) The need for stronger federal enforcement of self-insured health plans; (2) The lack of federal enforcement as a backup to state oversight of fully-insured health plans; and (3) The ability of state government employee health plans to opt-out of parity requirements.

Let me first explain the parity enforcement scheme set up by MHPAEA. For fully insured health insurance offered by employers, state insurance commissioners have primary enforcement authority, and HHS has secondary enforcement authority, as established under the Public Health Service Act (PHSA). Roughly half of Americans with employer-provided health insurance have this type of coverage. For self-insured health plans established under the Employee Retirement and Income Security Act (ERISA), the Department of Labor has primary enforcement authority.

While the Department of Labor (DOL) is the primary federal MHPAEA enforcement agency. DOL investigated and closed 180 parity complaints last year, HHS only resolved three complaints. DOL's MHPAEA enforcement is carried out by its staff at the Employee Benefits Security Administration (EBSA), which relies on approximately 350 investigators to review the compliance of roughly 2.5 million

private employment-based group health plans—a ratio of more than 7,000 health plans per investigator.[xxxiv] Although the agency needs more resources, its enforcement authority would be significantly strengthened by Congressman Donald Norcross's "Parity Enforcement Act of 2021," H.R. 1364, which would strengthen DOL's enforcement authority by giving DOL the authority to levy civil fines. The Parity Enforcement Act is strongly supported by APA, the Kennedy Forum, the American Society of Addiction Medicine (ASAM), and the Mental Health Liaison Group

The second issue is that HHS interprets its secondary enforcement authority as allowing it to intervene *only* if a state is substantially failing to enforce *all* of the insurance requirements established under the PHSA. Consequently, HHS is only enforcing MHPAEA compliance in a handful of states. APA has submitted comments to the agency on this issue.[xxxv] Consequently, in the vast majority of states HHS does not enforce critical but very complex compliance issues, such as the adequacy of an insurer's provider network, even if the state insurance commissioner lacks the resources, expertise, or interest in addressing this issue.

The third issue I raise concerns MHPAEA's permission for state employee health plans to opt-out of extending the law's protections to their state workers. Large numbers of state employee health plans have opted out of MHPAEA, which means that although many state employees—including teachers, police and firefighters—are essential, frontline workers directly affected by COVID and its mental health impacts, they are likely to be denied the same federal mental and behavioral health insurance protections in place for the people they serve. Congress should close this unjustified loophole and remove the option for state employee plans to decide that their state employees do not deserve MHPAEA protections.

Stronger MHPAEA enforcement and wider application of its requirements are key to achieving the law's potential. To provide greater enforcement resources and cover the expanded federal enforcement that these bills would create, APA supports a $25 million increase in funding for MHPAEA enforcement

work by EBSA within the Department of Labor, and for MHPAEA enforcement at HHS, a $10 million increase in funding for the Center for Medicaid and CHIP Services (CMCS) and a $5 million increase for the Center for Consumer Information and Insurance Oversight (CCIIO).

Extend Equitable Access to Telehealth Services

We would also like to note the critical role that telehealth services, including those furnished via an audio-only communication, continue to play in this pandemic to both broadly meet the expanded demand for mental and behavioral services and to help remedy long-standing disparities in access to these services. Audio-only services are a critical (and often the only) link to mental and behavioral health services for many individuals and communities that are less likely to have reliable access to technological training or broadband technology—including, but not limited to, older adults, individuals with disabilities, people in rural and frontier areas, lower-income families, and racial and ethnic minority communities.

However, audio-only telehealth coverage under Medicare is currently slated to end at the end of the COVID-19 PHE, at which point many of the communities who gained first-time access to mental and behavioral health services during the pandemic will suddenly lose that access. We hope members of this Subcommittee will support efforts to help avoid this "access cliff" by permanently allowing Medicare beneficiaries to receive essential mental and behavioral health services by audio-only telehealth.

Furthermore, during the COVID-19 pandemic, psychologists and other behavioral health providers found that mental health and substance use disorder services provided by telehealth for patients in self-insured ERISA plans and private health insurers are routinely reimbursed at a lower rate than for in-person care, and there are more restrictive barriers to coverage for telehealth services than in-person care. This is particularly important because most Americans have health care coverage through their employers.

The bipartisan Tele-Mental Health Improvement Act (H.R. 2264), sponsored by Representatives David Trone and Brian Fitzpatrick, would help support behavioral health providers and their patients by requiring these plans—during and shortly after the current public health emergency—to reimburse for tele-behavioral health services, including those services furnished via audio-only communication, at the same rate as in-person services, if telehealth for those services would otherwise be covered. Additionally, it would prevent such plans from imposing more restrictive barriers to coverage for telehealth services than in-person services.

I'd like to close by talking about something more positive, which is resilience. Resilience skills can be learned, and psychologists led the development of effective interventions, such as Psychological First Aid and Skills for Psychological Recovery, which are being used with frontline health care workers, first responders, and in hospital systems to give those bearing the brunt of this crisis the support they need. These services are important and need to be made more widely available, but we also need to think about community resilience. Social support (or lack thereof) is one of the strongest predictors of the development of post-traumatic stress disorder (PTSD) after a traumatic event.[xxxvi, xxxvii] The mental and physical suffering we are experiencing presents us with an opportunity, if not an obligation, to come together as a nation and in our communities to ensure that the most vulnerable among us get the help they need, and to build the social capital that will help us better weather the storms to come.

I am deeply grateful to the Subcommittee for this opportunity to testify today and look forward to further conversations with you on strategies to address the long-term mental health impact of this pandemic in an equitable manner.

[i] Czeisler, M. É., Lane, R. I., Petrosky, E., Wiley, J. F., Christensen, A., Njai, R., ... & Rajaratnam, S. M. (2020). Mental health, substance use, and suicidal ideation during the COVID-19 pandemic—United States, June 24–30, 2020. *Morbidity and Mortality Weekly Report*, *69*(32), 1049.

[ii] Ahmad, F. B., & Anderson, R. N. (2021). The Leading Causes of Death in the US for 2020. *JAMA*.

[iii] McKnight-Eily, L. R., Okoro, C. A., Strine, T. W., Verlenden, J., Hollis, N. D., Njai, R., ... & Thomas, C. (2021). Racial and ethnic disparities in the prevalence of stress and worry, mental health conditions, and increased substance use among adults during the COVID-19 pandemic—United States, April and May 2020. *Morbidity and Mortality Weekly Report*, *70*(5), 162.

[iv] Ahmad FB, Rossen LM, Sutton P. Provisional drug overdose death counts. National Center for Health Statistics. 2021. Accessed at https://cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm.

[v] Volkow, N. National Institute on Drug Abuse, 2021. *"U.S. Overdose Deaths Involving Psychostimulants (Mostly Amphetamine), by Race"* [Powerpoint presentation]. Accessed at https://www.apa.org/members/content/methamphetamine-addiction

[vi] American Psychological Association (2021). Stress in America: January 2021 Stress Snapshot. https://www.apa.org/news/press/releases/stress/2021/stress-snapshot-january.pdf.

[vii] Panchal, N., Kamal, R., Orgera, K., Cox, C., Garfield, R., Hamel, L., & Chidambaram, P. (2020). The implications of COVID-19 for mental health and substance use. *Kaiser family foundation*.

[viii] https://www.apa.org/news/press/releases/2020/11/anxiety-depression-treatment

[ix] Kaiser Family Foundation (March 2021). KFF Health Tracking Poll: Economic Hardship, Health Coverage, And The ACA. https://www.kff.org/coronavirus-covid-19/poll-finding/kff-health-tracking-poll-late-february-2021/.

[x] N. Leigh-Hunt, D. Bagguley, K. Bash, V. Turner, S. Turnbull, N. Valtorta, W. Caan (2017). An overview of systematic reviews on the public health consequences of social isolation and loneliness, *Public Health*, 152, 157-171. DOI: https://doi.org/10.1016/j.puhe.2017.07.035.

[xi] Kaiser Family Foundation (April 2020). KFF Health Tracking Poll - Early April 2020: The Impact Of Coronavirus On Life In America. https://www.kff.org/health-reform/report/kff-health-tracking-poll-early-april-2020/.

[xii] Gold JA, Rossen LM, Ahmad FB, et al. Race, Ethnicity, and Age Trends in Persons Who Died from COVID-19 — United States, May–August 2020. MMWR Morb Mortal Wkly Rep 2020;69:1517–1521. DOI: http://dx.doi.org/10.15585/mmwr.mm6942e1external icon.

[xiii] Kaiser Family Foundation (Feb. 10, 2021). The Implications of COVID-19 for Mental Health and Substance Use. https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/.

[xiv] Kaiser Family Foundation (October 2020). Race, Health, and COVID-19: The Views and Experiences of Black Americans. http://files.kff.org/attachment/Report-Race-Health-and-COVID-19-The-Views-and-Experiences-of-Black-Americans.pdf.

[xv] Czeisler, M.É., Lane R,I., Petrosky, E., et al. (2020). Mental health, substance use, and suicidal ideation during the COVID-19 pandemic — United States, June 24–30, 2020. *Morbidity and Mortality Weekly Report. 69*,1049–1057. DOI: http://dx.doi.org/10.15585/mmwr.mm6932a1external icon.

[xvi] American Psychological Association (May 2020). Stress in America: Stress in the Time of COVID-19, Volume One. https://www.apa.org/news/press/releases/stress/2020/stress-in-america-covid.pdf.

[xvii] Mental Health America (2020). COVID-19 and Mental Health: A Growing Crisis. https://mhanational.org/sites/default/files/Spotlight%202021%20-%20COVID-19%20and%20Mental%20Health.pdf.

[xviii] Centers for Disease Control and Prevention. (July 2020). Health Equity Considerations and Racial and Ethnic Minority Groups. https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html#fn1

[xix] Campbell, V. A., Gilyard, J. A., Sinclair, L., Sternberg, T., & Kailes, J. I. (2009). Preparing for and responding to pandemic influenza: Implications for people with disabilities. *American Journal of Public Health*, *99*, S294-S300, https://doi.org/10.2105/AJPH.2009.162677

[xx] Priestley, M., & Hemingway, L. (2007) Disability and disaster recovery, Journal of Social Work in Disability & Rehabilitation, 5:3-4, 23-42, DOI: 10.1300/J198v05n03_02

[xxi] Vindegaard, Nina and Benros, Michael E. (2020). COVID-19 pandemic and mental health consequences: systematic review of the current evidence, Brain, Behavior, and Immunity, Volume 89,pages 531-542.https://doi.org/10.1016/j.bbi.2020.05.048

[xxii] Fernández-Aranda, F., Casas, M., Claes, L., Bryan, D. C., Favaro, A., Granero, R., ... & Treasure, J. (2020). COVID-19 and implications for eating disorders. *European Eating Disorders Review*, *28*(3), 239.

[xxiii] Zhou, J., Liu, L., Xue, P., Yang, X., Tang, X. (2020). Mental health response to the COVID19 outbreak in China. *American Journal of Psychiatry*. https://doi.org/10.1176/appi.ajp.2020. 20030304

[xxiv] Leeb RT, Bitsko RH, Radhakrishnan L, Martinez P, Njai R, Holland KM. Mental Health–Related Emergency Department Visits Among Children Aged <18 Years During the COVID-19 Pandemic — United States, January 1–October 17, 2020. MMWR Morb Mortal Wkly Rep 2020;69:1675–1680. DOI: http://dx.doi.org/10.15585/mmwr.mm6945a3external icon.

[xxv] Jiao, W. Y., Wang, L. N., Liu, J., Fang, S. F., Jiao, F. Y., Pettoello-Mantovani, M., & Somekh, E. (2020). Behavioral and Emotional Disorders in Children during the COVID-19 Epidemic. *The Journal of pediatrics*, *221*, 264–266.e1. https://doi.org/10.1016/j.jpeds.2020.03.013.

[xxvi] Gallup (June 16, 2020). U.S. Parents Say COVID-19 Harming Child's Mental Health. https://news.gallup.com/poll/312605/parents-say-covid-harming-child-mental-health.aspx.

[xxvii] Dumas TM, Ellis W, Litt DM. What Does Adolescent Substance Use Look Like During the COVID-19 Pandemic? Examining Changes in Frequency, Social Contexts, and Pandemic-Related Predictors. J Adolesc Health. 2020 Sep;67(3):354-361. doi: 10.1016/j.jadohealth.2020.06.018. Epub 2020 Jul 18. PMID: 32693983; PMCID: PMC7368647.

[xxviii] Bryant, D. J., Oo, M., & Damian, A. J. (2020). The rise of adverse childhood experiences during the COVID-19 pandemic. *Psychological Trauma: Theory, Research, Practice, and Policy*.

[xxix] Cabarkapa, S., Nadjidai, S. E., Murgier, J., & Ng, C. H. (2020). The psychological impact of COVID-19 and other viral epidemics on frontline healthcare workers and ways to address it: A rapid systematic review. Brain, behavior, & immunity - health, 8, 100144. https://doi.org/10.1016/j.bbih.2020.100144.

[xxx] KFF and Washington Post. (2021). Frontline Healthcare Workers Survey (Feb. 11-March 2, 2021). https://www.kff.org/report-section/kff-the-washington-post-frontline-health-care-workers-survey-toll-of-the-pandemic/

[xxxi] American Psychological Association (2020, November). Patients with depression and anxiety surge as psychologists respond to the Coronavirus pandemic. https://www.apa.org/news/press/releases/2020/11/telehealth-survey-summary.pdf.

[xxxii] American Psychological Association of Graduate Students (September 2020). The Impacts of COVID-19 on Psychology Education & Training: Concerns Disparities & Recommendations. http://www.spssi.org/covid19andpsycheducation.

[xxxiii] Melek, S., Davenport, S., & Gray, T. J. (2019). Addiction and mental health vs. physical health: widening disparities in network use and provider reimbursement. *Mental Health Treatment and Research Institute: Milliman Research Report*

[xxxiv] https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/mhpaea-enforcement-2020.pdf

[xxxv] https://www.hhs.gov/programs/topic-sites/mental-health-parity/achieving-parity/cures-act-parity-listening-session/comments/behavioral-health-care-providers/american-psychological-association-practice-organization/index.html

[xxxvi] Ozer, E. J., Best, S. R., Lipsey, T. L., & Weiss, D. S. (2003). Predictors of posttraumatic stress disorder and symptoms in adults: a meta-analysis. *Psychological bulletin*, *129*(1), 52.

[xxxvii] Brewin, C. R., Andrews, B., & Valentine, J. D. (2000). Meta-analysis of risk factors for posttraumatic stress disorder in trauma-exposed adults. *Journal of consulting and clinical psychology*, *68*(5), 748.

APA.ORG
APASERVICES.ORG
Advocating for APA members and psychology

750 First Street, NE
Washington, DC 20002-4242

202.336.5800
202.336.6123 TDD

Chairman DESAULNIER. Thank you, Doctor. That was terrific. We will now go Dr. Yu Moutier. Doctor? There you go.

STATEMENT OF DR. CHRISTINE YU MOUTIER, MD, CHIEF MEDICAL OFFICER, AMERICAN FOUNDATION FOR SUICIDE PREVENTION

Dr. MOUTIER. Sorry about that. Great. I am Dr. Christine Moutier, Chief Medical Officer for the American Foundation for Suicide Prevention, the Nation's largest non-profit dedicated to saving lives and bringing hope to those affected by suicide. My message today about the growing gap between mental health needs and accessible care is critically serious, hopeful and actionable.

Thank you Chair DeSaulnier, Ranking Member Allen and Members of the subcommittee for your time today. The pandemic has clearly been a time of increased attention to mental health and very real heightened distress in our Nation.

However, even pre-pandemic we have seen changes in the landscape around mental health. We've seen a 35 percent increase in the national suicide rate from 1999 through 2018. One in four Americans has a diagnosable mental health condition in their lifetime, and yet less than half of those are receiving care.

The degree of suffering experienced by millions of Americans and families is enormous with barriers still impeding mental health, being approached on par with physical health. We say there is no health without mental health because research shows the brain and the body are connected.

People with mental illness have higher risks of suffering disability and die 15 to 20 years younger than their counterparts, mostly due to medical causes, and for people with mental illness of course the risk of dying by suicide is also much higher, as much as 30 times higher than the general population.

Health system delivery in the U.S. was oddly designed without mental health in mind. The public, including people with lived experience of mental health conditions and suicide loss, and suicidal experiences, have been making change at the grassroots level.

But until the health system improves and makes mental health a real priority, the gap between the demand for quality, timely, culturally competent treatment, and the ability to access those mental health services will only grow larger because attitudes are opening up among the public.

Research shows that when primary care and health systems embrace mental health, and substance use disorders as integral targets of health care delivery, many health outcomes improve. And there are enormous economic benefits for societies that prioritize mental health—a proven return on investment for each dollar spent on mental health promotion and prevention.

So, in many ways, we cannot afford inaction. To put it succinctly, with all of our advances in science, systems design and technology, we can, and we must reconcile the growing mismatch in our Nation's mental health needs with the ability to access services and support.

During the COVID–19 pandemic, data show that upwards of 40 to 50 percent of the population report elevations in experiences of depression, anxiety, trauma, loss and increased substance use. Suicidal thoughts are also much more prevalent during this time, especially among young people, with one in four young adults reporting suicidal ideation.

As the pandemic has progressed, the proportion of respondents to these surveys with detrimental effects on their mental health continue to rise, and there are reasons to be especially concerned about particular populations.

Minoritized communities, essential and frontline health workers, caregivers, youth, rural residents, and LGBTQ people. Despite the evident need for broad and equitable access to mental health care, many are having trouble accessing care. These challenges have

worsened during the pandemic despite greater access via telehealth services.

The subcommittee is asked to consider efforts that would support enhanced mental health parity enforcement, to ensure that coverage for mental health care is no less restrictive than medical or surgical care. Recent analyses found evidence of lack of parity and behavioral health services, compared with med/surg in terms of higher out of network use, and lower reimbursement for behavioral services.

And these disparities are trending in the wrong direction. There must be much more accountability and oversight of parity to ensure that mental health conditions are not being discriminated against.

In closing, I urge the subcommittee to consider legislation and policies to: one, ensure effective enforcement of mental health parity and broaden access to mental health care generally; two, support a robust, diverse mental health workforce; and three, integrate mental health and suicide prevention in health systems, workplaces and schools as critical touchpoints that can establish a culture that is responsive to mental health needs.

The steps we take in the aftermath of the pandemic will set the trajectory for the Nation's mental health for years to come. Parity must be enforced, and disparities must be addressed to ensure equitable access and care for those in need.

I thank the subcommittee for appreciating the gravity of the situation and look forward to hearing your comments and answering your questions. Thank you.

[The prepared statement of Dr. Christine Yu Moutier follows:]

PREPARED STATEMENT OF DR. MOUTIER

American Foundation for Suicide Prevention

April 11, 2021

Testimony: Dr. Christine Moutier, Chief Medical Officer, American Foundation for Suicide Prevention

House Education and Labor Committee, Subcommittee on Health, Employment, Labor, and Pensions

Hearing: Meeting the Moment: Improving Access to Behavioral and Mental Health Care

I am the Chief Medical Officer for the American Foundation for Suicide Prevention, the nation's largest non-profit dedicated to saving lives and bringing hope to those affected by suicide. Today I am here representing the hundreds of thousands of people walking in our Out of the Darkness Walks, participating in International Survivors of Suicide Loss Day events, our dedicated volunteers and field advocates from all 50 states and Washington, D.C., as well as several hundred suicide researchers who are advancing the science of suicide prevention. I am a psychiatrist, a medical educator, and someone who has addressed mental health conditions in my patients, medical trainees, my family, and my own life. My message today about the growing gap between mental health needs and the support that is critically serious, but hopeful and actionable. Thank you Chair DeSaulnier, Ranking Member Allen, and Members of the Subcommittee for your time today.

The Mental Health Crisis in Our Nation

The pandemic has clearly been a time of increased attention to mental health and very real heightened mental health distress for the nation. However, even pre-pandemic, we have seen changes in the landscape around mental health. For example, there has been a major shift in attitudes opening up around mental health as a legitimate and critical part of human health. There has been a rise in prevalence of mental health conditions in youth and young adults over the past decade. We have seen a 35% increase in the national suicide rate from 1999 through 2018 (and fortunately two years of declining numbers of suicides in 2019 and 2020). One in four Americans will have a diagnosable mental health condition in their lifetime - 1 in 5 each year - and the World Health Organization has declared depression a leading cause of medical disability globally. Other conditions such as substance use disorders are on the rise with an unprecedented number of opioid overdose deaths in 2020. And yet less than half of Americans with mental health conditions are receiving care. The degree of suffering experienced by millions of Americans and families is enormous, with barriers still impeding mental health being approached on par with physical health - in workplaces, schools and in healthcare delivery systems.

For those who do seek care, there's often a long delay between the onset of symptoms and the healthcare they receive - in many cases months to years. There is an alarming gap between the number of people who experience mental illness and those who receive care. And especially troubling is the fact that some populations have additional layers of inequity that pile on top of the health disparity that exists for people just due to mental illness alone.

American Foundation for Suicide Prevention

Research shows people with mental illness have a higher relative risk of death than the general population and die 15 to 20 years younger than their counterparts. Most die of the same natural causes that are leading causes of death nationwide, including heart disease, cancer, and cerebrovascular, respiratory, and lung diseases. For people with mental illness, the risk of dying by suicide is also much higher (as much as 30 times higher) than the general population. A lion's share of these terrible outcomes can be mitigated with early recognition and treatment, and even prevention of mental health conditions.

Health system delivery in the US was designed without mental health in mind. Most health professionals do not receive education in mental health, and even among mental health professionals, training in effective suicide prevention practices is at an early stage of implementation. The public, including people with Lived Experiences of mental health conditions and suicide loss survivors have been making change at the grassroots community level, implementing education programs in schools and workplaces, campaigns to reduce stigma, and have successfully advocated for increasing legislative changes at the state and federal levels. Celebrities across all fields are speaking out, a recent example being Meghan Markle in her interview with Oprah Winfrey, when she shared her experience with suicidal crisis. But until the *health system* including system leaders, payers, training programs and accrediting bodies, improves and makes mental health a real priority, the gap between the demand for quality, timely, culturally competent treatment and the ability to access those mental health services will only grow larger. Stigma is going down, more people are speaking out, families are desperate, but what are they encountering when they do come for help in primary care, emergency departments, substance use treatment or mental health care settings?

Research shows that when primary care and health systems embrace mental health and substance use disorders as integral components of primary care and healthcare delivery, many health outcomes improve. Individual suffering and disability improve, and families, schools and workplaces are benefited when individuals can live and function to their healthiest potential. There are enormous economic benefits for societies that prioritize mental health and an economic return on investment for each dollar spent on mental health promotion and prevention – in many ways, we cannot afford inaction.

To put it succinctly, with all of our advances in science, systems design, and technology, in the USA in 2021, we can, and we must, reconcile the growing mismatch in the mental health needs of our nation with the ability to access services and support.

The Impact of COVID-19 on Mental Health

During the COVID-19 pandemic, data show 50-70% of the population report elevations in experiences of depression, anxiety, loneliness, trauma, loss, grief and increased substance use. Numerous studies have kept abreast of the nation's mental health experiences and suffering during the pandemic through various mechanisms such as the CDC Household Pulse Survey during COVID which has been surveying 60-90,000 Americans adults every 3-5 weeks during the pandemic.

American Foundation for Suicide Prevention

The portion of the American public experiencing anxiety, isolation, symptoms of depression, insomnia and increased substance use has been rising. Suicidal thoughts are much more prevalent during this time especially among young people with 25% of young adults reporting suicidal ideation in the past 30 days, an increase of 2-3 times usual baseline rates. As the pandemic progressed during 2020, the proportion of respondents who reported detrimental effects on their mental health continued to rise—39% in May 2020 and 53% in July 2020 and just recently in March 2021, we are seeing the first decreases in distress by 8-10 percentage points for depression and anxiety across age and demographic groups.

Fortunately, preliminary suicide data in the US in 2020 find suicide deaths have actually decreased by 5.6% year over year.

There are reasons to be especially concerned about particular populations: marginalized communities, essential and frontline health workers, caregivers, youth, rural residents and LGBTQ people. For example, in CDC surveys, Hispanic and Black Americans have shown the highest rates of distress of all racial groups with 19% of Hispanic Americans reporting suicidal ideation and 15% of Black Americans, which was more than twice the rate of suicidal ideation in the general population. Additionally, while the overall suicide mortality is showing decreases, some states have begun analyzing their mortality data by groups and find that suicide rates went down in White residents (of MD and CT) but went up in Black and other non-white groups in those same states.

In my JAMA Psychiatry article, which was released April 8, 2021, on Suicide Threats and Opportunities during COVID-19, I outline the ways the pandemic is pressing on known risk factors. The pandemic affects people differently: we are all in this pandemic together, however we are not all having the same experiences. Many groups may be hit harder, either for reasons of pandemic-specific impacts such as the impact on essential workers and frontline health workers, groups experiencing greater economic strain, vulnerable youth, people in unsafe homes, people with pre-existing disabilities, and other groups who have long had the experience of discrimination and inequities which are being accentuated by the pandemic - these include LGBTQ people, women, and other potentially marginalized groups.

Some good news: help seeking is on the rise during the pandemic and conversations about mental health are at an all-time high with all our lives turned upside down in one way or another. One in four Americans are currently in mental health treatment per both CDC and our Harris poll. Calls to the National Suicide Prevention Lifeline and its subnetwork, the Disaster Distress Helpline (1-800-985-5990) have increased since the onset of the pandemic, with significantly higher increases to the Disaster Distress Helpline. Implementation of 988 will likely dramatically increase calls to the Lifeline network as that number goes live nationwide in July 2022 and efforts begin to promote the new number. Texts to the Crisis Text Line (text TALK to 741-741) have risen 40% during the pandemic.

American Foundation for Suicide Prevention

Health Disparities

The pandemic and recent events have laid bare the health, social and economic disparities leading to disproportionate trauma, suffering, and loss of life for certain groups. In the March 31 JAMA report of 2020 mortality, we see that overall mortality as well as COVID-19 deaths were disproportionately higher in American Indian, Hispanic and Black Americans than the general population. In fact, health disparities have been well studied and documented long before COVID-19, e.g., by the National Academy of Sciences (Institute of Medicine) in their landmark 2003 report.

Studies of implicit bias among health care providers reflect the general population biases related to women, LGBT people and people from minoritized race/ethnicities. These biases of physicians feed into clinical decision making, leading to worse outcomes for diagnosing and/or appropriately treating cardiovascular disease, cancer, HIV, diabetes, kidney problems, mental health conditions and pregnancy related health issues. Black adolescents are significantly less likely to receive care for depression, with experts identifying pervasive structural inequities even when socioeconomic status is controlled for. Other factors that lead to health inequities include generational trauma, workforce issues with lack of access to culturally competent providers, and mistrust of healthcare providers creating daunting barriers to treatment.

Pre-existing disparities in health, access to care, economic/job type disparities and education are showing up in these mental health experiences. For example, regarding educational background and the likelihood of having suicidal thoughts during the pandemic, education had a protective effect. Respondents with who did not complete high school are having the highest rates of suicidal thoughts (30%, more than 3 times greater than all other education levels).

The American Psychiatric Association reports that racial/ethnic minority communities are less likely to receive mental health care. In 2015, among adults with any mental health condition, 48% of white individuals received mental health services compared with 31% of Black and Hispanic individuals and 22% of Asian individuals. Lack of access, stigma, lack of providers, and inadequate support for mental health service safety nets are all barriers for marginalized communities.

AFSP applauds the work already undertaken by Congress to address longstanding disparities in mental health and suicide prevention support for all communities. The Congressional Black Caucus's Emergency Task Force's Report on Black Youth Suicide & Mental Health, new legislative efforts addressing mental health disparities in diverse communities, and conversations like these are moving policy in a positive direction, to ensure that the mental health of all people is prioritized, and so one day no one, in any community, will die by suicide.

Access to Mental Health Care and Need for Parity

The Education and Labor Committee is well positioned to address many of the critical challenges facing mental health care. I urge the Subcommittee to consider strategies to increase access to

American Foundation for Suicide Prevention

mental health resources, support a robust mental health workforce, integrate suicide prevention in clinical and professional settings, and enforce mental health parity.

Despite the evident need for broad and equitable access to mental health care, many are having trouble accessing care. In 2019 a CDC survey found 4.3% of American adults had tried to access mental health services but were not able to. These challenges have worsened during the pandemic, despite the greater access via teleservices. The demand is still outweighing the available services as the demand has grown. Compared with 4% in 2019, in Aug 2020, 9.2% of adults said they needed therapy but could not access it. In December 2020 that rose to 12.4%.

The Subcommittee should consider efforts that would support enhanced mental health parity enforcement, to ensure that coverage for mental health care is no less restrictive than medical or surgical care. A Milliman Research Report from November 2019, analyzing network use and provider reimbursement for 37 million employees and dependents indicates that despite the Mental Health Parity and Addiction Equity Act being enacted over a decade ago, disparities in mental health coverage have continued to increase.

- From 2013 to 2017, the disparity between how often behavioral inpatient facilities were utilized out of network relative to medical/surgical inpatient facilities increased 85%.
- From 2013 to 2017, the disparity for out-of-network use of behavioral outpatient facilities relative to medical/surgical outpatient facilities increased 90%.
- From 2013 to 2017, the disparity for behavioral health office visits relative to medical/surgical primary care office visits increased from 500% to 540%.
- In 2017, 17.2% of behavioral office visits were to an out-of-network provider compared to 3.2% for primary care providers and 4.3% for medical/surgical specialists. In 2017, primary care reimbursements were 23.8% higher than behavioral reimbursements.
- In 2017, a behavioral healthcare office visit for a child was 10 times more likely to be an out-of-network provider than a primary care office visit – this was more than twice the disparity seen for adults.

The report concludes that while "disparate results are not in and of themselves definitive evidence of noncompliance, significant disparities, such as high out-of-network use of behavioral health providers and/or lower reimbursement for behavioral health providers, could point to compliance problems." There must be much more accountability and oversight of parity plans to ensure that mental health conditions are not being discriminated against.

Furthermore, the Subcommittee should consider the positive benefits of an enhanced mental health workforce and integrated suicide prevention services in workplaces and educational settings. The supply of practicing psychiatrists and psychologists is expected to decrease significantly over the next decade and projected demand for mental health services will demand a much larger workforce across the continuum of care. It would also be incumbent to consider how representative the mental health workforce is of the communities they serve – a more diverse workforce will be essential for increasing access, combatting stigma, and encouraging help seeking in every community.

American Foundation for Suicide Prevention

Conclusion

In conclusion, the time to make mental health a priority in our nation is now. Specifically, COVID-19 is presenting a new and urgent opportunity to double down and focus on federal investments and policies that can improve the nation's mental health infrastructure and resources. We can do that by working together to speak out, notice when a colleague or loved one is struggling and learn how to have caring conversations, and by making the science that shows mental health is as impactful and critical to our lives as any other aspect of health. Parity must be enforced, and disparities must be addressed to ensure equitable access and care for those in need.

We have seen the entire healthcare apparatus of the United States dramatically respond to the threat of COVID-19. Now, we must do the same for mental healthcare. As the viral component of the pandemic gets more and more manageable it is crucial that we turn our attention to the mental health needs that the nation is already experiencing.

We must aggressively increase access to mental health care, through effective mental health parity enforcement and telehealth coverage. We must lead the world in mental health and suicide prevention research. We must ensure that no community impacted by these issues is disregarded. We as a country are beginning to take mental health seriously – we must ensure that our healthcare systems, our schools, and our workplaces do so as well to ensure equitable and affordable care.

I urge the subcommittee to consider legislation and policies to:

1. Ensure the effective enforcement of mental health parity and broaden access to mental health care generally.
2. Support a robust, diverse mental health workforce.
3. Integrate mental health and suicide prevention in health systems, workplaces and schools, as critical touchpoints that can establish a professional culture that is responsive to mental health needs.

The steps we take in the aftermath of the pandemic will set the trajectory for the Nation's mental health for years to come. I thank the subcommittee for appreciating the gravity of the situation and look forward to hearing your comments and answering your questions.

Thank you.

Christine Moutier, MD
Chief Medical Officer
American Foundation for Suicide Prevention

Chairman DESAULNIER. Thank you Doctor that was terrific. We will now go to Mr. Gelfand. Please go ahead, Mr. Gelfand.

STATEMENT OF MR. JAMES GELFAND, SENIOR VICE PRESIDENT, HEALTH POLICY, THE ERISA INDUSTRY COMMITTEE

Mr. GELFAND. Thank you Chair DeSaulnier, Ranking Member Allen and Members of the subcommittee for this opportunity to testify today. I'm James Gelfand, Senior Vice President for Health Policy at the ERISA Industry Committee or ERIC, a trade association representing large employer plan sponsors.

ERIC Member companies are the Nation's top employers in every sector of the economic, every region in industry, and in every congressional district. These employers offer comprehensive health benefits. Our Member companies pay around 85 percent of healthcare costs on behalf of beneficiaries, and that would be a gold or a platinum plan if bought on an exchange.

And every one of them includes a substantial mental and behavioral health program to protect employees and their families. Employers know all too well the challenges that patients face. Too often patients lack access to the providers they need, not enough low-cost in-network doctors available, unacceptable wait times, gaps in information about quality and efficacy.

The system is leaving many patients behind. And this is on top of an opiod epidemic, and COVID exacerbated the problem for many—the isolation, the disruption of routine, reduced access to medical care, and other interventions, all combined to make things harder for patients.

Employers are committed to being part of the solution, and we have acted. Employers offer health insurance to help our employees, so when we see unmet needs we address them.

Employers worked hard to stop the opioids crisis from limiting prescription drug fills to more carefully scrutinizing the facilities and providers in their networks, to offering new programs to help employees get counseling and care.

Employers have innovated many new programs and strategies to increase access to mental health from enhancing paid time off to beefing up employee assistance programs, mindfulness campaigns, sleep management programs, crisis hotlines and much more.

Many employers hire vendors specifically to enhance and manage mental and behavioral health benefits. When COVID hit, telehealth really shined, securing care for employees isolated at home. Telehealth vendors compete not just on cost and quality, but on metrics like how quickly they can get a patient access to an appropriate provider.

Employers moved quickly to expand telehealth, offering care for free, even to patients in high deductible plans, and offering telehealth benefits to part-time workers and others who are not eligible for full benefits. And employers who have worksite health centers often went virtual, offering more mental and behavioral health options to employees, but there's much more we can do.

ERIC Members have convened a mental health task force, and will soon be issuing a report, including dozens of policy proposals Congress could implement to improve access and affordability without compromising quality. Here are three options to consider today.

First, promote cross State medical practice, especially in ERISA plans. You can instantly improve mental health access for tens of millions of people by allowing some of the excess volume on the coast to serve patients in other parts of the country. Start by passing the TREAT Act to at least solve this during COVID.

But long-term we need a comprehensive solution to connect willing and able providers to patients in need.

Second, make the private sector gains in telehealth permanent. Allow employers to offer telehealth benefits to all of our employees. This isn't a replacement for comprehensive health insurance, but

it can be a lifeline for mental and behavioral health. Many employers, especially retailers, and others with large part-time, hourly or seasonal workforce have done amazing work expanding telehealth during COVID. But unless Congress acts soon, these gains will disappear due to antiquated rules.

Third, fix the rules in the high deductible plans. In the CARES Act last year Congress temporarily allowed dollar coverage of telehealth. We should make it permanent, and add coverage of worksite health clinics too. If Congress doesn't act starting on January 1, tens of millions of patients will have to pay their entire deductible before employers can subsidize these benefits.

And one quick caution—these problems won't be solved via penalties and mandates. It might make more money for trial lawyers, but patients will be hurt with higher premiums, lower value networks and the loss of quality, accessibility and safety within their plan.

Congress has repeatedly told the Department of Labor to do a better job explaining and investigating mental health parity requirements, including more new rules that were passed in December. Let's see how those rules work before piling on.

In conclusion, employers are acutely aware of the challenges patients face in accepting quality, affordable, mental and behavioral health treatment.

We are leading from the front, innovating, and finding ways to help our beneficiaries, but policy changes are needed, especially to ensure that millions can continue to have access to telehealth.

We hope to work with Congress to advance meaningful legislation to help our employees and their families. Thank you for this opportunity to testify.

[The prepared statement of James Gelfand follows:]

PREPARED STATEMENT OF MR. GELFAND

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

Meeting the Moment: Improving Access to Behavioral and Mental Health Care

Testimony Before the House Education and Labor Committee, Subcommittee on Health, Employment, Labor, and Pensions

Washington, DC

April 15, 2021

Introduction and About ERIC

Subcommittee Chair DeSaulnier and Ranking Member Allen, Chair Scott and Ranking Member Foxx, thank you for this opportunity to testify on the need to improve access to mental and behavioral health services for patients. I'm James Gelfand, Senior Vice President for Health Policy at The ERISA Industry Committee – ERIC for short – 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.

ERIC member companies voluntarily offer comprehensive health benefits to millions of active and retired workers and their families across the country. Our members offer these 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 85 percent of health care costs on behalf of our beneficiaries – that would be a gold or platinum plan if bought on an Exchange. But we don't buy or sell health insurance; these plans are self-insured. In other words, ultimately it is the company that is on the hook for the vast majority of the costs of our patients' care. Prior to COVID-19, there were an estimated 181 million Americans who got health care through their job, with about 110 million of them in self-insured plans like ours.

Employers like ERIC member companies roll up their sleeves to improve how 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' ERISA plans are not subject to many of the requirements that apply to fully-insured products such as those sold on an ACA

Exchange, because employers do not profit from health benefits – in fact, they're a huge expense.

The entire purpose of these benefits is to meet the needs of our plan beneficiaries. ERIC has noted an increasing need for mental and behavioral health care among our employees and their families, especially with the advent of the COVID-19 pandemic, and it is often far too difficult for them to obtain that care. To complicate matters further, the opioid crisis showed us that merely providing access to various treatments is not enough – plan sponsors need to work to drive quality and high-value care in this space. And, even as Congress and the private sector worked to get the opioid crisis under control, the COVID-19 pandemic hit, causing a new wave of demand for mental health care and substance abuse treatment, in an environment that made it even harder than usual to obtain such care.

Many employers' initiatives in mental health and combating the opioid epidemic have been disrupted due to the urgency to respond to the pandemic. Some even had to suspend their outreach, health campaigns, and projects early last year.[1] For example, many companies have formed state alliance groups in developing opioid education campaigns aimed at parents and caregivers, and these programs had to alter their approach strictly to a virtual setting, which took some time. Even before the pandemic, employers offered employees educational sessions on identifying and addressing drug activity. To limit employee contact, these sessions were delayed until virtual platforms were set up, and the lack of in-person contact proved to be a setback in identifying at-risk employees through this setting.

Prior to the pandemic, employers, including regional and national business groups, had taken actions to protect employees from prescription opioid overdose with a focus on the best ways to address pain management. The Midwest Business Group on Health has developed creative and effective strategies and recommendations for pharmacy benefit managers (PBMs) and health plans with an interdisciplinary approach such as promoting coordinated care for those with chronic pain, re-evaluating coverage options, and setting quantity limits.[2] Resolving the crisis takes multiple stakeholders, engagement, and action-oriented interventions to change drug behavior. Toolkits that evaluate workplace drug and alcohol policies along with policy rationale, goals, expectations, and compliance allow employers to benchmark and stay a step ahead in supporting and retaining employees who wish to recover and continue working. These resources, such as one issued by the Kentuckiana Health Collaborative, lay out best practices for helping workers receive the care that they need and transforming workforce culture.[3] Tools such as these have been used prior to the pandemic and will continue to be used during the current crisis.

---

[1] Weiner, Aaron. "An Epidemic During a Pandemic". National Safety Council. August 10, 2020. https://www.nsc.org/safety-first-blog/an-epidemic-during-a-pandemic
[2] Midwest Business Group on Health. "Addressing Pain & Opioid Abuse Strategies". https://www.mbgh.org/www/resources/employertoolkits/painmanagement/pain-management
[3] Kentuckiana Health Collaborative. "Opioids and the Workplace: An Employer Toolkit for Supporting Prevention, Treatment, and Recovery". Version 1.1. https://khcollaborative.org/wp-content/uploads/2019/07/Opioids-and-the-Workplace-1.1-1.pdf

And employers have gone beyond opioids mitigation, seeking to provide more assistance and support to employees on all manner of behavioral and mental health fronts. From telepsychiatry programs, to expansion of worksite health centers, to partnering with community groups and diversion programs, employers have led from the front, seeking to fill a gap they saw in existing benefits. With the goal of ensuring access to quality, affordable care that meets beneficiaries' needs, employers have innovated to create solutions where none existed before.

As states sought to mitigate virus transmission by enacting social distancing and lockdowns, employers saw significant upticks both in mental health claims and in self-reported incidences of anxiety, loneliness, depression, and more. We saw an increase in deaths of despair[4], some of the ground we had gained on the opioid crisis eroded as substance use disorders ticked back up[5], and some sources even report that marriage rates dropped and breakups increased.[6] Employers had to act, and they did. For example, employers working with one large insurance carrier added prescription digital therapeutics for substance use and opioid use disorder to their benefits packages, and provided telephonic medical concierge services so employees could get real-time help. Another employer involved in engineering partnered with a renowned health care think tank to explore forward-thinking health interventions.

COVID-19 also caused many companies to promote, make more accessible, or increase their employee assistance program (EAP) benefits. The National Safety Council found that many employees were unaware of their EAP benefits or unsure how to access them, so companies made the EAP information front and center online, and launched communications campaigns (including emails and short video instructions) on how to use the EAP, ultimately increasing usage.[7] Companies are also encouraging their employees to use their paid time off, and strongly encouraging their managers and supervisors to set examples for their direct reports by prioritizing mental health. While these are only a few examples of what employers have done to help their workforce during this critical time, employers have taken a diverse array of steps to help, because they understand that more needs to be done in tackling the crisis head on.

We commend this Subcommittee for holding today's hearing, to discuss solutions that could start to turn the tide, address shortages, improve access and affordability, and ultimately ensure that a patient who needs mental or behavioral health care is able to get that care when and where they need it.

---

[4] Mulligan, Casey B. "Deaths of Despair and the Incidence of Excess Mortality in 2020". National Bureau of Economic Research. December 2020. https://www.nber.org/papers/w28303
[5] Centers for Disease Control and Prevention. "Overdose Deaths Accelerating During COVID-19". December 17, 2020. https://www.cdc.gov/media/releases/2020/p1218-overdose-deaths-covid-19.html
[6] Brownwell, Taylor. "Divorce Rates and COVID-19" National Law Review. October 16, 2020. https://www.natlawreview.com/article/divorce-rates-and-covid-19
[7] National Safety Council. "State of Response: The Future World of Work". https://nsccdn.azureedge.net/nsc.org/media/site-media/docs/workplace/safer/state-of-response-future-world-of-work-report120820.pdf

Recognizing the Problem: The Need to Address Mental and Behavioral Health

Unless you live in certain high-population urban centers, the likelihood is that you have a shortage of mental and behavioral health providers. This leads to myriad problems, which no doubt patients 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. For those patients who do stay in-network, significant wait times can exacerbate mental health issues. 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.

But the problem is much greater than simply, "not enough providers." Many employers are deeply concerned about quality and efficacy in the mental and behavioral health space. When the opioid crisis was at its worst, employers were frustrated that our beneficiaries often received 90 days' worth of oxycontin (for example), when a 3-day fill would have been more than enough. In response, employers directed their vendors to limit fills, divert employees to other medications and treatments, and implement more gatekeeping such as prior authorization. Employers were aghast to learn that their plans were reimbursing certain facilities that may actually 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.

Meanwhile, patients are pitched on treatments of a questionable nature. For example, programs that take a patient camping, for whopping prices in the thousands of dollars per day. Or in-patient programs to address eating disorders, which did not appear to have any record of success (but again, command extraordinary prices). Maybe these treatments are the right choice in some cases, but without more data and evidence, how could a plan fiduciary justify coverage?

And to complicate matters even more, the COVID-19 pandemic hit. COVID-19 caused immense pressure on employers, their workforce, and families, as they adjusted to social distancing, business operation changes, and learning at home over the past year. During this period, about four in ten adults in the United States have reported symptoms of anxiety or depressive disorder, an increase from one in ten adults reported in 2019.[8] Of the 30 million people diagnosed with COVID-19, the Centers for Disease Control and Prevention (CDC) continues to evaluate the long-term effects of the virus and whether symptoms such as fatigue, depression, anxiety, and multi-organ effects will subside.

With so many Americans diagnosed with COVID-19, the long-term physical and mental effects of the pandemic must be addressed by all stakeholders. Employers recognize that mental and behavioral health access needs improvement, and are being proactive in providing mental health,

[8] U.S. Census Bureau, Household Pulse Survey, 2020.

behavioral health, and substance use disorder services during the COVID-19 pandemic and beyond. Employers are part of the solution, innovating new ideas to improve access, quality, and affordability.

Part of the Solution: How Employers Are Supporting Our Beneficiaries

Employers have quickly and efficiently set up new 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 resilience resources and free mobile apps to build emotional resilience, improve sleep, and manage stress. While these platforms are user-friendly and individual-based, employers are also setting 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. And many employers that offer one-on-one counseling with a company 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.

When COVID-19 caused many employers to shift to remote work or reduced employee presence onsite, many worksite clinics went virtual, offering mental and behavioral health via telehealth. Some clinics expanded eligibility to other employees in the same state, who may not be based at the same site. This helped create continuity for employees undergoing care, and a new access point for many others.

Employers are continually discussing available support resources and want to do more to help their workforce, even in addressing substance abuse 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 that initiated the change has shown that fewer than one in ten employees seeks 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 employees test positive, the company then finds the appropriate treatment for the employee. Employers that have onsite wellness centers are also promoting alterative pain treatment rather than prescribing pain medication such as physical therapy, acupuncture, and even massages. 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 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, there is no one size fits all approach in addressing the crisis. 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".*[9] Employers 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 our plans.

ERIC's Proposals to Improve Mental and Behavioral Health

As part of our commitment to being part of the solution, ERIC is actively working to develop policies that can meaningfully improve the lives of our plan beneficiaries by increasing their access to high quality mental and behavioral health care. Numerous ERIC member companies are participating in ERIC's Mental Health Task Force, which will soon be releasing a report on proactive solutions that Congress can consider in this space. Below are some highlights from the Task Force's findings, many of which this Committee could directly address.

(1) ***Improve Access by Encouraging Interstate Provider License Reciprocity.***

COVID-19 caused many provider offices to close with no way for patients to receive care for some time. Through technology advancement, telehealth enabled patients to see providers from their home or a safe setting without risking contracting the virus. Employers pivoted quickly to ensure our employees and their families would maintain access to care, greatly assisted by relationships with telehealth companies. Unfortunately, many patients who had access to good telehealth benefits were still stymied by provider shortages, because their states did not allow them to see providers licensed elsewhere.

ERIC believes that Congress can act to quickly correct this problem, by permitting ERISA plans to facilitate telehealth between a willing patient and a willing provider, so long as that provider holds a current license in a state in which the plan operates, and is affiliated with a network associated with the plan sponsor, their carriers, and vendors. This would be a novel and simpler approach, and would instantly solve a huge access problem, especially as it pertains to mental and behavioral health, for patients in self-insured plans.

Employers also believe that patients and providers can benefit from the *Temporary Reciprocity to Ensure Access to Treatment (TREAT) Act* (H.R. 708), which would provide temporary state

[9] Department of Labor. "DOL 2018 Report to Congress: Pathway to Full Parity". 2018. https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/dol-report-to-congress-2018-pathway-to-full-parity.pdf

licensing reciprocity for all licensed and certified practitioners or professionals (those that treat physical and mental health conditions) in all states and all types of services during the COVID-19 Public Health Emergency. Under the Act, a provider who holds a valid license in good standing in any state and is not barred in another state, would be permitted to practice in every state for the duration of the emergency declaration and a limited normalization period once the declaration of public health emergency is lifted.

While only temporary, **we encourage Congress to pass the *TREAT Act* so that all can have access to health care**, especially to address the immediate need for an increase in mental health providers in many parts of the country in the wake of COVID-19. 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 COVID-19 pandemic. Congress' immediate action will enable more competition and access in telehealth, creating incentives for providers to improve quality and affordable access for patients. In a recent study conducted in March 2021 of 2,000 people, 61 percent have had a telehealth appointment, showing its popularity one year into the pandemic.[10]

Later, **we hope that Congress will enact a more permanent interstate licensure solution**, at least in regards to telehealth. Congress previously fixed this issue in the realm of sports medicine, and can do the same for telehealth. While there are different possible paths forward (a specific fix for ERISA plans, national reciprocity, a national telehealth license, one comprehensive interstate compact with financial incentives for states), employers urge Congress to work through this challenge and come to consensus on a solution.

ERIC commends the 18 states[11] who have currently signed on to the Psychology Interjurisdictional Compact (PSYPACT), as well as the 16 states[12] that are currently considering legislation to do so. We believe that this is an important stopgap measure. However, federal leadership is needed in order to ensure that patients in all states can see all kinds of providers they need – especially mental and behavioral health providers. As such, while states continue to pursue PSYPACT, we urge the federal government to consider alternative methods of encouraging interstate license reciprocity.

(2) ***Leverage Telehealth to Improve Access to Care.***

a. Allow standalone telehealth benefits.

Currently, telehealth cannot be offered as a standalone benefit to anyone not enrolled in the full medical plan due to Affordable Care Act (ACA) rules. If telehealth-only benefits were

[10] SYKES. "How Americans Feel About Telehealth: One Year Later". March 2021. https://www.sykes.com/resources/reports/how-americans-feel-about-telehealth-now
[11] 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.
[12] 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.

designated as an excepted benefit, they 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.

And progress has indeed been made: on June 23, 2020, the Department of Labor issued a Frequently Asked Question (FAQ Part 43) that for the first time, allowed employers to expand standalone telehealth offerings, but with two key 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.

When this guidance was issued, employers acted. In fact, as a result, millions more Americans have telehealth benefits today. A broad array of ERIC members rolled these programs out to part-time workers, seasonal workers, interns, and more – with especially significant gains in the retail industry. This is an example of nimble policymaking that resulted in tangible benefits for many people, and one we hope to build on.

Specifically, we urge Congress to act before the end of the public health emergency to ensure that these programs can remain in place – and to allow employers to offer the benefit to more workers. If permitted to offer the benefit to those who are ***unenrolled*** rather than just those who are ***ineligible***, employers could expand telehealth benefits to more beneficiary cohorts – especially benefitting younger workers and those of less economic means. **It is critical that Congress make permanent the allowance to offer standalone telehealth benefits, and expand the offering to unenrolled individuals, in addition to just those who are ineligible**.

b. Make permanent 1st-dollar coverage of telehealth in HDHPs.

We will note one considerable improvement in telehealth that Congress has made 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, thanks to the enactment of the "*Telehealth Expansion Act*"(S. 3539) by Senator Steve Daines (R-MT), which was passed into law as part of the *CARES Act* (H.R.748). Unfortunately, this telehealth improvement is time-limited and set to expire at the end of 2021. **We urge Congress to make 1st-dollar coverage of telehealth permanent so that workers in these plans can receive the care they need**.

If Congress does not act, next year millions of Americans who currently enjoy cost-free access to telehealth benefits, will be required to pay the full "fair market value" of care, until they have paid their entire plan deductibles. This would be a barrier to care, and Congress should act to prevent it.

c. Establish one national telehealth standard for ERISA plans.

Further, **Congress should consider creating one consistent set of telehealth rules for ERISA plans**. Currently, telehealth is regulated at the state level, which has resulted in major barriers 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, mandates that telehealth cannot establish a doctor-patient relationship, or even bans on the use of telehealth for prescribing or provision of mental health services.

Congress could establish a national framework for telehealth delivered to ERISA plan beneficiaries, thus ensuring equal treatment for all of our employees no matter where they live, work, or receive care. The standard could be based upon ERIC's model state telehealth legislation, which is designed to ensure benefits are equally shared by those who may not have a medical home, those who may not have access to broadband internet, and those who live in provider shortage areas. This can be done in a way that encourages care coordination, eliminates unnecessary barriers to care, and maintains a high standard of care. ERIC stands ready to work with Congress to develop this national telehealth framework.

(3) ***Encourage innovation by reducing regulatory barriers.***

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. While we understand the need to provide legal protections for beneficiaries, there is also a serious need for innovation to improve benefits and meet unmet needs for patients. Employers believe that the current dire need for improved access to mental health justifies providing employers with new flexibility to innovate in this space.

Congress should consider allowing the creation of limited mental health programs that could be flexible, without being considered "group health plans." If these programs were designated not to create an employer-employee relationship, they could potentially be offered to independent contractors and gig economy workers. To encourage innovation in benefits subject to MHPAEA, Congress could consider authorizing "compliance certification" entities, who ERISA fiduciaries could rely on to evaluate group health plans for parity compliance. And reducing or digitizing many of the notice and disclosure requirements on plan sponsors would also help free up funds and bandwidth to innovate.

(4) ***Improve communication to patients by requiring providers to be clear about whether they are accepting new patients***.

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. 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 – worst of which could be a patient actually foregoing care due to frustration with getting turned away by providers. 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 or not 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.

(5) ***Study the Long-Term Consequences of COVID-19***.

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 we learn more about the consequences of the policy decisions made in order to combat the COVID-19 pandemic. It is imperative that the federal government develop a comprehensive categorization of "lessons learned," determine what could be done better, etc.

This is especially important in the area of mental health. ERIC member companies have reported all kinds of findings in this area, including challenges getting beneficiaries access to the care they needed (which often wasn't traditionally defined as care under medical benefits), mental health consequences related to isolation and loneliness, familial challenges related to job changes or losses, challenges obtaining needed prescriptions or counseling, and more.

But recognizing the challenges and problems is only half of what is needed; **Congress should direct an objective body to then suggest a roadmap to better prepare and eliminate said problems, should such a disaster ever befall the country again**. The roadmap should place a special emphasis on protecting Americans' health, both mental and physical, and providing the needed behavioral health support for individuals who may suffer from substance use disorders. 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 not receiving treatment.[13] More needs to be done for those in accessing outpatient, residential, and hospital inpatient service treatments.

[13] 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

(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. Congress should consider taking steps to alleviate the information gap, which is especially pertinent in the mental and behavioral health space.

ERIC member companies and our organizational partners have suggested a number of potential ways to improve the availability of quality information. For instance, the Centers for Medicare and Medicaid Services (CMS) could expand the availability of quality ratings, and the CDC's National Healthcare Safety Network could collect and report uniform patient safety data from different sites of care (as called for last year by many thought leaders and interest groups, led by the Leapfrog Group and the AARP). Congress could also direct the Patient-Centered Outcomes Research Institute (PCORI) to prioritize research on mental health, or direct CMS' Center for Medicare and Medicaid Innovation (CMMI) to experiment with Centers of Excellence (COE) programs, modeled off successful efforts in employer-sponsored coverage.

There is much more that can and should be done to enhance access to better information for patients and plan sponsors, and employers are especially interested in investing high-value networks for their plan beneficiaries. To do so, we would like to work with Congress to ensure that the necessary quality reporting and outcomes data are available to employers.

(7) ***Encourage care coordination to empower primary care and other nontraditional options for patients.***

One thing employers have increasingly learned is that, as access especially to psychologists and psychiatrists has proven a challenge to plan beneficiaries, they have responded by seeking out mental health care elsewhere. Participants increasingly rely on primary care providers, who oversee their "medical homes," to provision mental health care, including the prescribing of various medications. But this is by no means the only place our employees are going – and COVID-19 has revealed a number of things that Congress can do to facilitate the transition of some mental and behavioral health services to nontraditional providers.

For instance, employers know it is imperative to continue focusing on the transition to coordinated care. We have learned that "scope of practice" laws sometimes hinder the ability of various medical providers (a prime example being nurse practitioners) from meeting unmet mental and behavioral health needs. It has also become clear that a lack of fully interoperable electronic medical records (EMRs) is making it harder for providers and facilities to coordinate. And we are interested in 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.

There is more that we can do, with the goal of expanding the points of access to care for mental and behavioral health – but it starts with recognizing that there is capacity available.

(8) ***Modernize HDHP and DCFSA Rules to 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. ERIC member companies have suggested several changes Congress should consider to maximize the ability and the likelihood that patients will seek out and obtain the care they need.

One option is to update HDHP rules to allow plan beneficiaries to access subsidized care at worksite health centers, which are a critical access point for primary care. Congress could also give HDHP sponsors flexibility to provide a limited amount of 1st-dollar coverage for high-value services, since employers have learned that outcomes can be significantly improved when barriers are removed from high-value care. Similarly, policy could be updated to allow the coordination of capitated benefit (like Direct Primary Care) models with HDHPs[14]. Or Congress could consider permitting funds in dependent care flexible spending arrangements (DCFSAs) to be used to pay a broader definition of "caregivers," including family and friends, as the COVID-19 pandemic has shown employers that plan beneficiaries often sought help from those closest to them.

While it may not seem like HDHP and DCFSA rules would play a large part in mental health access, these rules hamstring employers who want to innovate, experiment, and try out new benefit models and options – while frustrating patients by serving as barriers to access the care they need. Congress should consider taking a fresh look at these rules, and allowing employers to try new things, develop best practices, and address the gaps in access and care experienced by their beneficiaries.

(9) Target Funding, Education, and Reimbursement at Mental Health.

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 care teams. Our task force has explored a number of options Congress could consider in this space.

One option would be to specifically target programs like Graduate Medical Education at mental and behavioral health providers, and to promote programs aimed at assisting providers entering into the mental health field (such as perinatal or reproductive psychiatry fellowships). Congress should consider programs that empower frontline health providers to address mental health such

[14] See: *Primary Care Enhancement Act* (H.R. 3708 in the 117th Congress)

as perinatal psychiatry access programs[15], which were included in the *21st Century Cures Act.* Medical schools should include a greater emphasis on mental and behavioral health, and non-mental health providers and systems should be incentivized to include coordination with mental and behavioral health professionals as part of serving as a medical home for patients.

Employers defer to Congress on the best way to achieve these aims, however, the point cannot be escaped: America needs more mental health providers, and it needs to equip other providers to engage in mental and behavioral health care.

(10) ***Spur Greater Adoption of Value-Based Payments.***

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 CMMI, there is more work to do, and a huge opportunity as it pertains to mental and behavioral health.

Demonstrations or nationwide programs could be launched to transition away from fee-for-service in the area of mental health, potentially in partnership with employers and private-sector initiatives. We hope that such efforts could include realigning payments to encourage the highest-value treatments, medications, and services, and ensuring that patient-reported outcomes measures are central to these efforts.

As you can see, employers are working to address gaps in access to mental and behavioral health, not only by innovating new and improved benefit designs and practices, but also by developing policy that we believe will empower plan sponsors and beneficiaries to offer and obtain high quality care. We look forward to working with members of the Committee to develop legislation based upon these and other ideas, and hope that the 117th Congress will act on meaningful solutions for patients.

Counterproductive Mandates Likely to Increase Costs Without Improving Access or Care

ERIC recognizes that many members of Congress are working in good faith to develop solutions to the mental and behavioral health access challenges Americans are facing. While many of these proposed solutions are innovative ideas worthy of further exploration, some of them are unlikely to help beneficiaries, instead serving only to increase costs in the health system, expose patients to improper or dangerous care, or penalize good actors who are trying to be part of the solution. ERIC's concerns with some of these proposals include:

[15] 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

(1) ***Do Not Implement Civil Monetary Penalties (CMPs) for Mental Health Parity 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 requirements. For instance, see the *Parity Enforcement Act* (H.R. 1364). We believe that this idea would increase costs without meaningfully improving care.

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. Congress has repeatedly pressed the agencies to give better guidance on NQTLs, including examples, and the agencies have repeatedly refused to do so, even though they recognize the difficulties in discerning the violations.[16] 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. As such, penalizing employers for these violations is unlikely to prevent them in the future.

The current process of remediating parity violations is sufficient not only to help solve these problems, but also to help consultants, vendors, and plan sponsors learn more about what DOL considers to be acceptable or unacceptable medical management practices. According to a Government Accountability Office (GAO) 2019 report, GAO recommended that the DOL and HHS evaluate whether relying on targeted oversight is effective for ensuring compliance with mental health/substance use parity requirements or whether alternative approaches are needed.[17] 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.

(2) ***Avoid Mandating a One-Sided Network Adequacy Requirement***.

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 counter-productive. The entire purpose of an employer-sponsored ERISA plan is to ensure that beneficiaries have access to the type and volume of care they need, when they need it. This is why we have continually worked to improve access and quality, including working with this Committee to crack down on abusive surprise medical bills.

Currently, many mental and behavioral health providers choose not to participate in any

[16] Department of Labor. "DOL 2018 Report to Congress: Pathway to Full Parity". 2018.
[17] Mental Health and Substance Use: State and Federal Oversight of Compliance with Parity Requirements Varies, Government Accountability Office, GAO-20-150, December 13, 2019

insurance network.[18] This could be for a variety of reasons – perhaps they prefer to accept the out-of-network rates and balance bill patients. Perhaps they choose to take cash only, thus obviating the need to engage in the bureaucratic processes necessary to obtain reimbursement from insurance carriers. 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.[19] Regardless, the end result is that many mental health providers are unwilling to accept market rates as payment in full, and as such, do not participate in networks.

As such, simply requiring insurers to include these providers in network must 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, but hitting patients in self-insured plans especially hard. After all, with half the workforce in high-deductible health 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.

Instead, 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. By requiring that providers go in-network in at least a few plans, Congress will be leveling the playing field, encouraging good-faith negotiations. If providers are going to demand that a mandate be placed on health plans, they should be prepared to also participate in this mandate, for the benefit of their patients.

(3) ***Protect Medical Management.***

ERIC member companies know that Congress is under pressure to address what patients see as "gatekeeping" within their health benefits. Employers believe that medical management is critical to controlling cost and improving quality for our plan beneficiaries. As ERISA fiduciaries, it is incumbent upon the employer to ensure that money is not wasted, that the network is not bloated with low-value or high-cost providers, and that plans are designed in such a way as to be good stewards of beneficiaries' funds. Medical management techniques such as prior authorization, "try-first" requirements, step-therapy, and the like, while sometimes unpopular with patients, are absolutely integral to performing our fiduciary duties. Medical management processes – and the processes to make exceptions to them – are designed

[18] 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/

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

by medical experts not only to protect all beneficiaries from higher costs, but also to drive quality, limit patient exposure to riskier treatments, improve utilization of best practices, and often to encourage the use of safer and less invasive interventions. Employers know that beneficiaries would prefer to have immediate access to any treatment, medication, or care that they would like instantly – and that providers may prefer to develop a care plan without the input of the plan fiduciaries. However, this is not in the best interest of the beneficiaries or the plan. We hope that Congress will take a balanced approach when considering medical management, and include the input of employers in any legislation.

(4) ***Do Not Mandate Coverage of Unproven, Experimental Treatments***.

There are numerous treatments some patients are seeking, but data is lacking to affirm the efficiency and effectiveness of the treatments, including (but not limited to) certain residential substance abuse programs, so-called "wilderness therapy," autism applied behavior analysis (ABA) therapy, and some treatments considered experimental. Employers and insurers may be criticized for taking time to evaluate new therapies before deciding whether to include them in coverage, but this is imperative to protect beneficiaries. And sometimes, the right decision is indeed not to cover a treatment.

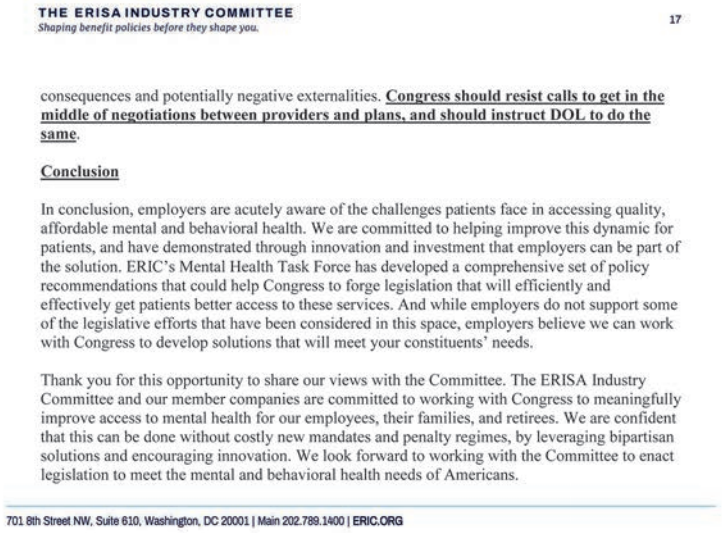
Congress should instruct the federal agencies to clarify that MHP requirements do not force plans to cover treatments of unproven value or medical efficacy. Right now, this is often left to litigation to decide. Plan sponsors want to offer high-quality care, but we cannot expend plan assets on care that is ineffective or dangerous. And not everything that might be beneficial to a patient is actually medical care. Mandating that plans cover these treatments – or placing burdensome rules or financially destructive consequences on plans that make a mistake – would only serve to increase costs for beneficiaries, while leading some plan participants to obtain care that does not actually help them.

(5) ***Avoid Creating a New "Reimbursement Parity" Regime***.

Some advocates are asking Congress or the DOL to impose a requirement that group health plans reimburse mental and behavioral health providers at the same rate paid to providers on the medical/surgical side of the plan. Employers believe that government should not mandate the methodology used to determine and negotiate rates paid to providers.

Under current practices, provider reimbursement is based on a series of factors that are built into medical coding and plan administration. It often takes into account provider education (and how long it takes to develop a specialty or obtain a license or certification), complexity of the services provided, risks to the provider and patient pursuant to the care provided, availability of the specialty, and more. Employers largely rely on insurance carriers to help design reimbursement structures for a plan's providers, and it is not done with any intent to discriminate.

If providers feel that they should be reimbursed at a higher rate, this should be worked out via negotiations between providers and plans, not by government fiat. And mandating the same payments for different kinds of providers and services is sure to have significant unintended



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

17

consequences and potentially negative externalities. **Congress should resist calls to get in the middle of negotiations between providers and plans, and should instruct DOL to do the same**.

Conclusion

In conclusion, employers are acutely aware of the challenges patients face in accessing quality, affordable mental and behavioral health. We are committed to helping improve this dynamic for patients, and have demonstrated through innovation and investment that employers can be part of the solution. ERIC's Mental Health Task Force has developed a comprehensive set of policy recommendations that could help Congress to forge legislation that will efficiently and effectively get patients better access to these services. And while employers do not support some of the legislative efforts that have been considered in this space, employers believe we can work with Congress to develop solutions that will meet your constituents' needs.

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 mental health 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 the Committee to enact legislation to meet the mental and behavioral health needs of Americans.

701 8th Street NW, Suite 610, Washington, DC 20001 | Main 202.789.1400 | ERIC.ORG

Chairman DESAULNIER. Thank you, Mr. Gelfand. I look forward to working with you for just that purpose. And our last panelist is Dr. Bendat. Please go ahead, Doctor.

STATEMENT OF DR. MEIRAM BENDAT, JD, PH.D., FOUNDER, PSYCH-APPEAL

Dr. BENDAT. Good morning Chairman DeSaulnier, Ranking Member Allen, and Members of the subcommittee. Thank you for the opportunity to testify at today's hearing. I'm Meiram Bendat, founder of California-based Psych-Appeal, a law firm exclusively dedicated to mental health insurance advocacy.

I am by education, training, and practice, an attorney and psychotherapist. Since 2011 I have spearheaded cutting-edge litigation against managed care barriers to mental health and substance use treatment. Most of my cases have been brought under ERISA.

ERISA establishes uniform, albeit limited, protections for approximately 136 million people covered by employer sponsored health plans, two-thirds of which participate in self-funded plans, entirely exempt from State insurance laws and regulation.

This renders the Department of Labor's role critical. Since 2014, ERISA has required fully insured small group plans to provide essential mental health benefits. Due to historic discrimination, the Federal Parity Act amended ERISA to prohibit health plans and fiduciaries from imposing disparate lifetime or annual limits, financial requirements, and treatment limitations on mental health and substance use disorder benefits.

Unsurprisingly, treatment limitations expressed quantitively are easier to identify and challenge than undisclosed, as applied nonquantitative treatment terms, which include medical necessity and network access standards.

Consequently, ERISA was recently amended to require health plans to robustly analyze and disclose their non-quantitative treatment limitation comparability analyses. While ERISA provides for essential mental health benefits, it does not define medical necessity, a core term of coverage.

And while the Federal Parity Act requires non-quantitative treatment limitations, such as medical necessity, to be applied comparably to mental health and medical benefits, it does not require medical necessity determinations to comport with generally accepted standards of clinical practice or GASC.

Thus, absent ERISA expressly conditioning medical necessity and adherence to GASC, health plans are free to create and operationalize self-serving, overly restrictive medical necessity definitions that undermine access to essential mental health benefits.

Even when ERISA plans include medical necessity definitions, adhering to GASC, coverage decisions and mental health cases are all too often based on deficient, non-transparent utilization review criteria, developed or licensed by risk-bearing health insurance issuers who also act as well-compensated claims administrators for self-funded group plans.

This dynamic was fleshed out in a landmark class action Wit v. United Behavioral Health, in which a Federal court found that over a 7-year period the Nation's largest managed behavioral health company developed and applied pervasively flawed utilization review criteria to wrongly deny nearly 70,000 claims for outpatient, intensive outpatient, and residential treatment by ERISA participants.

While mental health and substance use disorders are largely chronic and pervasive, UBH's utilization review criteria operationalized an acute care utilization management model that myopically focused on short-term crisis stabilization, rather than treatment of underlying conditions.

The lack of a uniform definition of medical necessity is not the only impediment to coverage of mental health treatment under ERISA plans. Since ERISA does not establish network adequacy standards, self-funded ERISA plans generally do not provide participants with any notice of timeliness or geographic access standards in plan documents.

Absent notice of such standards or remedies for the unavailability of in-network services, ERISA plan participants must often wait protracted periods, or travel extensive distances to receive mental health treatment to obtain inconsistent authorizations for out-of-network care.

Given the prevalence of narrow and phantom networks, it is unsurprising that mental health treatment at disproportionately rendered out-of-network or forsaken altogether.

In light of the low and disparate reimbursement rates set by health insurance issuers and claims administrators, it is equally unsurprising that mental health providers balk at joining their networks.

ERISA's remedial scheme should be updated to account for the modern reality that health plan issuers who serve as claims administrators are the actual fiduciaries who adjudicate mental health

benefits based on self-selected uniform criteria, and who sell network access to group health plans.

While these fiduciaries enjoy annual profits in the billions, ERISA's deferential standard of judicial review and exclusion of extracontractual damages against them, continue to reward and incentivize their brazen self-dealing.

To truly guarantee meaningful access to mental health care, I urge Congress to pass the Parity Enforcement Act of 2021, and consider legislation that conditions medical necessity and adherence to GASC, eliminate the differential standard of judicial review in benefit cases, permits damages against health insurance issuers and claims administrators that discriminate, and protects access to open courts by exempting ERISA claims from binding arbitration. Thank you.

[The prepared statement of Dr. Meiram Bendat follows:]

PREPARED STATEMENT OF DR. BENDAT

PSYCH
APPEAL
Safeguarding Mental Health Care

Testimony of Meiram Bendat, J.D., Ph.D.
Founder
Psych-Appeal, Inc.

Before a Hearing of
The Education and Labor Committee
Subcommittee on Health, Employment, Labor, and Pensions

Meeting the Moment: Improving Access
To Behavioral and Mental Health Care

United States House of Representatives

April 15, 2021

7 West Figueroa Street • Suite 300 • PMB #300059 • Santa Barbara • CA • 93101
Tel (310) 598-3690 • Fax (888) 975-1957 • www.psych-appeal.com

Good morning, Chairman DeSaulnier, Ranking Member Allen, and members of the Subcommittee. Thank you for the opportunity to testify at today's hearing, "Meeting The Moment: Improving Access to Behavioral and Mental Health Care."

I am Meiram Bendat, founder of California-based Psych-Appeal, Inc, the first private law firm in the country exclusively devoted to mental health insurance advocacy. I am, by education, training and practice, an attorney and psychotherapist. Since 2011, I have spearheaded cutting-edge litigation against managed care barriers to mental health and substance use treatment. Most of my cases have been brought under the Employee Retirement Security Income Act of 1974 ("ERISA").[1]

ERISA's Relationship to Mental Health Benefits

ERISA establishes uniform, albeit limited, protections for participants and beneficiaries of employer-sponsored health plans that cover approximately 136 million people.[2] Approximately 67 percent of these individuals are covered by self-funded plans, which are entirely exempt from state insurance laws and regulation, while 33 percent are covered by fully-insured plans.[3] ERISA's protections include disclosure requirements,[4] standards of conduct for plan fiduciaries,[5] and enforcement mechanisms.[6] Significantly, because state insurance laws do not apply to self-funded health plans, the Department of Labor ("DOL") is the sole source of oversight for these plans.

Despite the prevalence of mental health and substance use disorders,[7] until the Affordable Care Act ("ACA") amended ERISA to require fully-insured, small group health plans to provide essential health benefits,[8] ERISA did not mandate any coverage for the treatment of mental health and substance use disorders. In fact, prior to the ACA, only a patchwork of state laws required mental health benefits to be covered by some fully-insured plans.[9] The Paul Wellstone and Pete Domenici Mental Health and Addiction Equity Act ("MHPAEA"), which amended ERISA in 2008,[10] only required group health plans with more than 50 employees to cover mental health benefits at parity with medical/surgical benefits, if they chose to cover such benefits at all.

---

[1] 29 U.S.C. § 1001 *et seq*.
[2] DOL.gov. 2021. *FY 2020 MHPAEA Enforcement*. [online] Available at: https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/mhpaea-enforcement-2020.pdf [Accessed 11 April 2021].
[3] KFF. 2020. *2020 Employer Health Benefits Survey - Summary of Findings*. [online] Available at: https://www.kff.org/report-section/ehbs-2020-summary-of-findings/ [Accessed 11 April 2021].
[4] 29 U.S.C. § 1024.
[5] 29 U.S.C. § 1104.
[6] 29 U.S.C. § 1132.
[7] McCance-Katz, E., 2020. *The National Survey on Drug Use and Health: 2019*. [online] SAMHSA.gov. Available at: https://www.samhsa.gov/data/sites/default/files/reports/rpt29392/Assistant-Secretary-nsduh2019_presentation/Assistant-Secretary-nsduh2019_presentation.pdf [Accessed 11 April 2021].
[8] *See* 29 U.S.C. § 1185d, incorporating 42 U.S.C. 300gg-6(a).
[9] KFF. n.d. *Pre-ACA State Mandated Benefits in the Individual Health Insurance Market: Mandated Coverage in Mental Health*. [online] Available at: https://www.kff.org/other/state-indicator/pre-aca-state-mandated-benefits-in-the-individual-health-insurance-market-mandated-coverage-in-mental-health/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D [Accessed 11 April 2021].
[10] 29 U.S.C. § 1185a(c)(1).

Nonetheless, the adoption of MHPAEA marked a significant turning point for consumers and the managed care industry. No longer would federal law tolerate disparate lifetime or annual limits, financial requirements, or treatment limitations with respect to covered mental health and substance use disorder benefits,[11] discrimination that historically resulted in crushing debt and undertreatment. Under MHPAEA, "financial requirements" include deductibles, co-payments, co-insurance, and out-of-pocket expenses, whereas "treatment limitations" include both quantitative treatment limitations, which are expressed numerically (such as 50 outpatient visits per year), and nonquantitative treatment limitations, which otherwise limit the scope or duration of benefits for treatment under a plan or coverage.[12] MHPAEA's implementing regulations identify the following illustrative list of nonquantitative treatment limitations:[13]

(1) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
(2) Formulary design for prescription drugs;
(3) For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;
(4) Standards for provider admission to participate in a network, including reimbursement rates;
(5) Plan methods for determining usual, customary, and reasonable charges;
(6) Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);
(7) Exclusions based on failure to complete a course of treatment; and
(8) Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage.

MHPAEA requires financial requirements and treatment limitations to be analyzed within six categories in which medical/surgical benefits are offered: 1) inpatient, in-network, 2) inpatient, out-of-network; 3) outpatient, in-network; 4) outpatient, out-of-network; 5) emergency care; and 6) prescription drugs.[14] Unsurprisingly, written plan terms that are expressed quantitatively are easier to identify and challenge than undisclosed, "as applied" nonquantitative treatment limitations imposed by health insurance issuers and claims administrators.

Consequently, MHPAEA, and in turn, ERISA, were recently amended by the Consolidated Appropriations Act of 2021 ("CAA") to compel group health plans, including health insurance issuers, to robustly analyze and disclose their comparability analyses to plan participants and regulators,[15] who were charged by the 21st Century Cures Act with monitoring and enforcing plan violations entailing nonquantitative treatment limitations.[16] These mandatory disclosures include:

---

[11] 29 U.S.C. § 1185a(a)(1)-(3).
[12] 29 C.F.R. § 2590.712(a).
[13] 29 C.F.R. § 2590.712(c)(4)(ii).
[14] 29 C.F.R. § 2590.712(c)(2)(ii)(A).
[15] 29 U.S.C. § 1185a(a)(8).
[16] 29 U.S.C. § 1185a(a)(6)-(7).

(1) The specific plan or coverage terms or other relevant terms regarding the nonquantitative treatment limitations, that apply to such plan or coverage, and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification.
(2) The factors used to determine which nonquantitative treatment limitations will apply to mental health or substance use disorder benefits and medical or surgical benefits.
(3) The evidentiary standards used for the factors identified, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the nonquantitative treatment limitations to mental health or substance use disorder benefits and medical or surgical benefits.
(4) The comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the nonquantitative treatment limitations to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the nonquantitative treatment limitations to medical or surgical benefits in the benefits classification.
(5) The specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results of the analyses described in this subparagraph that indicate that the plan or coverage is or is not in compliance with this section.

Fundamental Gaps in ERISA

1. Medical Necessity

While the ACA requires access to essential health benefits, it does not define "medical necessity," a core term of coverage under ERISA benefit plans. And while MHPAEA requires nonquantitative treatment limitations such as medical necessity[17] to be applied comparably to mental health and medical/surgical benefits, it does not require medical necessity determinations to comport with generally accepted standards of clinical practice. Thus, absent ERISA expressly conditioning "medical necessity" on adherence to generally accepted standards of clinical practice,[18] health plans are free to create and operationalize self-serving, overly restrictive medical necessity definitions that undermine access to essential health benefits, including mental health and substance use treatment.

Even when ERISA plans include reasonable definitions of "medical necessity" that are contingent on coverage determinations being consistent with generally accepted standards of

[17] 29 C.F.R. § 2590.712(c)(4)(ii)(A).
[18] While some state laws, like California's SB855, define "medical necessity" for fully-insured plans, such laws are inapplicable to self-funded ERISA plans.

clinical practice,[19] ERISA fiduciaries who actually make final and binding coverage determinations in mental health cases all too often base their decisions on deficient, non-transparent utilization review criteria developed or licensed by them.[20] There is method to this madness: the ERISA fiduciaries who act as third-party administrators for self-funded plans generally apply the same utilization review criteria across their entire commercial book of business, including in the fully-insured markets where they are health insurance issuers and therefore directly assume the financial risk associated with benefit expense. This dynamic was fleshed out in the landmark class action, *Wit v. United Behavioral Health*, No. 14-cv-02346-JCS, 2019 WL 1033730 (N.D. Cal. Mar. 5, 2019).

In *Wit*, the United States District Court for the Northern District of California found that over a seven-year period, United Behavioral Health, the nation's largest managed behavioral health company, breached its fiduciary duties to nationwide classes of well over 50,000 ERISA plan members, including thousands of children, by developing and applying pervasively flawed utilization review criteria to wrongly deny nearly 70,000 claims for outpatient, intensive outpatient, and residential treatment for mental health and substance use disorders. Though "[e]very class member's health benefit plan include[d], as one condition of coverage, a requirement that the requested treatment must be consistent with generally accepted standards of care,"[21] the court found that UBH's utilization review criteria "result[ed] in a significantly narrower scope of coverage than is consistent with generally accepted standards of care."[22] While mental health and substance use disorders are, by nature, largely chronic and pervasive, UBH's utilization review criteria operationalized an "Acute Care Utilization Management Model" limited to crisis stabilization.[23] In fact, UBH's primary guideline author acknowledged that "services for severely and persistently ill members that are intended to endure[] don't play to an acute care UR [utilization review] model,"[24] and even UBH's sole retained expert testified that "'any practitioner worth his salt' would not rely on the [UBH] Guidelines themselves but instead, would go straight to the underlying documents that set forth generally accepted standards of care."[25]

The *Wit* court also noted that:

> The record is replete with evidence that UBH's Guidelines were viewed as an important tool for meeting utilization management targets, "mitigating" the impact of the 2008 Parity Act, and keeping "benex [benefit expense]" down.[26]
>
> [T]he evidence shows that UBH had a structural conflict of interest throughout the class period because a large portion of its revenues came from fully insured plans.

---

[19] Policysearch.ama-assn.org. n.d. *Policy Finder | AMA*. [online] Available at: https://policysearch.ama-assn.org/policyfinder/detail/H-320.953?uri=%2FAMADoc%2FHOD.xml-0-2625.xml [Accessed 11 April 2021].
[20] Mental Health Association in New York State, Inc. 2020. *MH Update - 11/24/20 - Behavioral Health Parity in New York State: Redefining Medical Necessity*. [online] Available at: https://mhanys.org/mh-update-11-24-20-behavioral-health-parity-in-new-york-state-redefining-medical-necessity/ [Accessed 11 April 2021].
[21] *Id*. at *13.
[22] *Id*. at *22.
[23] *Id*. at *23.
[24] *Id*.
[25] *Id*. at *7.
[26] *Id*. at *48.

> Moreover, the evidence shows that even as to the self-funded plans, UBH felt pressure to keep benefit expenses down so that it could offer competitive rates to employers. Second, regardless of whether the financial incentive to keep benefit expenses down was stronger with respect to the fully insured plans or the self-funded plans, the conflict of interest affected all members equally, regardless of which type of plan they were insured under, because UBH used a single set of Guidelines to make coverage determinations.[27]

As a consequence of its years-long fiduciary breaches, UBH was ordered to exclusively apply, over a 10-year period, utilization review criteria developed by nonprofit clinical specialty associations, including the American Society of Addiction Medicine, the American Academy of Child and Adolescent Psychiatry, and the American Association for Community Psychiatry, across all the ERISA plans it administers that condition coverage on adherence to generally accepted standards of clinical practice. *Wit v. United Behavioral Health*, No. 14-cv-02346-JCS, 2020 WL 6469764 (N.D. Cal. Nov. 3, 2020).

2. Network Adequacy

The lack of a uniform definition of "medical necessity" is not the only impediment to meaningful coverage of mental health and substance use treatment under ERISA plans. While the ACA established a network adequacy requirement for qualified health plans sold on ACA Exchanges,[28] it did not amend ERISA to require non-exchange plans to establish network adequacy standards for timely and geographic access to care.[29] Although MHPAEA identifies network adequacy as a non-quantitative treatment limitation,[30] it too does not set timeliness or geographic access standards for mental health and substance use treatment. While state laws may establish network adequacy standards for fully-insured plans, self-funded ERISA plans are not subject to them and generally do not provide participants with any notice of timeliness or geographic access standards in plan documents. Absent notice of any such standards set by their plans, or any remedies for the unavailability of in-network services, ERISA plan participants must often wait protracted periods or travel extensive distances to receive mental health and substance use treatment, or to obtain authorizations for out-of-network care, which are inconsistently granted. Given the prevalence of narrow and phantom networks, it is unsurprising that mental health and substance use treatment is disproportionately rendered out-of-network or forsaken altogether.

A fundamental driver of network inadequacy is that, in general, health insurance issuers and claims administrators significantly underpay in-network behavioral health providers, particularly in comparison to in-network medical providers. Given such low and discrepant reimbursement rates, it is hardly surprising that a far lower percentage of behavioral health providers choose to participate in networks, resulting in a much higher percentage of behavioral

---

[27] *Id*. at *53.
[28] 42 U.S.C. § 18031(e)(1)(D)(1).
[29] 42 U.S.C. § 18021(b)(1)(B).
[30] *See* 78 Fed. Reg. 68240, 68245 (Nov. 13, 2013) ("[N]etwork adequacy, while not specifically enumerated in the illustrative list of NQTLs, must be applied in a manner that complies with these final regulations.").

health services being rendered out-of-network, with the concomitant increase in out-of-pocket expenses.[31]

At a minimum, ERISA plans should be required to protect plan participants from cost-sharing that exceeds their in-network financial responsibility when out-of-network services must be sought due to network inadequacy.

3. Enforcement

The systematic application of substandard utilization review criteria for the treatment of mental health and substance use disorders, and the pervasive lack of access to timely and geographically proximate in-network mental health and substance use disorder treatment, would be far less likely if ERISA did not insulate plan fiduciaries, namely health insurance issuers that sell group health coverage and claims administrators of group health plans, from damages,[32] and further entitle them to a deferential standard of judicial review when challenged for their wrongful benefit denials.[33]

ERISA's remedial scheme should be updated to account for the modern reality that health plan issuers (of fully-insured group plans), who also serve as claims administrators (for self-funded group plans), are the actual fiduciaries who adjudicate benefits using self-selected, uniform utilization review criteria across their commercial lines of business, and who sell shared network access to group health plans. With annual profits in the billions,[34] they should not be incentivized to short-change premium-paying participants by artificially limiting their coverage for medically necessary mental health and substance use treatment, or by selling access to networks that are known to lack mental health and substance use providers.

Currently, ERISA constrains the Secretary of Labor from enforcing the ACA's and MHPAEA's protections against health insurance issuers that offer substandard mental health insurance coverage to group health plans.[35] Yet as noted earlier, approximately one third of ERISA participants and beneficiaries are covered by fully-insured ERISA plans. Legislation proposed by Congressman Norcross, H.R.1364—Parity Enforcement Act of 2021, would go a long way toward ensuring accountability and leveling the managed care playing field.

---

[31] Melek, S., Davenport, S. and Gray, T., 2019. *Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement.* [online] Milliman.com. Available at: https://www.milliman.com/-/media/milliman/importedfiles/ektron/addictionandmentalhealthvsphysicalhealthwideningdisparitiesinnetworkuseandproviderreimbursement.ashx [Accessed 11 April 2021].

[32] Courts have interpreted ERISA's remedial scheme as precluding all extra-contractual damages, including compensatory and punitive damages. *See Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134 (1985).

[33] *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 109 (1989) ("ERISA does not set out the appropriate standard of review for actions under § 1132(a)(1)(B) challenging benefit eligibility determinations. To fill this gap, federal courts have adopted the arbitrary and capricious standard developed under 61 Stat. 157, 29 U.S.C. § 186(c), a provision of the Labor Management Relations Act, 1947 (LMRA).").

[34] Abelson, R., 2020. *Major U.S. Health Insurers Report Big Profits, Benefiting From the Pandemic*. [online] Nytimes.com. Available at: https://www.nytimes.com/2020/08/05/health/covid-insurance-profits.html [Accessed 11 April 2021].

[35] 29 U.S.C. § 1132(b)(3).

To truly guarantee meaningful access to mental health care, I urge Congress to consider legislation that: conditions "medical necessity" on adherence to generally accepted standards of clinical practice; eliminates the deferential standard of judicial review in health benefit cases; permits damages against health insurance issuers and claims administrators that discriminate against and undermine access to mental health treatment; and protects access to open courts by exempting ERISA claims from binding arbitration.

Chairman DESAULNIER. Thank you, Doctor.

Under Committee Rule 9(a), we will now question witnesses under the five-minute rule. I will be recognizing subcommittee Members in seniority order. Again, to ensure that Members' five-

minute rule is adhered to, staff will be keeping track of time and the timer will sound when your time has expired.

Please be attentive to the time, wrap up when your time is over, and remute your microphone.

As chair, I now recognize myself for five minutes.

Dr. Bendat, I apologize for the mispronunciation, Dr. Moutier and my high school French. Forgive me for silencing your name. So, I wanted to ask you a question about California, my home state's parity law that was recently passed, SB 855. The law included a new definition of the term medical necessity.

It requires insurance companies to cover behavioral health based on generally accepted standards of care. Could you explore—you did explore this concept of medical necessity in your testimony when you discussed the United Behavioral Health case.

I was wondering if you might be willing to briefly give us an assessment of the California law, and what lessons can we learn from it?

Dr. BENDAT. Sure. So, I would hold that the California legislation that's now law as of January 1 should serve as model legislation around the country, and I would urge Congress to consider adopting the definition of medical necessity in SB 855.

Essentially, the law defines medical necessity to mean, among a few other things, that services that are offered for mental health and substance use disorders must be consistent with generally accepted standards of care.

And it requires health insurers who operate in the State of California to make decisions about medical necessity utilizing, or based on utilization review criteria that are in fact consistent with generally accepted standards of care.

These standards are generally set by non-profit clinical specialty associations with familiarity over subject matter and peer reviewed research. In California, the law requires exclusive application of the non-profit professional society guidelines for determining the level of care—meaning outpatient, intensive outpatient, residential treatment—that patients seek.

And it limits the ability of insurers to apply self-serving criteria that they developed or licensed, that may not at all be consistent with generally accepted standards of care that may have boilerplate references and footnotes to underlying standards but that deviate markedly from them.

Chairman DESAULNIER. Thanks. Clearly a challenge as the science evolves to make this as understandable as possible, and benefits the consumer, also benefits the employers and the consumers as well in a balanced way.

One of the big challenges is of course the concept of mental health parity and putting it in the reality of the consumer level is dealing with the issue of non-quantitative treatment limits, or NQTL. These are restrictions that plans place on benefits through medical management, have a number associated with them, and so it can be tricky to compare between behavioral health and medical and surgical cases.

Dr. Bendat how has the newly enacted law, the Strengthening Behavioral Health Parity Act, helped improve oversight of NQTLs

and can you think of any ways that we should further strengthen it?

Dr. BENDAT. So, the law is wonderful in that it really shines a light on the most complicated part of parity, which is enforcement and compliance with the non-quantitative treatment limitation rules. As I mentioned in my testimony, non-quantitative treatment limitations can be written, but often they are just applied.

In other words, you don't get advance notice of what they are. They are not spelled out for you in the plan documents. So a plan sponsor, an employer may write a really nice package, or benefits into a plan, but then these plans, especially in the ERISA context, the self-funded plans are effectively administered day-to-day by claims administrators, not the employers, not the plan sponsors.

These claims administrators employ all sorts of internal policies and procedures to effectuate their administration of plans across entire swaths of group plans and market sectors. And the law that has been enacted essentially requires a robust analysis of these, as applied, as well as written, non-quantitative treatment limitations.

The issue historically has been that although ERISA requires disclosure of the non-quantitative treatment limitations, employers are generally stumped when asked for these, and must obtain them from health insurance issuers.

Chairman DESAULNIER. Can I ask you to wrap up, Doctor?

Dr. BENDAT. Sure. These aren't often disclosed, so to the extent that the law really takes into account disclosure from health insurance issuers, and puts it into the hands of consumers, all the better.

Chairman DESAULNIER. Thank you. I appreciate that. I now want to recognize the Ranking Member for the purpose of questioning the witnesses. Mr. Allen.

Mr. ALLEN. Thank you Mr. Chairman. Mr. Gelfand the COVID–19 pandemic has completely disrupted many American's way of life. Business closures have caused Americans to relocate, to find a job, and students returning home to live with parents and attending classes online.

In relocating many have unfortunately lost access to mental health care during a time they need it most. Patients may face provider shortages in their new areas, government lockdowns may prevent them from finding a new provider, and they may be unable to visit their old provider remotely due to barriers created by State licensure laws.

How do you propose we overcome these barriers to preserve and expand access to care?

Mr. GELFAND. Thank you Representative Allen. While employers support long term solutions to increase the supply of mental and behavioral health providers throughout the country, many employees need help right now. They don't have the luxury of waiting for 50 states to sign interState compacts, or for providers to be coaxed into moving from the coast.

So to help them right now employers propose focusing on telehealth. There are willing and able providers out there. Telehealth is interState commerce, and we should eliminate State barriers by allowing providers who are practicing via telehealth within one uniform framework to see patients in other states.

There are a half a dozen different ways Congress could do this, but one might be to say that a provider participating in an ERISA plan, or a service contracted by an ERISA plan, can be subject to one uniform framework.

Mr. ALLEN. Well Congress recently added additional mental health parity requirements as part of the Consolidated Appropriations Act of 2021. Mr. Gelfand can you update this committee on the implementation status of these new provisions. In your view is it premature for Congress to consider additional mandates, or to suggest monetary penalties for parity violations?

Mr. GELFAND. Yes. So in the December Omnibus Bill for probably the third time, Congress told Department of Labor to be clear about parity rules, and non-quantitative treatment limitations, ordered more audits, and clarified that employers, not vendors, need to have documents ready to explain all of the limits in their plans.

So this triggered a process by which the employers are now working with vendors to produce a huge amount of documents explaining any limitations on mental behavioral health and benefits, analyzing how they compare to the medical side, explaining a lot of very in-depth info.

DOL is going to start selecting plans and asking to review this info. So we think it would make sense to see what DOL finds, and how employers do on compliance before piling on new requirements for punishment. It's our opinion that employers are doing a good job of compliance, and that violations are concentrated outside of the large group self-insured market.

It's imperative that we see the results of these new requirements before we invent new ones or create penalties.

Mr. ALLEN. Well as I said in my opening statement, it's obvious we're in the middle of a mental health crisis. This COVID–19 pandemic and lockdown have taken a toll on employers, workers, and their families. How are your Member companies helping their employees cope with the stress created by the pandemic and associated lockdowns?

Can you elaborate on programs or best practices that Congress should support?

Mr. GELFAND. Sure. Employers have been part of the solution stepping up to improve access for our employees and their families. We've contracted with companies that specialize in this area, created many new programs for employees. Employers also realized that the pandemic created mental health needs that were beyond just insurance coverage.

For instance, people needed time off, and we actually needed management to lead by example and show that it was OK to take their time off. We set up virtual challenges to sort of gamify and get people engaged on these issues.

Employers offered online classes and more. But the best thing Congress could probably do would be to give employers more space to experiment and innovate. So right now the rules related to mental health parity, the ACA, Americans With Disabilities Act, GINA, COBRA and other laws, they make it super complicated to try anything new.

So what if Congress was to say you know so long as an employer has a plan that meets the requirements under these rules, they

could experiment with a new, more limited benefit that could be offered on a supplemental basis, not subject to all of those complicated new rules.

That would get new ideas and new money on the table to potentially help employees.

Mr. ALLEN. Well thank you so much. I'm about out of time, but I do understand the importance of price transparency, and if you could address this maybe with another Member. We should use every dollar wisely. The employees enrolled in high deductible health plans with health savings accounts are rightly cost conscious and seek to make healthcare choices that work best for their families and their budget.

The CARES Act allows employees participating in such plans to benefit from first dollar coverage for telehealth, but only through 2021. And what I'd like you to address is how do you explain further how does first dollar coverage of telehealth services help these patients?

And we'll be able to do that with the next question and I yield back.

Chairman DESAULNIER. Thank you, Mr. Allen. We're now going to go to Chairman Scott for five minutes, Chairman Scott.

Mr. SCOTT. Thank you, Mr. Chairman. And I'd like to point out that in introducing Dr. Smedley you left out a substantial portion of his distinguished resume, and that is the fact that a long time ago he served as an American Psychological Association Fellow in a congressional office—mine.

Mine. He did a great job and it's great to see him now.

Chairman DESAULNIER. Dr. Smedley. I need an intervention on my behalf with the Chairman.

Mr. SCOTT. So, Dr. Smedley we've heard a lot about stretching out the providers we have. What initiatives do we have to increase the number of providers? I understand in terms of psychiatrists, if the VA staffed up appropriately with psychiatrists, there wouldn't be any left for anybody else.

And obviously, that is a great problem. What are we doing to increase the number of providers?

Dr. SMEDLEY. Well thank you, Congressman. It's good to see you again. You are absolutely right that in terms of the mental health and behavioral health workforce, we are sorely behind. We need to dramatically increase the number of well-trained, culturally competent providers that are available, and we need to increase the diversity of these providers to better reflect the demographics of the U.S. population.

At the APA we're very proud of programs such as the Minority Fellowship Program, which has done a tremendous job in increasing access to behavioral health and mental health careers for diverse populations.

These are talented individuals who are often going into underserved communities and providing those services. But we certainly need to increase and expand these kinds of programs. As has been indicated, we are woefully under prepared to address the mental health challenges that are before the country now, so we urge expansion of these kinds of important programs.

Mr. SCOTT. Are there scholarship programs, or something that can get people on track through college and professional schools to get them on track to be providers?

Dr. SMEDLEY. Certainly, there are some resources. Yes, the Minority Fellowship Program helps to provide some of those resources, but it's also true that the National Health Service Corps and other programs have been vitally important in providing access to training, often with service payback agreements whereby those trainees go into underserved communities for a number of years, provide high-quality services in exchange for government assistance with their tuition costs.

So, again, these programs need to be expanded. They are vitally important, and we certainly call for more psychologists, behavioral health and mental health professionals to be able to access these important programs such as the National Health Service Corps.

Mr. SCOTT. Thank you. Dr. Bendat it's true that the Department of Labor has enforcement over ERISA programs in terms of mental health parity. Isn't there a private enforcement right by consumers?

Dr. BENDAT. So, there is in fact a private enforcement right for consumers. The problem however is that it is a very limited right. Consumers are not able to generally recover anything more than their benefits, and while $5,000, $10,000 may seem—and actually be—a lot of money to most Americans, if that's the size of your claim you're generally not able to pursue it because there are very plaintiff's attorneys around the country who are able to bring claims of that sort.

So, the end result is that you have lots and lots of people who are out precisely amounts in this kind of range, and are unable to vindicate their claim. So essential that the DOL steps in. Also essential that Congress consider bringing in again the opportunity for extracontractual damages to be obtained from fiduciaries, namely claims administrators, TPA's that improperly deny claims and disincentivize people from getting the care they need.

Mr. SCOTT. And what arbitration clauses do to the right to bring a claim even if you could bring it?

Dr. BENDAT. Well, for one they make things secret. So DOL doesn't find out about potential allegations and findings. Arbitrations don't always follow the law in a way that courts do, and arbitrations can also potentially limit the types of relief sought, so a real danger.

Mr. SCOTT. Thank you, Mr. Chairman.

Chairman DESAULNIER. Thank you, Mr. Scott. I apologize for that omission. Next we go to Mr. Walberg. Mr. Walberg?

Mr. WALBERG. Thank you Mr. Chairman. And before I begin my questioning I would like to ask permission for unanimous consent to put into the record a letter from the partnership for employer sponsored coverage if that would be allowed?

Chairman DESAULNIER. Without objection.

Mr. WALBERG. Thank you Mr. Chairman. And thanks for the hearing today. And thanks to the witnesses for being here. We all know, and as we've heard already on this hearing that the COVID–19 pandemic has exacerbated barriers to care as people have be-

come fearful or discouraged from traveling to seek the care they need.

If there's one bright spot that we've discussed even this morning from the pandemic it's been the expansion of telehealth services which really has become a lifeline for ensuring access to healthcare during the pandemic.

However, State licensing restrictions can hinder a patient's ability to receive care from health professionals that are not licensed in the patient's State. Occupational licensing reform has been an issue of particular interest of mine, and I recently cosponsored the TREAT Act, which would provide temporary State licensing reciprocity for licensed practitioners during COVID–19 public health emergency.

And so, Mr. Gelfand, in your written testimony you note that encouraging interState provider license reciprocity would improve access to mental health services. Can you please describe the regulatory barriers providers face when they seek to treat patients from across State lines?

Mr. GELFAND. Absolutely. Thank you Mr. Walberg. So there is a financial cost for providers to get licensed or certified in different states. That cannot be overlooked. We've estimated the cost for a doctor just to practice in the 28 states that participate in the InterState Medical Licensure Compact, at nearly $12,000.00 payable every 2 years or so.

However, that is only one of many complicating factors. Every State has its own set of rules which could include different continuing education requirements, different renewables, different financial systems et cetera.

Some states might require applications to be completed in person. Others might have fingerprinting requirements. The list just goes on. The problem is particularly extreme for patients with rare or complicated diagnoses who need to see a very specialize provider like those who practice at academic medical centers, but there are many other examples like a patient who travels a long distance for highly specialized care, but isn't well enough for whom they could travel, or traveling would be a major inconvenience.

We recently heard a story about a spouse who was left with no other option than to drive his wife, the patient, across the State line into Maryland to receive post-surgery telehealth from her car, parked in Maryland, rather than from her home in Delaware because of the differing rules.

So this isn't serving patients, and it's certainly causing a lot of barriers for doctors.

Mr. WALBERG. Amazing, amazing, but glad we're finding these things out now. How are employers that operate in multiple states navigating these barriers? And especially as they relate to telehealth?

Mr. GELFAND. Right. So an employer sponsored ERISA plan will offer pretty much identical benefits to all of our beneficiaries all over the country no matter where they live, where they work, or where they receive medical care, except not for telehealth.

Telehealth is governed at the State level, which means that an employee in one State may be able to do all kinds of telehealth visits, whereas in another State they may be required to do video

only. So unless they have broadband internet access, they're banned from telehealth.

In some states the patient can simply pick up their smart phone and find a doctor, while in other states you can only do telehealth with a provider who is already your doctor. In some states they don't allow prescriptions over telehealth. In some states they still have super antiquated originating site rules as if it was 1992, and to use to the internet we had to go to a cybercafe.

So that's why ERIC is calling for a national set of rules for telehealth, so that our plan's beneficiaries can get one set of rules and we can end this mismatched set that is creating a fundamental unfairness for our employees and their families.

Mr. WALBERG. Mr. Gelfand following that track a bit as you are well aware, this committee has jurisdiction over the Employer Retirement Income Security Act, ERISA, which was enacted way back in 1974, long before the internet or concept of telehealth.

Does Congress need to take a look at ERISA or other laws if we want to encourage expansion of telehealth services and promote states to adopt licensing reciprocity?

Mr. GELFAND. It is our belief that ERISA is one avenue through which a national framework could be made such that an ERISA plan could contract with providers, and those providers could see their patients in that ERISA plan no matter where they worked.

There are still going to be details that will have to be worked out to ensure that a patient has somewhere that they can go if there's a problem. If they have an authority that is regulatory in nature, but Congress can absolutely work those problems out. It's not a question of whether. It's a question of how.

Mr. WALBERG. Thank you my time has expired. I appreciate your input. I yield back.

Chairman DESAULNIER. Thank you, Mr. Walberg. Nicely done. We are now going to the distinguished gentleman from New York, Mr. Morelle.

Mr. MORELLE. Thank you very much, Mr. Chairman, for hosting this hearing on obviously one of the most important questions coming out of the pandemic, and I appreciate everything my colleagues said, and appreciate the witnesses.

I did want to follow up a little bit with Mr. Walberg's questions regarding telehealth. I spent a fair number of years in the State legislature, and was a big advocate for telehealth and telemedicine, and I've been I think pleasantly surprised by some of the information that's come out about how people have received treatment and services through telehealth, and it may be just auditory with just telephonically.

And I know Dr. Smedley had mentioned in his opening comments. Just aside from the public policy issue, we're talking to constituents and taxpayers about telehealth. They may have some hesitancy. They may wonder how this could be successful.

Do you have any thoughts on first of all the degree to which people are compliant with going to actual appointments and not missing appointments—which I gather happens in the physical arena—as well as mental health arena with some degree of frequency—how that's worked in the pandemic.

And also just the efficacy of treatment either through telehealth on sessions like this, or that are purely telephonic. Could you just comment on that anything that you gleaned, or any information that would help us talk to people about the efficacy of this treatment?

Dr. SMEDLEY. Congressman is that for me?

Mr. MORELLE. Yes sir.

Dr. SMEDLEY. OK yes thank you. Yes, we certainly know that telehealth services has been indicated, can be an equity enhancer in terms of ensuring that people have appropriate access to culturally appropriate mental health services, reducing geographic, cultural and linguistic barriers by increasing the pool of available providers to patients is critically important.

Certainly, it has great potential to reduce the number of no-shows, and we're certainly looking to compile research on efficacy, but to date all the indications are that telehealth can provide high-quality services that importantly improve patient outcomes just as the case for the traditional in-person service.

Mr. MORELLE. Well I appreciate that, and I look forward to working with some of my colleagues to expand opportunities for the telehealth services. A different topic, Dr. Smedley. I wonder, we talked about the disproportionate impact of the pandemic in communities of color, older Americans, and people with disabilities, particularly those who receive long-term care in congregate settings have also been particularly hard hit by the pandemic.

This does not get as much attention from my perspective, but can you talk about the impact that it's had on older Americans and people with disabilities, and what you think, if anything, the recommendations for us on how we can address this lack of service?

Dr. SMEDLEY. Sure. Congressman you are correct that there are many populations that have been disproportionately impacted by the COVID pandemic with the combination of physical distancing, social isolation, economic anxiety, fears of transmitting the virus, and for many in communities of color we are facing a resurgence of overt expressions of racism, xenophobia and intolerance, which adds to stress, fear and anxiety in many communities of color.

What can we do? Certainly, No. 1 for me would be to enforce the Mental Health Parity Act, particularly for the Medicaid-eligible patient population, ensuring that we have adequate networks, ensuring adequate reimbursement will be a huge step that can be taken to ensure that these patients have access to needed high-quality services, and then as we've discussed expanding and ensuring the continuation of audio-only telehealth will be a significant opportunity for patients to receive services that they might not otherwise receive.

So these are important steps that Congress can take now addressing the needs of these vulnerable populations.

Mr. MORELLE. And what's your sense in terms of the underserved population, you talked about communities of color. We now just talked about older Americans, people with disabilities. What are the long-term consequences of this?

What should we expect in terms of additional healthcare costs, et cetera of going forward as a result of the lack of services during the pandemic?

Dr. SMEDLEY. Sure. As the other witnesses have described, we certainly know that there's a strong relationship between mental health symptoms and distress, and other physical health symptoms. We absolutely need to address both and ensure that we have a holistic approach to treating the needs of patients, and particularly for those populations that you indicated which have been historically underserved and marginalized in our health care systems.

Mr. MORELLE. Thank you. Thank you, Mr. Chair. I yield back.

Chairman DESAULNIER. Thank you, Mr. Morelle. We're now going to Mrs. Harshbarger.

Mrs. HARSHBARGER. Thank you Chairman and Ranking Member Allen. I appreciate the witnesses being here today. I do have experience with this. I've been a pharmacist for 34 years and I absolutely have seen the increase in mental health, you know, drug therapies, the increase in opiod abuse, especially during COVID–19.

I just came back from the border. I hear my counties talking about how methamphetamine use is up by 40 percent. It's unbelievable. And I think brain health is the last frontier, and I talked to psychologists that say it's absolutely an organ that we treat that we cannot see.

One of the few professionals that do that. You know Mr. Gelfand I live in an area that's very rural, and we have a deficiency and a limited amount of behavioral health and mental healthcare providers. And you know I've talked to counties that absolutely have to wait a year to get one applicant to treat patients in their communities, and I'd like to know what Congress can do as a whole to increase the number of behavioral health providers.

I understand telehealth has exploded during COVID, and it's here to stay. And we need to have reciprocity rules. As a pharmacist I know that every State has different rules, and if I want to reciprocate to another State that's a large fee. You know there's different rules, State laws, all that.

We know that we need to make that cohesive across State lines, but how do we recruit these individuals, especially into rural areas where they are the hardest hit with the opiod crisis, and you know we need those mental health providers there.

What can you tell me, and what can Congress do to help with that issue.

Mr. GELFAND. Thank you Representative. In the long-term employers very much support efforts like targeting education funds and loan forgiveness to mental and behavioral health providers, but that's a long-term solution. And it's not going to help your constituents today.

So if you want to do something today, the No. 1 thing that Congress should do is just pass the TREAT Act. You pass the TREAT Act, you instantly open up an immense supply of providers to these patients, both via telehealth and in-person, but it's only temporary right?

So if we want to sustain the gain we have to explore permanent solutions to allow cross State practice. And you know we have to be honest about this that it's not at all clear that increasing you know pay for providers you know, $30.00-$40.00 an hour is going

to get them to close up shop and move, right, and change where they're practicing.

So we need to think about you know this committee has jurisdiction over ERISA, and could potentially give our plans and their vendors the ability to contract with providers elsewhere and beam them him via telehealth. ERISA is not the only way to do it, but it's a way that this committee could do it and could do it quickly.

Mrs. HARSHBARGER. OK. Well I appreciate that verse. Like I said we've seen that uptick in opiod abuse. You know people they're anxious, and it's those younger people that we see the most, and we've seen an uptick in that. And it's because they haven't been on the job. They haven't been able to get out and socialize. That's a huge problem.

And I think we would benefit if we did get things opened up. You know as more people get vaccinated, hopefully that will happen, but addressing this real shortage of healthcare providers is key, especially in my district. And I'm here to help in any way I can, and I appreciate all the witnesses today.

I know this is a problem. This is something that like I said it's the last frontier and we need to address these situations, and I appreciate you being here, and I yield back.

Chairman DESAULNIER. Thank you. We are now going to recognize Mr. Norcross from the great State of New Jersey.

Mr. NORCROSS. Thank you, Chairman. And it's good to see you there. I really appreciate your insight and quite a legacy coming from George Miller and what he's done for this great committee. Dr. Smedley, thank you for your opening comments, particularly in dealing with the parity issue.

By giving this additional support tell me how the Department of Labor can use this to change the way that some of the bad actors are playing now. If you can give us some context of why this is relative and important.

Dr. SMEDLEY. Sure. Thank you, Congressman. So, as we discussed earlier what's lacking with the current mental health parity law is teeth—enforcement. And so for the Department of Labor clearly capacity has been part of the problem.

There are an enormous Member of insurance plans to regulate a few investigators, and an analogy would be that if we had only one State trooper patrolling I–95 between Washington, DC and Richmond that would not suffice to adequately police that highway.

So, we need better enforcement, more teeth, we need to ensure adequacy of networks. We need to ensure adequacy of reimbursement, and so your legislation would give the Department of Labor that capacity to ensure that insurers are complying with the law.

Mr. NORCROSS. I would certainly appreciate that. I thought you were going to comment about my driving techniques, but the idea we believe, even without police, that they'll do the right thing is simply not happening across the board and we appreciate.

Dr. Bendat tell me the ways that the insurance companies, as you see them, try to circumvent the Parity Act. What are common areas that you've been involved in, or that you've seen that you can share with us.

Dr. BENDAT. Sure. So, as I mentioned earlier the easiest way to circumvent parity is to adopt non-quantitative treatment limita-

tions that are not disclosed, or that are discrepant. In other words, incomparably applied to mental health and substance use benefits.

The most prominent NQTL of them all is medical necessity. Medical necessity is generally again something that has to be set by law or a plan, and it can be interpreted in different ways if it isn't properly structured, so I would say medical necessity and utilization review criteria that interpret medical necessity, those are tremendous ways in which insurers can deny coverage without triggering any oversight or alerting the public that there is something really foul going on.

Mr. NORCROSS. Well, when you look at the capacity for the Department of Labor in its present configuration to go after this and there was a letter circulated today by my colleague Joe Courtney about increasing the funding to the Department of Labor. Right now, it seems that the balance is extremely far off.

Our capacity to look at this and those to come into compliance willingly. Are there some more subtle ways? The two that you mentioned obviously, are out there and easier to see. What are some more of the subtle ways that some of this is going on?

Dr. BENDAT. Well, apart from medical necessity and network adequacy, which are huge in their right, and probably the biggest impediments to access to care that health insurance issuers control, you all—and reimbursement figures into the equation. In other words, how are reimbursement rates set? That is not a transparent thing.

How are in-network reimbursement rates set? That's particularly not transparent. So, when we get more answers to those questions, we'll have a lot more insight as to kind of the methodologies that are being applied and the incomparability. I would also say that you know apart from these you've got potential deductibles and plan specific things that can drive people not to receive benefits.

Mr. NORCROSS. I very much appreciate it. And it's the context of which we live in and the pandemic. You never want to suggest that there's a silver lining, but the idea that mental health is so important, and so many people who have not really been challenged by it are now seeing it across the board, and we have to get that to them, that's why this legislation is so important.

Mr. Chairman, I yield back and thank you for the time.

Chairman DESAULNIER. Thank you, Mr. Norcross. And having ridden with you, I want to confirm your observations about your driving skills. We will now go to Congresswoman Miller.

Mrs. MILLER. Sorry.

Chairman DESAULNIER. No worries.

Mrs. MILLER. Yes. Mr. Gelfand thank you again for your thought provoking testimony. It's wonderful to hear about the great work that companies across the country are doing to support the health and well-being of our employees. And I have witnessed what we are discussing as I travel the district, and people are struggling to fill their—get workers.

But anyway back to the opiod epidemic. I would like to know you shared testimony that some actions that employers have taken to combat this terrible epidemic, you've already explained some, but could you expand on any other unique approaches that your Member organizations have taken?

Mr. GELFAND. Thank you Representative. You know unfortunately COVID did cause a lot of disruption, including for many employers opiod mitigation efforts. The economic squeeze separated a lot of employees from these programs, made it impossible to do a lot of things that we were doing in person, and activities that we have rolled out, plus mental health toll taken on workers because of COVID and because of isolation and lockdown have led some back to dependency.

So this is very real for us. The good news though is that many of these programs that we implemented before COVID, we were able to sustain because they were cultural changes within our health benefits. For instance, we're not going back to unlimited fills for opioids.

I mean should we dispense the amount that they need for immediately relief? And this should be monitored and re-evaluated, and when possible a patient should be steered to other options. These are just lessons learned, and we're never going to let those go.

And many of the programs that we developed like educational sessions, group counseling, this can and has gone virtual, and maybe that will change back when we can meet in person again. But for now it seems sustainable to use these online platforms.

Mrs. MILLER. I do have another comment. Do I have time?

Chairman DESAULNIER. Yes, you do.

Mrs. MILLER. OK. I don't know if this would be the appropriate place, but actually my son-in-law is an orthopedic surgeon, and of course he prescribes these. But he brought up how Americans want to be pain free and they demand pain relief. But then when physicians don't give them what they want, then they turn a bad report in on the physician.

And so they're kind of caught in between on that.

Chairman DESAULNIER. Any of you care to comment?

Dr. SMEDLEY. Mr. Chairman, I would if you don't mind. This speaks to the importance of non-pharmacologic behavioral treatments. There are many behavioral treatments that are highly effective in reducing pain and increasing patient comfort, and of course they're much healthier coping responses.

So, doing what we can to ensure the promotion of non-pharmacologic behavioral treatments can be an important and effective alternative.

Mrs. MILLER. Well getting the doctors to use those and then get that out to the patients.

Chairman DESAULNIER. Absolutely. Anyone else?

Mrs. MILLER. Thank you

Chairman DESAULNIER. Thank you Representative, is that it? I appreciate it. We will now go to Representative Wild.

Ms. WILD. Thank you, Mr. Chair. My question is for Dr. Moutier, but I'm happy to have any of the panelists respond. As many of you know I am proud to be a leading advocate in Congress for, excuse me, suicide prevention.

I am extremely concerned about the rise of suicide among young people and children and the deterioration of their mental health. And although many have claimed and argued that school closures have adversely affected children's mental health, and I'm sure that is true, we know that this problem existed long before COVID–19.

The number of children ages 6 to 12 who visited children's hospitals for suicidal thoughts or self-harm has more than doubled since 2016, according to data released earlier this month from children's hospitals across the country. They documented 5,485 emergency room or inpatient visits for suicidal thoughts and self-harm among 6 to 12 year old's at these hospitals in 2019, which is notably pre-pandemic, which is up from 2,555 in 2016.

And visits for teenagers with suicidal thoughts or self-harm at these hospitals also rose from 2016 to 2019 by a staggering 44 percent. According to the most recent data we have from the CDC, suicide is now the second leading cause of death among young people ages 15 to 24.

How can making sure that our kids get the mental health care they need, including mental health care covered by their health insurance the same way they cover physical health issues, prevent these suicides, and address these suicidal thoughts?

And how do we ensure, and I know this has been touched on already, but it's such an important issue. How do we ensure that robust mental health care receives parity in insurance coverage? And with that Dr. Moutier I'm going to turn it over to you, and if anybody else would like to weigh in on this very important topic I'd be happy to hear them. Thank you.

Dr. MOUTIER. Thank you, Congresswoman Wild. Yes, the suicide crisis in our Nation has been on the rise and that actually is true for all age groups, but certainly for youth. The rise in not only suicidal ideation attempts but rates, has been tremendous pre-COVID.

What we know so far during COVID is that during 2020 the number of suicides compared to 2019 actually went down by 5.6 percent around the Nation. We don't know the demographic breakdown of that yet by age, or by race ethnicity. And we know that the pandemic is affecting all people, but affecting different groups differently.

So, I am very concerned about what we will ultimately see in terms of not only the demographic breakdown for suicide rates during 2020, but also now what is coming here now in 2021 because the effects of trauma can be delayed.

So, the big picture is that we have had a broken system when it comes to accessing mental health care. There has been stigma, internal and external, cultural barriers, but now that that is going down, I believe that that is one of the reasons we see help-seeking so much more on the rise, but the access to care has not been there to meet it.

And so, parity is essential when it comes to suicide prevention. It is one of the most concrete and powerful things we could do to potentially prevent suicide and drive suicide rates back down, and particularly now that mental health needs are being expressed by everyone, as has been pointed out.

That's a good thing. People can talk about their internal experiences now. But it's not a good thing if we don't have care that is ready to meet that. And that is certainly incumbent upon the legislative tool that we have to enforce parity.

But it also means that parents in schools, in workplaces, that we have to build cultural competency and capacity around being able to dialog about these things and get people the help that they need.

Ms. WILD. Thank you. And I'm going to just take the last 30 seconds and ask you Dr. Moutier. Can you comment on the new 988 line for suicide prevention that will be available I believe within the next year? Would that help adolescents and children?

Dr. MOUTIER. Yes, it absolutely will. That will come into effect. It's planned for July 2022. It's an extension of the suicide prevention lifeline. What will happen is that volume will go up tremendously more. Right now we have capacity limitations due to funding as well as having culturally appropriate providers available, but yes, that is an enormous opportunity for us as a nation to build a new system that is ready to meet the demand.

So, the 988 legislation is a critically important piece, but we have to pay attention to how we resource it and staff.

Ms. WILD. How we fulfill that need. Thank you so much, Dr. Moutier. I look forward to continuing the work with you on this very important topic.

Dr. MOUTIER. Thank you.

Ms. WILD. I yield back Mr. Chair.

Chairman DESAULNIER. Thank you. And thank you for your advocacy on this issue in particular. We next go and recognize Representative Fitzgerald.

Mr. FITZGERALD. Sorry about that.

Chairman DESAULNIER. There you go.

Mr. FITZGERALD. Sorry about that. Yes Mr. Gelfand and maybe some of the other witnesses would like to comment as well. But a challenge over the last year continually trying to stay in contact with some of the healthcare systems within my congressional seat, and even before that in my State Senate seat that I had represented for a number of years, but the one hospital is Children's Hospital in Milwaukee.

And there was this kind of constant drum beat about trying to find qualified providers for kids who were experiencing behavioral health care issues, and obviously issues related—not just for the pandemic, but family situations, school situations.

And I'm just curious if some of the things that ERIC or its Members have done or are currently doing on the provider shortage front, because it seems to be something that you hear about quite a bit.

Mr. GELFAND. Thank you Representative, and Children's Wisconsin is well-known to be an outstanding hospital. So if even they are having trouble attracting these professionals, there should be little doubt that this is a market-wide problem. This is a problem that exists all over the United States.

Employers know that sometimes throwing more money at the problem just isn't enough, and in this case you may be able to double the amount that you're paying per hour, and you still may not get those child psychologists to leave New York and LA. So we think that you have three options here.

Option one is focus on increasing the number of these providers that exist. And we should do this, but it takes a lot of time. So that alone won't suffice. No. 2 is we can do more with the providers that we do have with more resources, tools, education, collaborative care and colocation efforts, we can enhance access to care by equipping more professionals to practice in this space.

So for instance, you know funding, perinatal psychiatry access programs. But third, and perhaps most immediate, to help patients right now is we've got to be able to bring those providers from out of State to Wisconsin and into your district, and to do that we just need more access to telehealth, and we need to be able to facilitate across State practice period.

Mr. FITZGERALD. Thank you Mr. Chair I yield back.

Chairman DESAULNIER. Thank you, Mr. Fitzgerald. We will now go to Mrs. McBath. Lucy, the floor is yours.

Mrs. MCBATH. Thank you, Chairman DeSaulnier. Thank you so much for convening this group of experts today to discuss the issues of access to mental health services. Almost a year ago we began social distancing in order to stop the spread of this deadly pandemic, but social distancing has really taken a toll on our mental health and feelings of isolation and disconnection that has affected just absolutely everyone.

And it's been inspiring to see so many people across America kind of come together to actually help and support and service one another. And the mental health and recovery community has really been a shining example, I believe, of how people can really come together to overcome this terrible disease.

However, you know these communities have not always been able to access the care that they need, and we've talked about that today. And COVID–19 has just truly laid bare many of the inequities of our health care system. And you know I have seen a host of disparities develop and worsen with the onset of this pandemic, even within my own constituency.

So, as the increased isolation of the pandemic has taken its toll on people with mental health issues, I've observed how barriers to coverage and access to care have just contributed to increased rates of severe mental illness and even suicide.

Dr. Bendat, in your testimony you talked about the issue of the adequacy of provider networks, and the importance of making sure that you have enough doctors in your plan, and in your plan network to make sure that parity is meaningful.

Can you tell us what are some of the issues that lead to relatively narrow behavioral health networks?

Dr. BENDAT. Well so you've got narrow networks that are narrow by design. In other words, there are insurance plans out there that intentionally sell access to networks that are meant to be narrow. Nonetheless, these types of plans are supposed to cover all of the benefits that they promised to offer.

So, the problem of course is that when it comes to mental health care, oftentimes they don't. We also have networks that on the surface appear to be robust. They're not limited. Plans sell them as PPO's, essentially large group products that they offer the promise of wide coverage.

But when patients try to access in-network care for mental health and substance use disorders they can't. Largely the issues they confront have to do with not being able to get timely care, so if there's an urgent situation patients are not able to access the type of provider within a reasonable period of time, or they can't find someone that is available and accepting patients within a particular distance.

The problem is that insurers typically, or thus far at least, have failed to update their provider directories. And so, patients are just told go take a look at our directory. Find yourself a provider. That is not a very helpful stance to take when someone is in crisis or in distress. And so, and especially when patients have to call multiple providers and be told no, we're full or no, we no longer are with this insurer. That's just terrible.

So, I would say that putting the onus in the hands of the patient who's already struggling with distress, having that patient look for providers instead of telling them here is where they're available, here is where they are, here's their availability window. That really creates a major barrier to care.

Mrs. MCBATH. So, then let me ask you how do some states like California for example address the issue of network adequacy for insurance, and if you can give us a very brief explanation as to why laws do not apply in self-insured ERISA plans.

Dr. BENDAT. Sure. So, there's ERISA preemption for self-funded plans which means that they are just not subject to State laws period. That is something that only Congress can address. So, your committee has absolute jurisdiction over this issue. The way that California deals with fully insured plans is by telling them hey, you've got to arrange for example coverage within 15 miles or 30 minutes to a patient's home.

You've got to do it within a certain period of time. If you don't, you must let the patient go out of network and subject the patient to no more than in-network cost-sharing. So in other words, if there's a balance, you're on the hook for it—you the insurer, not the patient.

That's going to create an incentive for insurers to broaden their networks and to raise reimbursement rates to attract providers.

Mrs. MCBATH. Thank you, Mr. Bendat. And Mr. Chairman I yield back the balance of my time.

Chairman DESAULNIER. Thank you, Representative. Now we're going to go to the Ranking Member Representative Foxx.

Ms. FOXX. Thank you Mr. Chairman. I want to make a quick comment before I ask my questions. It's so frustrating when we focus these hearings on bashing employers, bashing providers, or bashing healthcare networks.

Mr. Gelfand has given us some great alternatives that don't require money, and I think it would have been wonderful if we could have heard more about how the private sector is handling these things and looking for ways. Employers want to help their employees, not harm them.

Mr. Gelfand thank you for being with us today. On June 23, 2020, the Department of Labor issued temporary guidance allowing employers to offer stand alone telehealth coverage to certain employees ineligible for any other group health plan. Had this guidance increased access to mental health services for employees, should Congress consider expanding this flexibility to all employees and making it permanent?

Mr. GELFAND. Thank you Dr. Foxx. The guidance temporarily allowing stand alone telehealth has been a huge success. Millions of part-time workers and others have deemed coverage that they

didn't have before, largely at the employer's expense, and employers celebrate this.

But as you know though, when the emergency ends, so too does the guidance, and so those benefits will disappear. And keep in mind that the temporary nature of the guidance caused some employers to hold back. So we think that if we were to permanently allow stand alone telehealth benefits, a lot more employers would roll it out since they could do it for the long-term.

And we ought to help even more patients, and we do that by broadening the eligibility to include unenrolled workers—for instance young adults that are on their parent's plan.

Ms. FOXX. Thank you. Mr. Gelfand the Mental Health Parity and Addition Equity Act requires employers to offer mental health and behavioral health benefits, do not place more stringent limitations such as visit limits or preauthorization requirements on those benefits than they do on medical or surgical benefits.

Your testimony explains the Department of Labor's parity regulations are especially subjective and difficult to interpret. What steps can Congress, or the administration take to ensure that plans are able to comply with mental health parity requirements?

Mr. GELFAND. So Congress has more than once directed DOL to better explain the most complicated part of parity which is the nonquantitative limitations, but for some reason DOL has given many examples of what is not allowed, but continually failed to give clear guidelines on what is allowed.

There is now an extremely complicated self-compliance tool that just seemed to further confuse folks. Considering that these NQTL's did not exist in the legislation that Congress passed, and were invented by President Obama's Department of Labor, the least that the department could do is to give a more complete and comprehensive explanation, not just on how to violate the rules, but on how to affirmatively comply with them.

Perhaps the most important thing that Congress can do is to continually support DOL's compliance-driven, rather than penalty-driven approach. Right now when there's a problem DOL helps the employer to get it right and re-adjudicate claims to make patients whole.

This doesn't make much money for trial lawyers, but it ensures that our workers actually get the care that they need.

Ms. FOXX. Thank you. Mr. Gelfand 151 million Americans are covered under employer-sponsored coverage, which is more individuals than are covered by Medicare, Medicare or the exchanges.

Knowing that employer-sponsored plans are the largest single source of coverage, can you discuss how health benefits, including those related to mental and behavioral health are mutually beneficial for workers and employers?

What actions have employers taken to manage the increasing costs of coverage?

Mr. GELFAND. Thank you Dr. Foxx. Employers are committed to offering quality affordable mental and behavioral health benefits. Remember that parity is not a mandate. Employers are choosing to offer this benefit, and thus choosing to become subject to these very complicated rules, but they do it because it's the right thing

to do, and it's integral to keeping our employees healthy and productive, and providing peace of mind.

Now as with any employee benefit, there are always tradeoffs. Some limitations are needed to keep coverage affordable because if costs go up health employees start opting out which makes costs go up even more.

Now employers work hard to develop strategies focused on improving health and safety, which can also help to control costs, but in the end if we're not able to employ sophisticated medical management and offer reasonable reimbursement to providers, or make decisions to exclude certain low-value facilities or treatments, this will just make it impossible to offer affordable coverage to our workers.

Ms. FOXX. Yep. Has the COVID–19 pandemic changed the way employers deliver mental health care, and what innovations would you highlight that they have put into place?

Mr. GELFAND. So it's safe to say that the past 13 months have seen more innovation and experimentation in employer coverage than ever before. And here are the three big takeaways. First, telehealth is crucial.

We can overcome a lot of provider shortages, we can overcome access and wait time problems, and already some are advocating that we need to tear it down by having the government mandate reimbursement rates in telehealth.

Second, a lot of people are getting their mental and behavioral health needs met in the primary care setting. We've got to support this, from enhancing worksite health clinics, to providing education and resources. This should be an easy one.

And third, a lot of our employees are getting support that's not traditionally thought of as medical care right? Whether that's attending AA meetings, or care giving by family Members, or they're engaged in meditation, mindfulness type programs.

Employers are going to pivot even more to support these activities, but there are some areas in which law and policy really needs to catch up to help us do that.

Ms. FOXX. Mr. Chairman I thank you very much. I want to make one more quick comment. My husband was having a problem with terrible indigestion about 3 months ago, and he was able to do a telehealth meeting.

He had an appointment with the doctor. The doctor got sick, and was afraid to see him in person. And so, he had my husband do it through telehealth, and he was able to diagnose—maybe not completely, but help him a lot. So I really am an advocate for the telehealth opportunities that are out there.

So thank you Mr. Chairman for your dispensation here.

Chairman DESAULNIER. I'm always happy to dispensent you, Ranking Member, and as a friend, I just want a brief comment that I was just saying to my staff how happy I was at the tone of this conversation and very hopeful that we can work together so.

Ms. FOXX. Thank you.

Chairman DESAULNIER. With all due respect I didn't hear the bashing, although I have heard it in the past. And I do appreciate Mr. Gelfand's comments and look forward to continuing conversation about how we get these needed services, which I hear a con-

sensus about from everyone, as efficiently as possible, and on that I agree with you.

Ms. FOXX. Thank you.

Chairman DESAULNIER. The best of employers do it. We just want to make sure that they do. With that we go to the distinguished gentleman from Michigan, Mr. Levin.

Mr. LEVIN. Thank you so much, Chairman DeSaulnier for this really important hearing. And thanks to all the witnesses. Dr. Smedley, let me start with you.

In your testimony you discussed the structure of mental health parity enforcement, and you point out there are a lot of problems—Federal oversight of ERISA plans is weakened by several factors, the requirements for insurance laws vary state-by-State, and for State and local government employees plans can simply opt out of the system altogether.

What long-term consequences could patients experiencing COVID–19 related trauma face if they have limited mental health coverage due to weak enforcement?

Dr. SMEDLEY. Well thank you, Congressman. As I indicated in my testimony, we are witnessing a mental health tsunami. It is upon us. And so, it is critically important that we do all we can to ensure access to appropriate behavioral and mental health services.

As some of the other witnesses have indicated, the absence of culturally appropriate high-quality services can make these conditions worse, leading to far more debilitating illness and worse case, you know, suicidal ideology, et cetera.

And also, has been indicated these mental health issues are not limited to psychological stress and anxiety. They also manifest as physical health problems as well. So, we need to do all we can right now to get out ahead of these challenges starting with things like putting teeth into the parity law.

Mr. LEVIN. Well so, let's focus in particular on you know sort of the meat of this question of better enforcement. And given our committee's jurisdiction, which is ERISA, what are your top recommendations to improve enforcement for ERISA plans? Lay that out for us.

Dr. SMEDLEY. Sure. There are a number of steps we can take, and I actually would like to respond to your question more fully with a written statement, but certainly.

Mr. LEVIN. I would appreciate that.

Dr. SMEDLEY. Yes. The legislation offered by Representative Norcross is an important start toward ensuring that we have adequate capacity for enforcement, and that plans are aware of the consequences of not ensuring appropriate access to mental and behavioral health services.

Mr. LEVIN. OK. Let me ask you about a different thing which is peer support for people with mental health issues. I'd like to ask you to speak about the importance to that, and you know whether there are challenges to ensuring that people are able to access the peer supports that may be critical to their ability to build resilience during these difficult times.

Dr. SMEDLEY. That's a great question, Congressman. Thank you for that. Certainly, there are a number of risk factors that people

are facing in terms of building and enhancing social support. So certainly, the need to be physically distant during this time is one of those, but we have encouraged people while we are physically distancing, to be socially—to not socially isolate.

Because it's important that we build those connections. Doing things like training people in psychological first-aid, and skills for psychological recovery, offer ways of helping to train lay individuals, non-professionals to provide health coping skills and mechanisms to others.

And certainly, there have been other very impressive developments. Like mutual aid societies that again provide social support without the risks associated with physically coming together. So, it is critically important that we address peer support. These informal sources of support, and often based in communities, drawing on sources of community-based resiliency are critically important, and we should do all we can to help enhance and support those efforts.

Mr. LEVIN. Thank you very much. Mr. Chairman let me end with a couple comments. One is the reflection on this whole thing, the immense complexity of achieving parity for mental health services.

I just want to emphasize that those of us who support Medicare for all, are not just talking about giving the current Medicare program, with all its limitations to everybody, but having a full system of health care, including dental, vision, and mental health, you know to all Americans.

And second, I want to emphasize how strongly I feel that we have a new opportunity to permanently expand telehealth services. I've been on the hearing the whole time, and I think I'm going to try to partner with my colleague from Michigan, Mr. Walberg on this, because his questioning was really great on it, and it would be wonderful for Mr. Walberg and I to be able to collaborate.

With that I yield back, Mr. Chairman, with more thanks for your leadership on this.

Chairman DESAULNIER. Thank you. And I do note the disproportionate number of Members from the State of Michigan on this subcommittee. I'm glad to have you all here. Speaking of which, we have a great State. We will now go to the distinguished gentleman from Connecticut, Mr. Courtney.

Mr. COURTNEY. Thank you, Mr. Chairman. I have not unfortunately, been able to attend the full hearing as much as Andy did, but you know I actually just wanted to follow up on his last question with the other witnesses where again, I thought, you know, Dr. Smedley got right into really the crux of the issue, which is what does non-compliance mean to the patient.

And Dr. Moutier and Dr. Bendat if you wanted to sort of comment on you know what we're really talking about here is the impact on people.

Dr. MOUTIER. Absolutely. Thank you, Representative Courtney. What it means is that in the moment when an individual or a family is realizing that their loved one may be struggling with a mental health condition, may be suicidal. And so, the need becomes dire, that they go to figure out how to access a mental health professional.

And there are more external barriers in the way of that than probably any other type of health situation. So, you know I think it does boil down to the way it's playing out in day to day real people's lives and families, is presenting enormous, and honestly unnecessary barriers that should not be there.

It is an absolute form of discrimination right now, the way that mental health conditions are not being addressed in actuality, even though there's a lot now of kind of open-mindedness. I don't want to say lip service, but until we fix this issue, we can say that mental health is valid, critically important, that suicide is a complex, but a health issue at the end of the day.

But we will only get so far because in every instance of every suicide prevention effort that is shown to be effective, it drives people who have those needs to a health professional. And so, this really is the crux of the matter, and I appreciate you bringing it up in terms of the impact on real people and real families.

Mr. COURTNEY. All right thank you. And Dr. Bendat?

Dr. BENDAT. Yes, so ultimately non-compliance with parity and with the essential health mandates is that patients either are undertreated, or not treated at all, and ultimately end up far worse than they began, if not dead. And it's very simple.

Mr. COURTNEY. Well thank you for your clarity and bluntness because I do think that that's really important for people to realize that you know this is not sort of a you know, kind of a bureaucratic, you know, political argument. This is really about saving lives, so thank you.

You know assuming you know we were able to put in again a better sort of regulatory structure, someone has to regulate it, OK, at the Department of Labor. And the agency, you know, Mr. Norcross's bill you know would appropriately designate is the Employee Benefit Security Administration, EBSA, and you know it's a big job.

You know if we're going to put in a new sort of effective regulatory structure that requires you know boots on the ground and resources. Again, the American Psychological—sorry, American Psychiatric Association has worked with my office about trying to get EBSA's budget actually increased in this year's Fiscal Year budget, which again is not sort of our portfolio.

But you know, Mr. Chairman, I would like to ask that the Psychiatric Association's statement be added to the record regarding again this important piece of the puzzle if we're able to again enact smart legislation.

Chairman DESAULNIER. Without objection, Mr. Courtney.

Mr. COURTNEY. Thank you. And again, I don't know if any of the witnesses would want to talk about that because again, you know obviously having you know a cop, you can pick up the phone and call when there's a non-compliance issue, is kind of a critical piece.

And you know obviously the Psychiatric Association I think flagged this for Congress, and I don't know if any of you wanted to sort of join in with any comments.

Dr. BENDAT. Well I would add that there's absolutely no doubt that strengthening EBSA's ability to enforce parity in ERISA, particularly with respect to mental health benefits is critical. Again,

it's a large department, but by no means substantial enough in order to be able to take on 136 million people.

You can imagine at least one-fifth at least, have mental health and substance use disorders. That's a national statistic. So, think about what that means for EBSA's regulation and the importance of being able to effectively address issues that States cannot touch because of preemption, again critical.

Mr. COURTNEY. Thank you. You get the final word Dr. Bendat, and again I appreciate the witnesses—really, you know, great testimony on such a critical issue. I yield back Mr. Chairman.

Chairman DESAULNIER. Thank you, Mr. Courtney. I'll now go to Ms. Stevens.

Ms. STEVENS. Well thank you so much, Mr. Chairman for this critically important hearing, particularly as it's something that I hear from constituents and stakeholders in my district, on the regular, from the Livonia Chamber of Commerce, President Dan West who asked me about what we are going to do to meet the moment to improve access to behavioral and mental health care.

And, to our panelists who have done just a great job today, and I want to recognize you, Dr. Moutier, for your testimony and your expert asking, answering of questions. Although the last 2 years have seen an overall reduction in suicide rates, the number of young people who have reported suicidal ideation has increased dramatically since the pandemic.

And I know you have been touching on this throughout today's session, but over the past year communities in my district have just experienced countless tragedies of young people dying by suicide. Sometimes, oftentimes with no warning. No warning indicators, and no recognition that they might be depressed, or might be in need of help.

Going out with their friends or family the night before such a tragic incident takes place. So, Dr. Moutier can you just speak a little bit to the importance of either early recognition, or community conversation that we could take, the accessing of care, and maybe the ways in which we can broach this topic as community leaders more effectively.

And if there's anything that we need to know about trends, or maybe not fully developed brains that are also contributing to these tragic incidences.

Dr. MOUTIER. Thank you so much. This is such a huge part of the pandemic experience as well. Because young people, as you mentioned, our brains don't finish all the way developing until we're in our mid–20s. So it means the primitive part of our brain, fear, anxiety, stress, fight-or-flight, is fully developed, but the thinking part, the planning part, the part that allows us to see the long-term future, and see through the crisis moment is not fully in place for most people until their mid–20s.

And so, impulsivity can be a much greater factor for young people when they're in suicidal distress, and that is something that we are gravely worried about. Again, stigma going down is fantastic, but that has to be just the start.

And so we have to build capacity for parents, communities, faith leaders, school personnel, workplaces, to have dialog about these experiences because the truth is while it always feels out of the

blue, and like you're blindsided by a suicide attempt or a death, the truth is that person was experiencing something that we as a society have not provided ways for them to express and have their needs met.

And that's what we're building. And we are doing that. But much more is needed in that regard.

Ms. STEVENS. Right. And just as we say that we have been working really closely with stakeholders on removing the stigma of depression and trauma, and needing help, or asking for help in providing those spaces, we also want to send a message that we don't want you to kill yourself, and that it is, you know, that we want you to get the help.

And so, looking at you know the role that mental health services play or just the understanding of, for an underdeveloped brain, what actually happens when you do kill yourself, and the results of it.

Dr. Smedley, COVID–19 has had devastating consequences for millions of people, but there are you know also just some lessons that have been learned from this pandemic that will allow us to improve health care moving forward, including the advancement of telemedicine and making mental health services available in communities that might traditionally lack access.

Could you just walk us through some of the things that we've learned during the pandemic about the different ways that mental health services can be provided? I know we've been covering that at length today.

And also, do you have any other recommendations for Congress so that we can ensure high-quality mental health services are available, including communities that might be lacking sufficient access to the internet for example?

Dr. SMEDLEY. Thank you, Congresswoman. I will try to speak very quickly because I know time's running short.

Ms. STEVENS. Yes.

Dr. SMEDLEY. And I would love to offer a full written response as well, but you are absolutely right that we need to ensure that culturally appropriate community-based services are available. I would point out that suicide rates are particularly escalating among African-American and Native American youth. We need to have services in communities for those young people, and so we will be very happy to provide a fuller written response to your question given the time.

Ms. STEVENS. Thank you. And I yield back, Mr. Chair.

Chairman DESAULNIER. Thank you for yielding back. Very artfully getting that last question in was good work. Excuse me. So, that is our last testimony unless I've missed someone. I'm going to before we go to the Ranking Member for closing comments and conclude, I just want to thank everybody again.

Thank the Members, terrific, terrific hearing, and an important one that we intend to pursue on this committee and would love to work with all of you, all of you, in a bipartisan way. I'm sure we're going to have some differences in terms of the deployment, but what I hear is so encouraging and just following up the last conversation.

It's striking to me, having been involved in this field for a long time, personally and professionally that the lack of stigma, and it's really beyond my expectation when I started in this 30–35 years ago. That we don't have more stigma, so a wonderful thing I thought it would—I'm encouraged by that.

Having said that, it's very frustrating to see the richness of the research, and the ability to get that research deployed to individual Americans, and we're losing people that we don't need to lose if we get the infrastructure up, and get the performance standards right so Congress can provide the necessary oversight.

So, I want to remind my colleagues that pursuant to committee practice materials for submission for the hearing record must be submitted to the Committee Clerk within 14 days following the last day of the hearing, so by close of business on April 28, 2021, preferably in Microsoft Word format.

The materials submitted must address the subject matter of the hearing, obviously. Only a Member of the subcommittee or an invited witness may submit materials for inclusion in the hearing record. Documents are limited to 50 pages each. Documents longer than 50 pages will be incorporated into the record via an internet link that you must provide to the Committee Clerk within the required timeframe.

Please recognize that in the future that link may no longer work, so just we'll work with you as best we can, but we wanted to give you some warning.

Pursuant to House rules and regulations, items for the record should be submitted to the Clerk electronically by emailing submissions to *edandlabor.hearings@mail.house.gov*.

Member officers are encouraged to submit materials to the inbox before the hearing or during the hearing at the time the Member makes the request. We will furnish that email to anyone who has trouble getting it.

Again, I want to thank the witnesses. Really terrific hearing, thanks for your vocation, your commitment to these issues. It's certainly an exciting time to be in your field with your expertise, and we intend to take advantage of your expertise. And I would include all of those, the witnesses.

Mr. Gelfand, I really appreciate your perspective. And Members of the subcommittee may have additional questions and we ask witnesses to please respond to those questions in writing. The hearing record will be held open for 14 days in order to receive those responses.

I remind my colleagues that pursuant to committee practice, witness questions for the hearing record must be submitted to the Majority Committee Staff, or the Committee Clerk within 7 days. The questions submitted must address, again, the subject matter of the hearing.

I now recognize Mr. Allen for any closing comments that you have. Go ahead, Rick, if you could unmute.

Mr. ALLEN. OK we'll try again. Thank you Mr. Chairman. And I want to thank all the witnesses for their testimony today. This has opened my eyes a great deal to the complexity of this issue. I would like to ask unanimous consent to enter in the record state-

ments from the American Benefits Council and the H.R. Policy Association.

Chairman DESAULNIER. Without objection.

Mr. ALLEN. Thank you Mr. Chairman. And to just highlight a couple things that I think are important, particular with listening to the discussion today that we need to consider is according to a 2020 Congressional Budget Office estimate, 151 million Americans received health insurance through employer-provided plans, which is the largest single source of coverage.

Yet the democrats are seeking to eliminate employer-sponsored healthcare through their socialist Medicare for all plan which would force millions of Americans into a one-size-fits-all government-run system, and cost more than 30 trillion dollars over the next decade.

A 2018 survey by America's Health Insurance Plan reveals that 71 percent of Americans are satisfied with their current employer-provided health coverage. By all metrics, satisfaction with employer health coverage outpaces public support for the democrats Medicare for all scheme.

Employers around the country continue to make concerted efforts to meet the mental and behavioral health needs of workers through implementation of coordinated care programs, employee wellness programs, use of telehealth services, and additional employee assistance programs.

The democrats will ignore this fact and unjustifiably assume that employers are short-changing their employees. I encourage Members to talk with companies about this, and find out exactly what they are doing, so we can get to the root of the issue.

House republicans want to empower America's job creators to expand access to quality care and mental health services, for workers and their families. While the system can be improved, we also recognize employers are attuned to the needs of their employees, as I know first-hand.

For 37 years I ran a construction business where we provided staff benefits. I knew my employee's needs, and what benefits and services were best suited to meet their needs. That is why I believe employers play a critical role in enhancing the system moving forward, which will benefit workers by ensuring that effective mental and behavioral health services are offered.

I believe that employers truly know that their employees are the most important factor in the success of their business, and they want to take care of them. Again I thank the witnesses for participating today, and I yield back.

Chairman DESAULNIER. Thank you, Mr. Allen. I look forward to continuing the conversation, discussion with you. We have mutual experiences as former employers. You, in the construction industry, and I admire that, and myself in the restaurant business, as I have explained many times in this committee.

One of my big concerns about employer-based wages and benefits is not that the employers are bad, or inherently bad, but some of them are. So, I think the discussion is, and I always—some of my colleagues on the left, sometimes they're surprised that I actually admire some of the work by Francis Fukuyama at the Hoover Insti-

tute, in particularly his work about trust, about the most efficient way to deliver services.

Having said that, and government isn't always that provider, what we want to do, and what I've heard clearly from everyone's testimony, and I hope we can focus on, is the importance of these services. Being able to have metrics so we could measure them both at the clinician level through the employer relationship, and the health provider relationship.

But most importantly, for Congress and the Department of Labor, for us to be able to clearly evaluate the quality and the access for Americans to get these services. Because my own belief is over the next 30–50 years as all this research evolves, we're going to learn a lot, and we're going to save a lot of people's lives, and allow them to be able to live great lives, even if they've been challenged either genetically, or through their environment.

So, I'm really excited about this. I really hope, and I appreciate the testimony and the tone, that for me, I want to focus on the deliverables of these important resources as we go through. And I know you do too, Rick, and I'm looking forward to focusing on that.

We'll have our disagreements, and I respect that, but you and I share a perspective. In my case we both ran low profit margin businesses. The restaurant business is historic, so it was just getting the services that my employees needed, that I wanted them to get.

And then the challenge of competing against other employers who weren't doing the things that you and I did and tried to. And in California we had a big initiative that was bipartisan, yet at the underground economy, to incentivize employers who needed those incentives.

So, I agree with you. The hammer is not always the best tool to reach for in the toolbox. So, I'd love to work with you to figure out ways to get those, to reward those good employers. And Mr. Gelfand, I'd be happy to have those further discussions, but also to be mindful.

Human nature being what is it, that not everyone, whether they be employers or employees, or providers, always have those best interests. So, how we do that, I think is really important. And it would really be wonderful I think for this country to know that this little subcommittee really focused on those things and accepted the fact that we're going to have some disagreements.

But the delivery of these services are so important, and we're losing. We've lost 87,000 Americans to overdoses in this country. When you look at diseases of despair, Deaths of Despair, a wonderful, but sad book, a recent book on this subject matter.

And there really is an emergency. We're losing too many people every day. For me this is personal. As I've mentioned, on April 20, it will be the 32d anniversary of when I found out that my father took his life. He had had chronic problems with substance abuse, and depression.

He was actually the first behavioral health substance abuse counselor. He went back to college, got a master's degree at Rutgers, so he could give substance abuse counseling to the New England Patriot's players and staff.

He was terminated after a couple of years because they got a new coach who said in Sports Illustrated—editorialized against

this. The next coach said, "These are professional athletes. They don't have substance abuse problems."

So, we can look back on that comment and that culture, and say that clearly isn't true either for them, or for the general public. So, as I reflect on my dad's experience and having lost him, and the years I've spent dealing with that, but also discovering the things that we could do, and the wonderful work you all do, but particularly Ms. Moutier and a bill that we've worked with your group on that we helped provide for services that will help with suicide.

But there's so much to be gained, and I think back on my dad, and think, you know if we knew then what we know now, and got him the services he wouldn't have done what he did, and he would have lived a full contributing life where he could help other people who dealt with depression and substance abuse.

So, I'm not depressed by that. I am encouraged by how far we've come. But I do feel the urgency, and we're going to work on this in this committee.

And last, just an observation. The jurisdiction of this committee and the relationship of employer-employee benefits of course came up historically during out of the Depression. And to some degree it is the jurisdiction of this committee, we'll focus on that.

But be mindful that although this is a key component, there's so many other areas, and I think of a field hearing that then Chairman Foxx had in the Bay Area about 5 or 6 years ago when we dealt with the gig economy, and how we get benefits to people who don't have traditional employer-employee relationships.

So, I'll conclude there and just say again how encouraged I am, and, Mr. Allen, I hope you share this, the tone, the tenor of this conversation and all of our witnesses. And I want to thank the staff again, and look forward to really delivering for the United States on a bipartisan level to get these services to people out there in the community, so there will be less suffering tomorrow, next month, and years to come by people because we delivered these services to the American people.

Thank you so much. We are now adjourned.

[Additional submission by Chairman DeSaulnier follow:]

April 9, 2021

The Honorable Mark DeSaulnier
Chair
Subcommittee on Health, Employment, Labor, and Pensions
Committee on Education & Labor
House of Representatives
2176 Rayburn House Office Building
Washington, DC 20515

The Honorable Rick W. Allen
Ranking Member
Subcommittee on Health, Employment, Labor, and Pensions
Committee on Education & Labor
House of Representatives
2101 Rayburn House Office Building
Washington, DC 20515

Dear Chair DeSaulnier and Ranking Member Allen:

In advance of the Subcommittee's April 15, 2021 hearing, Meeting the Moment: Improving Access to Behavioral and Mental Health Care, attached please find Western Governors' Association (WGA) Policy Resolution 2020-05, *Physical and Behavioral Health Care in Western States*.

This policy resolution addresses health care challenges in the West, including access to mental health, behavioral health, and substance use services, and efforts to meet these challenges.

Please contact me if you have any questions or require further information. In the meantime, with warm regards and best wishes, I am

Respectfully,

James D. Ogsbury
Executive Director

Attachment

WESTERN GOVERNORS' ASSOCIATION

Policy Resolution 2020-05

Physical and Behavioral Health Care in Western States

A. BACKGROUND

1. Ensuring access to high-quality, affordable health care is critical to maintaining and enhancing the quality of life in western states for our growing populations and is the foundation of building and maintaining healthy communities and healthy economies.

2. Western states face unique challenges in health care, including growing rates of substance use disorder, provider shortages in underserved and rural areas, and limited access to broadband. Low population densities and the vast distances between population centers also make it difficult for providers to establish economically-sustainable health care practices in rural areas.

3. Distance and density also inhibit construction of the technology infrastructure that would provide or improve broadband connectivity in underserved and rural areas. Expanding broadband access provides numerous quality-of-life benefits for rural Americans, including economic development, social connectivity, education, public safety, and access to telehealth and telemedicine.

4. The health care sector faces severe personnel shortages in western states, despite efforts of Western Governors, such as the foundation of Western Governors University and other medical training programs in western states, to ensure adequate numbers of qualified medical personnel. This challenge is particularly acute in the West's underserved and rural areas. Ensuring access to health care services requires an adequate number and distribution of physicians, nurses, counselors and other trained health care professionals. Population growth, aging residents, and challenges involving Tribal health care and services for veterans require a renewed focus on developing our nation's health care workforce.

5. In many cases, health disparities and barriers to accessing health care are particularly acute for certain populations in the West. Understanding the impact of social determinants of health (SDOH) on health and health care can inform the development of effective policy to increase access and improve health outcomes for these populations. The U.S. Department of Health and Human Services (HHS) defines SDOH as conditions in the environments in which people live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. It has also identified five key areas of SDOH: economic stability; education; social and community context; health and health care; and neighborhood and built environment.

6. Western states have a unique body of experience, knowledge and perspective with respect to health care. The Western Governors' Association (WGA) is ideally situated to collect and disseminate information, including best practices, case studies and policy options, that states can use to improve the foundation for health care services and advocate for shared policy priorities on behalf of their citizens.

Behavioral Health Considerations

7. Behavioral health needs are often associated with negative stigma and harmful misperceptions, which can have many detrimental effects, including: a lack of understanding by family members, friends, co-workers and others; reduced professional, educational and personal opportunities; various forms of discrimination; and bullying, physical violence or harassment. Stigma can result in a reluctance to seek help or treatment, and contribute to self-doubt and shame associated with behavioral health conditions and substance use disorders.

8. Western states struggle with access to behavioral health services and higher-than average suicide rates. The ten states with the highest suicide rates in the nation are all located in the West.

9. Integrating behavioral and physical health care services can have many positive effects on health outcomes and health care spending. Behavioral health integration presents a more holistic approach to patient care, offers increased convenience and access for consumers, and can produce significant cost savings for the health care system. Integration can also be an effective tool to de-stigmatize treatment for behavioral health and substance use disorders.

10. Substance use disorder (SUD), including alcohol and drug misuse, is a major public health and safety crisis affecting nearly 21 million Americans. It is particularly prevalent in western states where individuals are more likely to experience or have a family member with SUD. SUD crosses all social and economic lines and tragically takes the lives of tens of thousands of Americans every year. Much attention has been focused on opioid use, and recent federal investment has prioritized opioid prevention and treatment. In western states, however, methamphetamine overdose deaths outpace those resulting from opioid use. It is important to recognize that SUD encompasses all drug classes and to balance SUD investment accordingly. While state and federal progress has been made to address SUD, additional efforts are necessary to help bridge prevention, treatment and recovery gaps in western states.

11. Jails and prisons have become de facto behavioral health treatment facilities. This reality results in inefficient use of public resources and poor outcomes for patients. Youth experiencing a first episode of psychosis are too often sent to juvenile halls, and adults with mental illness and SUD become incarcerated without proper treatment for their underlying chronic behavioral health conditions.

12. Many people experiencing homelessness also struggle with a behavioral health condition. Both supportive housing and adequate, coordinated health and social services must be available to prevent and reduce homelessness for people with mental health and substance use disorders.

13. The quality and completeness of patient records is an important element of care coordination and patient safety. Ensuring the protection and privacy of these records is a critical aspect of maintaining patient confidence in the health care system and ensuring that patients are forthcoming about their behavioral health needs.

14. Currently, federal privacy rules prohibit substance use disorder treatment providers from fully participating in health information exchanges. This may leave health care providers without a full understanding of a patient's medical history and use of medications, which can reduce the quality of care and lead to negative patient outcomes, including potentially deadly medication interactions.

15. Electronic health records (EHR) and state Prescription Drug Monitoring Programs (PDMP) are important tools in addressing the opioid crisis, allowing prescribers and pharmacies to help prevent opioid misuse. At present, there are instances of limited interoperability between EHRs and PDMPs that reduce the potential positive effect of these tools on patient safety.

16. Current federal statute limits the ability of state Medicaid programs to cover inpatient and residential treatment and recovery services at facilities with more than 16 beds, also known as the Institutions for Mental Diseases (IMD) exclusion. This antiquated limitation prevents many adults with behavioral health needs from receiving adequate treatment in a licensed health care facility. Waivers for this exclusion offered by the U.S. Department of Health and Human Services (HHS) have provided states with important flexibility and improved access to treatment for patients with SUD, but barriers still remain.

17. Medication-assisted treatment (MAT), including opioid treatment programs, combines behavioral treatment and recovery services with medications to treat substance use disorders. While MAT has been proven to improve health outcomes and reduce mortality among opioid addiction patients, stigma and myths surrounding the use of MAT limit its potential use in SUD treatment and recovery.

18. The passage of the SUPPORT for Patients and Communities Act in 2018 was a significant step forward for MAT, including by promoting greater flexibility in the use of MAT and expanding access to and coverage for MAT. However, significant limits remain on MAT use and providers' ability to take full advantage of these treatment methods.

19. Support from individuals with lived experience, peer support groups and community-based organizations, including faith-based and cultural organizations, is an important component of effective treatment and recovery for SUD and other behavioral health conditions.

B. GOVERNORS' POLICY STATEMENT

1. Federal efforts to address health care workforce and access needs should reflect early, meaningful and substantive input from Governors, who are best positioned to assess the needs of their states and help develop solutions to meet these needs. State-federal collaboration and coordination are integral to addressing these health care challenges. Wherever possible, and where appropriate, the federal government should respect state authority and maximize flexibility granted to states and Governors.

2. The federal government should work with states to facilitate the deployment of broadband to underserved and rural areas, recognizing that adequate broadband access has a direct correlation to rural populations' ability to access telehealth and telemedicine.

3. Despite efforts by Western Governors to address the shortage of qualified health care workers, significant challenges remain. Governors urge the federal government to examine and implement programs to ensure states have an adequate health care workforce – including in primary care, behavioral and oral health as well as other in-demand specialties – that is prepared to serve diverse populations in urban, suburban, and rural communities. Understanding that there remain significant disparities in access and treatment for many populations, Governors also support efforts to increase the diversity of the health care workforce to improve health outcomes for all.

4. Western Governors recognize the role that social determinants of health (SDOH) have on the health outcomes and well-being of our citizens, and the effect that social determinants – including economic stability, education, social and community context, and neighborhood and built environment – have on an individual's health status. Western Governors support efforts to identify risks facing high utilizers of health care services including food insecurity, domestic violence risk, unmet transportation needs, housing, utility and other essential supports and services, and to develop innovative models designed to improve coordination of medical and non-medical services and use of evidence-based interventions. These models can provide valuable information on how meeting non-health needs and addressing other social determinants can improve overall health status and decrease health spending.

5. Western Governors encourage Congress to adopt legislation that would empower states and local governments to address persistent economic and social conditions – like limited access to health care providers, stable housing, reliable transportation, healthy foods, and high-quality education – that often hinder health outcomes. Such legislation would assist states in developing plans to target social determinants that negatively affect health outcomes for western populations.

Behavioral Health Policy

6. Western Governors believe patients should have the same access to behavioral health care as they have for physical health care.

7. Western Governors support efforts to improve the quality and quantity of behavioral health services available to our residents, as these services are essential to reducing suicide rates and treating a range of behavioral health conditions, including substance use disorder.

8. Western Governors recognize and support efforts at the federal, state and local levels to promote the integration of physical and behavioral health services. The Governors encourage Congress to adopt legislation and the Administration to implement policies that support states' integration efforts and that encourage health care providers to better integrate behavioral and physical medicine into their practice of care.

9. Western Governors believe the federal government should work toward treating addiction as a chronic illness and work with Western Governors to develop strategies for addressing substance use disorder that work in concert with state efforts and recognize regional variations in substance use disorder patterns.

10. Western Governors believe that the federal government should take steps to increase opportunities for early intervention and law enforcement diversion to prevent entry into the justice system for individuals with behavioral health conditions. That includes providing law enforcement and emergency service providers with the resources and training they need to divert when appropriate, and expanding the availability of community reentry programs that provide appropriate treatment for underlying behavioral health conditions that contribute to involvement in the justice system.

11. Western Governors support efforts to increase the availability of transitional and permanent supportive housing with coordinated health and social services to more fully support and sustain recovery for people with behavioral health conditions.

12. Western Governors encourage Congress to pass legislation that aligns federal privacy requirements for substance use disorders (42 CFR Part 2) with the requirements for all other types of medical conditions under the Health Insurance Portability and Accountability Act (HIPAA) to improve care coordination and reduce stigma for patients with SUD.

13. Western Governors believe the federal government should take steps to support and help sustain states' administration of PDMPs and ensure that EHRs and PDMPs are fully interoperable between states and the federal government, accessible to relevant health care providers, including opioid treatment providers, and include adequate protections for patients from stigmatization and discrimination.

14. Western Governors support legislation to address the so-called Institutions for Mental Diseases (IMD) exclusion to improve access to SUD treatment and recovery services at residential and inpatient facilities with more than 16 beds, as well as to the full continuum of community-based behavioral health care. This policy solution must also improve access to both inpatient and ongoing, recovery-focused treatment in community settings. Until a legislative solution is enacted, the federal government should continue working with states to provide IMD waivers that offer important flexibility and improve access to treatment for patients with SUD. Implementation of these waivers must also occur in connection with expansions of the full community-based continuum of behavioral health care so that consumers receive services in the lowest level of clinically appropriate care in the community whenever possible.

15. Western Governors support legislative action to increase access to MAT for patients with substance use disorder. This includes eliminating the unnecessary and burdensome registration requirements for physicians, physician assistants, and nurse practitioners to obtain a waiver from the Drug Enforcement Administration to treat opioid use disorder with buprenorphine, which would provide health care professionals with additional flexibility to use MAT to treat opioid-related SUD.

16. Western Governors urge the federal government to develop an evidence-based national education and awareness campaign to reduce the stigma associated with mental health and substance use disorders and encourage individuals to seek help for these health conditions.

C. GOVERNORS' MANAGEMENT DIRECTIVE

1. The Governors direct WGA staff to work with Congressional committees of jurisdiction, the Executive Branch, and other entities, where appropriate, to achieve the objectives of this resolution.

2. Furthermore, the Governors direct WGA staff to consult with the Staff Advisory Council regarding its efforts to realize the objectives of this resolution and to keep the Governors apprised of its progress in this regard.

Western Governors enact new policy resolutions and amend existing resolutions on a bi-annual basis. Please consult westgov.org/resolutions for the most current copy of a resolution and a list of all current WGA policy resolutions.

[Additional submission by Mr. Allen follow:]

HR POLICY ASSOCIATION
The Association of Chief Human Resource Officers

AMERICAN HEALTH POLICY INSTITUTE

April 14, 2021

STATEMENT FOR
U.S. HOUSE OF REPRESENTATIVES, EDUCATION & LABOR COMMITTEE
SUBCOMMITTEE ON HEALTH, EMPLOYMENT, LABOR, & PENSIONS
HEARING ON
"IMPROVING ACCESS TO BEHAVIORAL AND MENTAL HEALTH CARE"
APRIL 15, 2021

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

The HR Policy Association is the leading organization representing chief human resource officers of over 390 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 American Health Policy Institute, a part of HR Policy 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.

The HR Policy Association and the American Health Policy Institute are also part of The Path Forward initiative to execute a disciplined, private sector approach to systematically and measurably improve five established best practices of mental health and substance use care.

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

Network Access

Background – 119.3 million Americans live in areas designated as Mental Health Professional Shortage Areas and 6,464 additional behavioral health (BH) providers[1] are needed to fill these provider gaps.[2] Provider shortages, in conjunction with limited in-network providers, make it difficult for patients to find in-network providers. A survey of privately insured patients also found that 53 percent of those that used provider directories found inaccuracies in their insurer's provider directory often leading them to use out-of-network providers.[3]

---

[1] 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.

[2] Bureau of Health Workforce, Health Resources and Services Administration (HRSA), U.S. Department of Health & Human Services, Designated Health Professional Shortage Areas Statistics: Designated HPSA Quarterly Summary, as of September 30, 2020 available at: https://data.hrsa.gov/topics/health-workforce/shortage-areas.

[3] Busch, S. & Kyanko, K. June 2020. Incorrect Provider Directories Associated with Out-Of-Network Mental Health Care and Outpatient Surprise Bills. *Health Affairs.* Retrieved February 1, 2020 at https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.01501.

Policy Recommendations

1. Increase/provide federal funding to encourage BH providers to practice in Professional Shortage Areas.
2. Require health care providers and facilities to notify the group health plan or issuer whether or not they are accepting new patients.
3. Employer health plans should not be required to meet network access standards unless behavioral health care providers are required to participate in those networks.
4. Expand telebehavioral health services (see below).

Collaborative Care Model (CoCM)

Background – Behavioral health is not integrated with primary care leaving patients with undiagnosed or poorly managed behavioral health conditions. Behavioral health conditions often initially appear in a primary care setting. Primary care clinicians provide mental health and substance use care to the majority of people with behavioral disorders and prescribe the majority of psychotropic medications. However, most primary care physicians do not provide evidence-based care to these patients. A collaborative care model that integrates behavioral health and primary care would significantly reduce the burden of other illness, reduce the demand for BH services, lower medical costs and reduce disparities in identification and the effectiveness of treatment for BH issues. Over 70 randomized controlled trials have demonstrated collaborative care models are more effective and cost efficient than usual care.[4] Collaborative care interventions have a CMS/AMA billing code that pays for the service.

Policy Recommendations

1. Allocate funds to support a change effort to provide technical assistance, training and startup funds to allow for large scale adoption for collaborative care across the country. Collaborative care can be delivered virtually or by in person care managers so this model can deliver to large medical groups or small and rural primary care practices.
2. CMS to establish a national Technical Assistance (TA) center and regional extension centers to assist primary care practices in implementing the CoCM.
3. Incentivize behavioral health care providers to adopt electronic health record technology that is interoperable with general health care providers into their practices.
4. Expand research on promising integrated care models: There have been a number of integration models promulgated over the past two decades. These integration models represent important efforts to improve the care of behavioral conditions in primary care and have added value by supporting primary care practitioners. Additional evidence is needed for these other models to document improved clinical outcomes, costs savings and feasibility of implementation in multiple practice settings (*e.g.,* rural and urban, population health-based care).

[4] https://www.chcs.org/media/HH_IRC_Collaborative_Care_Model__052113_2.pdf.

Measurement Based Care

Background – Primary care and BH providers are generally not utilizing evidence-based BH assessment tools such as the PHQ-9 or GAD-7. It is estimated that only 18% and 11% of psychiatrists and psychologists, respectively, use assessment tools regularly.[5] 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.[6] 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

1. 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.
2. 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.
3. 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 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.
4. Increase incentives for using existing CPT Codes such as GO444, 96127, 96160, 96161, 96130, 96139.
5. Include measurement-based care as a standard of care regardless of the modality.

TeleBehavioral Healthcare (TBH)

Background – During the COVID-19 pandemic, Medicare rules related to TBH have been liberalized resulting in an exponential growth in the use of TBH, including enabling cross-state care which has been critical to underserved areas and rural communities. However, the requirements for employer health plans around how TBH is provided and reimbursed remain far too restrictive and result in access and quality disparities. TBH has the potential to overcome patient stigma and improve access and efficiency of care for BH services. We know that since

---

[5] 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.

[6] 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.

the COVID-19 public health emergency, there has been a significant increase in patients keeping their appointments. In general, when patients keep their first appointment, they are more likely to keep subsequent appointments; and when patients are satisfied with treatment, they are more likely to continue with their course of therapy. Research also suggests that TBH results in better medication compliance, fewer visits to the emergency department, fewer patient admissions to inpatient units, and fewer subsequent readmissions. However, many older adults and people with disabilities, lack access to video-enabled devices or struggle to use the more complex video-enabled devices even if they have them. Likewise, many in racial/ethnic and low- income communities lack access to broadband or video-enabled devices, which only expands the health inequities in the US. While TBH has demonstrated comparable efficacy to in-person BH care in many instances, there remains concern that quality of care is not uniform in TBH settings and additional research is needed.

Policy Recommendations

1. Eliminate cross-state border restrictions on TBH on a permanent basis for Medicare, employer and commercial plans. Licensing requirements should be based on the location of the provider not the patient.
2. Enable patient access to TBH without having the first provider appointment be in person.
3. Make permanent the allowance of first-dollar coverage of telehealth in high deductible health plans.
4. Allow employers to offer standalone "excepted benefit" telehealth benefits.
5. Adopt technology-neutral requirements, permitting use of different types of technology platforms for telehealth services.
6. Establish a uniform set of rules for multi-state telehealth benefit plans to eliminate state restrictions that block patients from telehealth benefits.

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

AMERICAN BENEFITS COUNCIL

WRITTEN STATEMENT

FOR THE HEARING OF THE U.S. HOUSE OF REPRESENTATIVES COMMITTEE ON EDUCATION AND LABOR, SUBCOMMITTEE ON HEALTH, EMPLOYMENT, LABOR AND PENSIONS

ENTITLED

MEETING THE MOMENT: IMPROVING ACCESS TO BEHAVIORAL AND MENTAL HEALTH CARE

APRIL 15, 2021

1501 M Street NW Suite 600 Washington, DC 20005 202-289-6700 Facsimile 202-289-4582 www.americanbenefitscouncil.org

The American Benefits Council ("the Council") thanks the U.S. House of Representatives Education and Labor Committee's Subcommittee on Health, Employment, Labor and Pensions for holding a hearing examining how to improve access to behavioral and mental health care. The toll of the COVID-19 pandemic on the nation's public health and economy is readily apparent. Less apparent but similarly devastating is the mental health toll of the pandemic.

Even before the COVID-19 pandemic, large employers recognized the value and importance of providing comprehensive benefits coverage for mental health and substance use disorders and were often frustrated by challenges in access to quality care for their employees and their families. Since the onset of the pandemic, employers have focused attention and resources on expanding access to behavioral and mental health care to help their employees get through these unprecedented times. Yet challenges to these efforts remain. Just as lawmakers have acted to address the public health and economic crisis brought about by the COVID-19 pandemic, so too must lawmakers focus on combatting the behavioral and mental health crisis exacerbated by the pandemic. The physical health and economic threat of the pandemic will pass, but the mental health toll may be felt for years to come.

The Council is a Washington, D.C.-based employee benefits public policy organization. The Council advocates for employers dedicated to the achievement of best-in-class solutions that protect and encourage the health and financial well-being of their workers, retirees and families. Council members include over 220 of the world's largest corporations and collectively either directly sponsor or administer health and retirement benefits for virtually all Americans covered by employer-sponsored plans.

THE IMPACT OF THE COVID-19 PANDEMIC ON MENTAL HEALTH

There are over 31 million confirmed cases of COVID-19 in the United States.[1] The stress and isolation of the pandemic have profoundly impacted millions more. To rapidly monitor recent changes in mental health care during the pandemic, the Centers for Disease Control and Prevention (CDC) partnered with the Census Bureau on Household Pulse Survey. According to the Household Pulse Survey, from March 17, 2021, to March 29, 2021, more than 30% of adults experienced symptoms of an anxiety or a depressive disorder.[2] During this same time period, 24.1% of survey respondents

[1] https://coronavirus.jhu.edu/region/united-states

[2] https://www.cdc.gov/nchs/covid19/pulse/mental-health.htm

reported taking prescription medication for mental health and/or receiving counseling or therapy.

A Kaiser Family Foundation (KFF) Health Tracking Poll from July 2020 also found that many adults are reporting specific negative impacts on their mental health and well-being, such as difficulty sleeping (36%) or eating (32%), increases in alcohol consumption or substance use (12%), and worsening chronic conditions (12%), due to worry and stress over the coronavirus.[3] The KFF reports notes that: "Mental distress during the pandemic is occurring against a backdrop of high rates of mental illness and substance use that existed prior to the current crisis."[4]

Employer Action to Combat the Mental Health Crisis

Employer efforts to combat the mental health and substance use crisis predate the pandemic and are predicated on the recognition that mental health care coverage is vital to the health and productivity of their workforce. Even though neither the Affordable Care Act (ACA) nor Mental Health Parity and Addiction Equity Act (MHPAEA) mandate that large employers offer such coverage, they voluntarily do so to improve employee well-being while simultaneously improving productivity and business performance. Mental health conditions and medical conditions are often co-morbidities, thus treating an employee's mental health will also support the employee's general health and well-being. the McKinsey report Mental Health in the Workforce: The Coming Revolution[5] cited a 2015 study which estimated the total cost of major depressive disorders in the United States to be $210 billion, with about half of that amount attributable to costs of treatment and the rest attributable to absenteeism and presenteeism costs incurred in the workplace. The McKinsey report also highlighted that stress and depression increase not just the costs associated with treating behavioral health problems but also the incidence of other costly physical diseases. Notably, the report found that obtaining an antidepressant increased the odds of subsequently receiving a drug for diabetes by 30 percent, cancer by 50 percent, and heart disease by almost 60 percent.

---

[3] https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/#:~:text=During%20the%20COVID%2D19%20pandemic,largely%20stable%20since%20spring%202020.

[4] According to estimates of mental health based on the January-June 2019 National Health Information Survey, 11.0% of adults had symptoms of anxiety disorder or depressive disorder. https://www.cdc.gov/nchs/data/nhis/earlyrelease/ERmentalhealth-508.pdf

[5] https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/mental-health-in-the-workplace-the-coming-revolution

Long before the pandemic, Council member companies were embarking on innovative solutions to address the mental health and substance use disorder needs of their workforce. These strategies included collaborative care models that integrate behavioral health with primary care, removing the stigma associated with mental illness, enhancing Employee Assistance Programs (EAPs) and telehealth offerings, and combating the opioid crisis.[6] When the pandemic hit, employers recognized the toll that the isolation, stress and uncertainty was taking on their workers and built on these efforts to help working families across the country access the behavioral health care they needed to get through the crisis.

Employers have been leading efforts to protect the well-being of their employees both physically and emotionally throughout the pandemic. A Mercer survey of employers taken from April to October 2020 found that employers are focusing on two areas of health care that have been in the spotlight during the pandemic.[7] Both areas of focus are closely linked with respect to the goal of increasing access to behavioral health care services.

The first is explicitly in the area of behavioral health, with 71% of respondents saying this was a focus for 2021. As the Mercer report explains: "Already in short supply, behavioral health care is needed more than ever due to the stress and isolation of the pandemic, and employers have made it a priority to expand access to care and to promote it with their employees."

The second focus is the area of telemedicine, with 59% of respondents saying this would be a focus for 2021. The COVID-19 pandemic has transformed telehealth from an innovative option for delivering services into a vital lifeline to care for millions of patients, including those needing access to behavioral health care. In the years before the pandemic, a growing number of employers were turning to telemedicine to improve access to value-driven care for employees and their families. With COVID-19, what may have been a slower march toward telehealth use became a sprint. The onset of the crisis sparked a dramatic rise in the utilization of telehealth services. The Council recently partnered with Mercer and the Catalyst for Payment Reform on a paper entitled "Telemedicine in the Post-COVID-19 World."[8]

Telemedicine utilization has increased more in a few months than was expected in five years. Employers recognize the important role of telehealth in caring for patients during the COVID-19 crisis by increasing access to mental health services for employees

[6] https://www.americanbenefitscouncil.org/pub/?id=2f21fbaf-9ed0-db9b-4aab-ceed75ea80b0

[7] https://www.mercer.us/our-thinking/healthcare/leading-through-the-surge-using-what-we-learned.html

[8] https://www.americanbenefitscouncil.org/pub/?ID=FDD5BCEA-1866-DAAC-99FB-73ABA53755E5 and https://www.americanbenefitscouncil.org/pub/?ID=FD5C9596-1866-DAAC-99FB-2BB0A37399A3

and their families while abiding by social distancing that is essential to containment of the pandemic. Many employers have made, and are continuing to make, efforts to expand access to telehealth during the COVID-19 crisis in order to protect the public health and safety of their employees while ensuring that they still receive the care they need, including for those with mental illness and substance use disorders. Indeed, 95% of employers are satisfied with their telemedicine provider's response time and member service during the pandemic.

A recent survey by the Council highlights the commitment of employers to helping their employees through the pandemic and their focus on expanding access to behavioral health and telehealth in doing so. A significant number of employers reported expanded EAPs and mental health offerings as well as telehealth offerings. Among the employer actions to expand EAPs and mental health offerings are more education and frequent communications about the benefit in team meetings and conference calls and partnering with vendors to provide confidential webinars covering topics like COVID-19 anxiety, resilience, work-life balance, and mental health awareness. These efforts are designed to remove the stigma associated with mental illness and substance use disorders and lack of understanding about available resources that serve as barriers to care. Employers also reported adding more EAP visits, integrating their EAP network with their health plan networks, setting up an onsite counseling service and adding access to behavioral telehealth services with no cost sharing.

Organizations have leveraged the power of telehealth to expand access to mental health services. Notably, employers reported adding mental health to telehealth services and providing free access to online services, adding new on-line mental health tools through the EAP, launching mental health virtual care visits through their onsite health clinic provider, and providing that telehealth for all mental health was covered by the plan at 100%.

Barriers to Employer Efforts to Expand Access to Behavioral and Mental Health Care Remain

Despite the action employers have taken to expand access to behavioral and mental health care, their efforts are hamstrung by barriers to access to care. Barriers to accessing mental health and substance use disorder services predate and are magnified by the pandemic, notably the shortage of mental health providers in general and lack of in-network providers specifically.

According to the Household Pulse Survey, among adults reporting symptoms of anxiety and/or depressive disorder, more than 25% reported needing but not receiving

counseling or therapy in the past month.[9] For many of these individuals, a significant barrier to accessing mental health care is a shortage of mental health professionals.

The Bureau of Health Workforce, Health Resources and Services Administration at the U.S. Department of Health and Human Services estimates that 123 million people in the United States are living in Mental Health Care Professional Shortage Areas. More than one out of three Americans reside in these so-called mental health 'deserts' where patients are unable to access mental health care services because of a shortage of mental health providers in the area.[10] An additional 6,430 providers are needed to fill this gap nationwide. For patients with private insurance coverage, the provider shortage is compounded by a lack of in-network options for mental health and substance use care. The bottom line is that there are simply not enough mental health providers – this stems from either a shortage or unwillingness of mental health providers to participate in networks – which raise access issues and costs for employees and employers.

Policy Recommendations to Expand Access During the COVID-19 Pandemic and Beyond

We appreciate the efforts of Congress and the administration to address the gaps in access to mental health and substance about disorder services. However, sustained funding to support the mental health workforce is needed and will bring vital care to the mental health care deserts. Increasing the mental health workforce can also come from policies aimed at retraining the existing workforce to provide behavioral health services and promoting the availability of behavioral health services within primary care practices.

Employers are innovators and are always looking for ways to increase employee access to high-value mental health services by holding down costs and improving quality. The importance of quality and need for evidence-based care is critical to the value equation with respect to behavioral health as well medical benefits. We encourage policymakers to promote the use of evidence-based care by behavioral health providers.

Mental Health Parity

The Council remains strongly supportive of mental health parity. The ambiguity and subjective nature of the non-quantitative treatment limitations (NQTL) rule has been a real challenge for group health plans subject to MHPAEA. Having clear standards, particularly for the NQTL rule, is essential to compliance with MHPAEA. In the Council's experience with its members, employers work in good faith to comply with

[9] https://www.cdc.gov/nchs/covid19/pulse/mental-health-care.htm

[10] https://data.hrsa.gov/topics/health-workforce/shortage-areas

MHPAEA requirements but have struggled to understand the components and expectations of the NQTL rule. A key factor in achieving compliance is having a clear understanding of the rules.

We urge lawmakers to reject proposals to create a new civil monetary penalty regime pursuant to mental health parity rules. Employers continue to be committed to providing quality benefits – both medical/surgical and mental health benefits. We feel strongly that creating a new penalty regime is unwarranted. Given the complexity of understanding mental health parity compliance obligations, creation of new civil monetary penalties will neither enhance compliance nor address any perceived shortcomings in enforcement.

Telehealth

Employers, already at the forefront of innovative strategies to pay for value, drive to quality and harness technology, will play a key role in realizing the full potential of telehealth to expand access to behavioral and mental health care. We applaud Congress and the regulatory agencies for taking initial action to expand access to telehealth services offered by employers during the pandemic. We ask Congress to build on these actions to bring greater access to telehealth, including for behavioral health, both during the pandemic and beyond.

The provision allowing Health Saving Account (HSA)-eligible high-deductible health plans to cover telehealth services without cost-sharing under the Coronavirus Aid, Relief, and Economic Security (CARES) Act is an important positive step in expanding access to telehealth services during the pandemic. This provision is effective March 27, 2020, and applies to plan years beginning on or before December 31, 2021.

Also helpful is guidance from the U.S. departments of Labor, Treasury and Health and Human Services ("the Tri-Agencies"). It provides for non-enforcement of Summary of Benefits and Coverage (SBC) advanced notice requirements during the COVID-19 public health emergency or national emergency for situations where a plan or issuer adds benefits, or reduces or eliminates cost sharing for telehealth and other remote care services.

However, recognizing the significant demands of behavioral health services, further action is needed to more fully support the efforts of employers to expand telehealth coverage, in the interest of employees and the public health. Helpful guidance from the Tri-Agencies provided temporary flexibility for employers during the pandemic who wish to provide stand-alone telehealth services to employees who are not benefits eligible without the employer running afoul of the ACA market reforms. The Council urges codification and expansion of this relief to ensure that an employer's more robust offer of telehealth services is an excepted benefit and, thus, does not result in a violation

of the ACA's market reforms to the extent the benefits provided give rise to an ongoing administrative scheme (i.e., an ERISA plan) and provide significant benefits in the nature of medical care.

In addition, Congress should take immediate action to support audio-only behavioral health services, as patients may be more comfortable and have greater access to audio-only rather than video counseling. We also call upon Congress to take prompt action to remove state barriers to telehealth care, such as removing the requirement that patients have a pre-existing relationship with the provider, and allowing licensed providers to provide services to patients in other states via telehealth. Access to telehealth should not be stopped at state lines. Although some states have temporarily modified licensure requirements in limited circumstances, state-by-state variability of these waivers and gaps in waiver availability have led to uncertainty, complexity and lack of prompt access to care.

The federal government acted decisively to expand access to telehealth services for Medicare beneficiaries during the pandemic by removing state licensing barriers. However, for all too many patients covered by private insurance, state licensing barriers remain. This comes at a time when access to care, including behavioral health care service, is more important than ever. During this mental health crisis exacerbated by the ongoing pandemic, telehealth can bring much needed mental health services to underserved communities and vulnerable populations.

We urge Congress to take action now to ensure that patients in private plans, wherever they live, are able to turn to telehealth to access the care they need. We call on Congress to pass the Temporary Reciprocity to Ensure Access to Treatment (TREAT) Act (S. 168/H.R. 708), which would provide temporary state licensing reciprocity for all licensed and certified practitioners or professionals (those who treat physical and mental health conditions) in all states for all types of services (in-person and telehealth) during the COVID-19 Public Health Emergency.

We also request Congress to look beyond the pandemic era and make permanent the CARES Act provision allowing HSA-eligible high-deductible health plans to cover telehealth services on a pre-deductible basis. The benefits of telehealth will extend beyond the pandemic, and so must the ability of HSA-eligible high deductible health plans to cover telehealth without cost-sharing.

Conclusion

The COVID-19 pandemic has shined a light on mental illness and substance use disorders. The pandemic has also shined a light on the role employers play in helping to remove the stigma of mental illness and substance use disorders and helping working families acknowledge and address their need for care. However, the pandemic has also

highlighted and magnified barriers to access that impede these employer efforts. We urge Congress to pursue policies that remove these barriers and better enable employers to lead the way in improving access to quality, affordable behavioral and mental health care not just during the pandemic, but beyond.

Thank you for your consideration of our comments. Please let us know how the Council can further assist in your important efforts.

[Additional submission by Mr. Courtney follow:]

AMERICAN PSYCHIATRIC ASSOCIATION

800 Maine Avenue, S.W.
Suite 900
Washington, D.C. 20024

Testimony of the

American Psychiatric Association

On

April 15, 2021

Submitted for the record to the

U.S. House of Representatives Education and Labor Committee

In advance of the

HELP SUBCOMMITTEE HEARING:

Meeting the Moment: Improving Access to Behavioral and Mental Healthcare

Chairman DeSaulnier, Ranking Member Allen, and distinguished members of the Health, Employment, Labor, and Pensions Subcommittee of the House Education and Labor Committee, thank you for the opportunity to submit this testimony for the record on behalf of the over 37,400 psychiatrists of the American Psychiatric Association (APA) for your April 15, 2021 hearing entitled "*Meeting the Moment: Improving Access to Behavioral and Mental Healthcare.*"

The APA is dedicated to providing our physician members with education and training on the most modern evidence-based treatments to diagnose and treat patients with mental illness and substance use disorders (SUD). The APA and our members are focused on ensuring humane care and effective treatment for all persons with mental illness and SUD, and is actively engaged in pursuing policies that affect our patients' access to quality care. Our sister organization the American Psychiatric Association Foundation (APAF), through its Center on Workplace Mental Health, is a premier source of workplace mental health expertise for employers. APAF also helps to facilitate the availability of culturally competent care through the training of minority fellows entering the field of psychiatry.

In our testimony today, we will highlight data related to access to mental health and SUD care in schools, for employees and for BIPOC communities. We will also use this testimony to offer policy recommendations to alleviate barriers to care with the overarching goal to improve our country's mental health system, with a particular focus on compliance with mental health parity requirements.

Mental Health in Education and the Workplace

The costs associated with untreated mental illness in the workplace—numbering in the billions of dollars—far outweigh the costs of providing treatment. Yet mental and physical health are both vital to overall health, as is their treatment through integrated, evidence-based care. As the Centers for Disease Control and Prevention has recognized, mental illness, particularly depression, elevates the risk for many other health conditions, such as stroke, type 2 diabetes, and heart disease. The presence of chronic conditions also increases the risk of mental health conditions.

When employees do receive effective treatment for mental illnesses and substance use disorders, the results are seen in lower total medical costs, increased productivity, lower absenteeism and presenteeism, and decreased disability costs. Yet, fewer than half of the 17 million adults with depression in the United States get care for it, with resulting impacts on their personal and work lives. Therefore, it is essential to ensure that the health plans covering employees provide access to the care they need in order to lead healthy, productive lives.

Early identification of mental illness is also essential in preparing children for the workforce and for the healthiest possible life. Half of all lifetime illnesses present in children by the time they are 14 years old, while seventy five percent of lifetime mental illnesses begin by age 24.[1] Further, 1 in 6 youth between the ages of six to seventeen years old experience a mental health disorder each year[2] and sadly suicide is the second leading cause of death among people between ten and thirty-four years old.[3] Early identification for mental health conditions in the primary care setting, through behavioral health integration, and in specialty care, enables early intervention and treatment in the school, family or the medical setting, which helps children become healthy adults.

---

[1] https://pubmed.ncbi.nlm.nih.gov/15939837/

[2] https://jamanetwork.com/journals/jamapediatrics/fullarticle/2724377?guestAccessKey=f689aa19-31f1-481d-878a-6bf838445368

[3] https://www.nimh.nih.gov/health/statistics/suicide.shtml

In the broader context, we have seen the costs of untreated mental illness for both youth and adults in the concurrent suicide and SUD epidemics that claimed over 300 lives every day prior to the COVID-19 pandemic.[4] The pandemic has exacerbated this crisis, as evidenced by numerous data: roughly 88,000 people died by overdose in the 12-month period ending in August 2020, a 26.8% increase over the previous 12-month period.[5]

Mental Health Parity Law

In order to reverse these trends, we must first focus on ensuring that people have equitable access to mental health and SUD treatment. Essential to meeting this need is full implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA). The APA applauds the Subcommittee for recognizing this during the 116th Congress and is grateful for the invaluable bipartisan assistance of the Education & Labor Committee and other key congressional committees in amending MHPAEA by including language within the Consolidated Appropriations Act, 2021 (CAA). Section 203 of Division BB of the CAA added important new compliance requirements for group health plans and health insurance issuers, and provided new responsibilities for the federal agencies, most notably the Department of Labor (DOL), to enforce the federal parity law.

Of particular note for the Subcommittee are the new requirements for group health plans subject to the Employee Retirement Income Security Act (ERISA) and the new responsibilities of DOL. Group health plans must now perform comparative analyses that demonstrate their compliance with the nonquantitative treatment limitation (NQTL) requirements of MHPAEA and submit them to DOL upon request. NQTLs include prior authorization, provider network design, reimbursement rate setting, and many other treatment limitations. Importantly, under section 203, plans must perform comparative analyses of all NQTLs, as further reinforced by recent guidance issued by DOL.[6]

DOL must request these analyses from plans whenever there is a complaint or a suspected violation involving an NQTL and in any other instances in which DOL deems necessary. DOL is also required to request analyses from at least 20 plans every year, but given the volume of MHPAEA complaints (92 in 2020) it is likely that DOL will need to request far more analyses than that minimum threshold.[7] The Employee Benefits Security Administration (EBSA) within DOL will be responsible for this work.

Meeting Federal Compliance Resource Needs

It is important that the EBSA have the resources and capacity necessary to review plan-submitted comparative analyses and are able to take action to correct violations or collect additional information when the initial analyses provided are insufficient. APA has worked with numerous state regulators that collect and review similar comparative analyses. Reviewing these analyses is a time-intensive process that requires expertise and frequent engagement with insurers to ensure that sufficient information is provided. Special templates and tools must be created to collect the necessary information. Regulatory staff must be trained so that they are aligned in how they are interpreting the dense NQTL language

[4] https://www.phe.gov/emergency/news/healthactions/phe/Pages/opioids-7April2021.aspx
[5] National Center for Health Statistics. National Vital Statistics System. Retrieved from https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm
[6] Q8, FAQS ABOUT MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY IMPLEMENTATION AND THE CONSOLIDATED APPROPRIATIONS ACT, 2021 PART 45. Retrieved from https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf
[7] FY 2020 MHPAEA Enforcement Fact Sheet. Retrieved from https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/mhpaea-enforcement-2020.pdf

from the final rules implementing MHPAEA. Findings of noncompliance must be worded precisely and be firmly grounded within the terminology of the NQTL rules. Providing technical assistance to a plan about what it did that was noncompliant or insufficient can take months. Structuring corrective action plans must be meticulous and provide meaningful and tangible ways for a plan to achieve compliance.

EBSA already faced resource and capacity challenges before new requirements included in the December 2020 CAA were enacted. **Without additional funding, it is unlikely that the EBSA will be able to fulfill these new obligations as Congress intended**. Congress took action last year because there was great concern that plans were not meeting their obligations under MHPAEA, in the face of increasing suicide and overdose deaths. If EBSA is not able to hold plans accountable and implement these new standards, the opportunity to increase access to care and save lives may be lost.

APA recommends that Congress appropriate an additional $25 million for the EBSA to implement its new responsibilities and ensure that plans are in compliance with the law. This funding would enable EBSA to do the following:

- Hire additional investigators who would focus exclusively on MHPAEA, with special attention on reviewing the comparative analyses and then tailoring investigations of plans based on the information (or lack thereof) within the analyses. Currently EBSA only has 400 investigators whose responsibilities are split among the more than 5 million employee benefit plans. A singular focus on MHPAEA will give investigators the bandwidth to fully immerse themselves in and master the dense and complicated NQTL requirements.[8]
- Hire and retain MHPAEA subject matter expert consultants. While dedicating some investigators solely to parity enforcement will help increase agency expertise, outside subject matter experts in this highly specialized field will be needed to create data collection tools, train numerous agency staff, including the investigators, and help render determinations of compliance or non-compliance on submitted comparative analyses.
- Enhance capacity within EBSA to better tailor investigations and fully investigate plans whose comparative analyses warrant further examination.
- Provide training to benefit advisors who interface with beneficiaries about the new compliance requirements so that they may better inform beneficiaries of their rights.
- Enhance coordination among the 10 DOL regional offices so that there is a uniform approach to understanding and reviewing NQTL analyses.

Given the labor-intensive nature of this specialized compliance work the new responsibilities given to DOL in the CAA will likely require several thousand additional staff hours for adequate and effective implementation.

Meeting State Compliance Resource Needs

APA is also advocating for **additional Congressional action on parity related to the new compliance requirements added by the CAA in the states.** We are supporting the introduction of new legislation that would provide grant funding to state insurance departments for the purposes of implementing the new compliance requirements. While we understand that this legislation may not fall under the

[8] DOL 2020 Report to Congress. Parity Partnerships: Working Together. Retrieved from https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/dol-report-to-congress-parity-partnerships-working-together.pdf

jurisdiction of this Subcommittee, or full Committee, APA believes this legislation will likely be of interest to you.

Section 203 of the CAA amended MHPAEA so that all state-regulated health insurance issuers must perform the same comparative analyses that group health plans must complete. State insurance commissioners may request these analyses from issuers, and the issuers must supply them to a requesting commissioner. APA has been working with state regulators and state legislatures in recent years to require issuers to submit comparative analyses to insurance commissioners. Since the beginning of 2018, through either legislative or regulatory means, over 20 states have required issuers to submit comparative analyses nearly identical in structure to those in Section 203. Working with these states in particular is how APA developed insight into how time and labor intensive it can be to collect, review, and act upon these analyses.

Through this new legislation, APA is advocating that $50 million in grant funding be made available for state insurance departments to implement the new comparative analysis specifications. Under the bill, a state would only be eligible to receive grant funding if it requested and reviewed the comparative analyses from issuers. This proposal builds on the precedent set by the Department of Health and Human Services (HHS) in providing such compliance resources to states in 2017 and 2018.[9] Congress essentially gave every insurance commissioner in America new authority to collect comparative analyses from issuers whenever they deem necessary (most state laws and regulatory processes merely created annual reporting of comparative analyses; not reporting upon request). **Without Congressional action, many states will lack the resources and bandwidth to meaningfully review the analyses.**

This is an issue of great bipartisan interest in the states. Over 30 states are participating in the MHPAEA working group at the National Association of Insurance Commissioners.[10] This formal working group was created in early 2020 after informal meetings revealed the high demand for collaboration and information sharing on effectively implementing mental health parity law.

Though access to mental health care and substance use disorder treatment would be much improved if health insurers all came into compliance with MHPAEA, we cannot begin to improve our country's overall mental health without concurrently addressing health disparities.

Racial Disparities in Mental Health Care

The existence of health disparities is a significant problem facing our country that will not be resolved without direct and sustained intervention targeting the root causes. Systemic racism, intergenerational trauma, persistent poverty, a dearth of cultural competency, and criminalization of mental illness in minority populations, among many other causes, have led to a landscape of stark health disparities that is deeply embedded and resistant to change. As the Subcommittee focuses attention on behavioral health, including compliance with MHPAEA and the impact of mental health on overall health, the APA is eager to work with you to identify bold legislative solutions to meaningfully improve health inequities.

---

[9] Center for Consumer Information and Insurance Oversight. Health Insurance Enforcement and Consumer Protection Grants. Retrieved from https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Health_Insurance_Enforcement_and_Consumer_Protections-Grants-

[10] National Association of Insurance Commissioners MHPAEA (B) Working Group of the Regulatory Framework (B) Task Force. Roster. Retrieved from https://content.naic.org/sites/default/files/inline-files/2021%20B-MHPAEA%20Working%20Group_0.pdf

The pandemic has laid bare the glaring reality of health and healthcare disparities in our country. Data collected during the pandemic has continually indicated that BIPOC individuals experience disparate health outcomes and experience more insurmountable barriers to accessing mental health and SUD care than their white counterparts. These findings continue to play out in our schools, in the health care system and for employers, alike. While health disparities across the spectrum of health outcomes have been further exposed during COVID-19, the extreme disparities and health inequities related to mental health and SUD have been quite clear.[11]

Denial of necessary mental health and SUD care due to violations of MHPAEA adversely impacts workers and, therefore, their employers. In addition, the long-term adverse impact of structural racism on overall health—physical and mental--is also clear. For example, data show that the COVID-19 virus has disproportionately impacted minority and vulnerable populations, exacerbating the health inequities faced in this country. **A study published on April 6, 2021 in the Lancet found that one-third of individuals diagnosed with COVID-19 developed a neurologic or psychiatric disorder within six months of their diagnosis.** Just as it is in the interest of our society, including employers and workers, to address the COVID-19-specific challenges we have been facing, it is also in our collective interest to intentionally address the racial disparities and health inequities that the pandemic has further exposed.

Cultural competency and disparities in treatment are essential for improving the mental health care of racial/ethnic groups. Compared with the general population, African Americans are less likely to be offered either evidence-based medication therapy or psychotherapy.[12] Physician-patient communication differs for African Americans and whites. One study found that physicians were 23% more verbally dominant and engaged in 33% less patient-centered communication with African American patients than with white patients.[13] African Americans with mental health conditions, particularly schizophrenia, bipolar disorders, and other psychoses are more likely to be incarcerated than whites.[14] Approximately, 19% of Hispanics are uninsured[15] and those who are insured, are more likely to report poor communication with their health provider. Several studies have found that bilingual patients are evaluated differently when interviewed in English as opposed to Spanish and that Hispanics are more frequently undertreated.[16] Native Americans/Alaska Natives experience post-traumatic stress disorder twice the rate of the general population and suicide among Native youth is higher than any other racial/ethnic group. [17, 18]

Another barrier to eliminating mental health disparities in underserved communities is the number of mental health practitioners entering the mental health workforce. According to the Health Resources

---

[11] Shim RS. Mental Health Inequities in the Context of COVID-19. *JAMA Netw Open.* 2020;3(9):e2020104. doi:10.1001/jamanetworkopen.2020.20104. Retrieved from https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2770142

[12] Wang PS, Berglund P, Kessler RC. "Recent care of common mental disorders in the Unites States: Prevalence and conformance with evidence- based recommendations." J Gen Intern Med. 2000. 15(5), 284-292.

[13] Johnson R, et al. "Patient race/ethnicity and quality of patient-physician communication during medical visits." Am J Public Health. 2004. 94(12), 2084-90.

[14] U.S. Department of Justice. "Prisoners in 2015." NCJ 250229 (Bureau of Justice Statistics Bulletin). 2016. https://www.bjs.gov/content/pub/pdf/p15.pdf

[15] United States Census. American Community Survey. (2019) https://data.census.gov/cedsci/table?q=hispanics%20insurance&tid=ACSDT1Y2019.C27001I&hidePreview=false.

[16] The League of United Latin American Citizens. Latino Health Disparities. http://lulac.org/programs/health/health_disparities/

[17] Mental Health America. (2020). Native American Communities and Mental Health. https://www.mhanational.org/issues/native-american-communitiesand-mental-health.

[18] Downing, J., & Collier, B. (2020). Native Americans and Mental Health– Seeking Connections Between Historical Trauma, PTSD, Substance Abuse, and Suicide

and Services Administration (HRSA), there are 123 million Americans residing in 5,836 mental health professional shortage areas in the United States. Data indicate that it will require 6,430 mental health providers to enter the workforce to eliminate health professional shortage areas where mental health disparities prevail.[19]

In order to alleviate these disparities in access to culturally competent care, the APA strongly urges Congress and this Committee to examine how to recruit and retain more BIPOC individuals into the health care workforce at every level from x-ray technicians to care coordinators to nurses, psychologists and psychiatrists. We cannot begin to combat racial health disparities without making a concerted effort to recruit and retain a BIPOC-representative workforce who can treat patients in communities who look like them. This initiative must start early by encouraging BIPOC students to pursue and excel in science, technology, engineering, and mathematics (STEM) and the health sciences.

In promoting strong STEM and health science-focused elementary and secondary education, we will effectively train and encourage BIPOC individuals to continue their studies through higher education. Institutes of higher learning and technical training-focused organizations need to actively recruit BIPOC candidates and engage in comprehensive career-preparation to help these students go on to work in both the medical practice and medical tech fields. In addition, elementary, secondary and higher learning schools need to offer these students mental health support and services throughout their student careers, as schools are one of the best ways to reach populations plagued by persistent poverty and inequity to health services. By encouraging BIPOC students to pursue STEM and medical field careers and offering these students the MH/SUD supports they need through our education system, we in turn promote both the diversity and the productivity of the next generation of the workforce.

Further, in order to address systemic poverty that has plagued many minority communities, the APA implores Congress, including this Committee, to consider how social determinants of health, including access to high-quality education and social services, food insecurity, access to affordable housing and reliable broadband, lack of transportation, pay inequality, economic security and childhood experiences impact overall health outcomes. Congress should also focus on providing targeted, sustained, investments in community-based support systems that help these communities address social determinants of health. Investments should also be directed towards community organizations that work to help reduce the persistent stigma that serves as a barrier to patients asking for help, especially mental health and SUD treatment, in these communities. APA also encourages Congress to build on the American Rescue Plan Act and increase health insurance coverage, including enrollment of individuals in underserved and BIPOC communities.

The APA looks forward to working together with this Committee and our colleagues across the mental health community to improve our mental health care system and make mental health care accessible for every American. Please consider us a resource for the subcommittee on this and the many other important issues you consider related to behavioral health.

[19] Health Resources and Services Administration. (2020). https://data.hrsa.gov/topics/health-workforce/shortage-areas

[Additional submission by Mr Walberg follow:]

PARTNERSHIP FOR EMPLOYER-SPONSORED COVERAGE

STATEMENT FOR
U.S. HOUSE OF REPRESENTATIVES
EDUCATION & LABOR COMMITTEE SUBCOMMITTEE ON HELP
HEARING ON
"MEETING THE MOMENT: IMPROVING ACCESS TO
BEHAVIORAL & MENALTH HEALTH CARE"
APRIL 15, 2021

The Partnership for Employer-Sponsored Coverage (P4ESC) appreciates the Education and Labor Committee's Subcommittee on Health, Employment, Labor, and Pensions Subcommittee holding this important hearing on improving access to behavioral and mental health services. We agree that now more than ever is an important time to assess the mental and behavioral health support needs of Americans.

P4ESC is an advocacy alliance of employment-based organizations and trade associations representing businesses of all sizes and the millions of American workers and their families who rely on employer-sponsored health coverage every day. We are working to ensure that employer-sponsored coverage is strengthened and remains a viable, affordable option for decades to come.

According to the Society for Human Resource Management's (SHRM) *Navigating COVID-19: Impact of the Pandemic on Mental Health*[1], "the COVID-19 pandemic has put unprecedented strain on workers' mental health… the research finds that a majority of employees are experiencing symptoms of depression, but very few are receiving care." Findings include:

- Two out of three employees report experiencing symptoms of depression sometimes amid widespread lockdowns
- More than two in five employees feel burned out, drained, or exhausted by work
- 37 percent of employees have not done anything to cope with depression-related symptoms and only 7 percent have reached out to a mental health professional

As the Committee explores ways to improve access to behavioral and mental health services for Americans, we would like to raise two policy areas that should be addressed: expansion of telehealth services and insurance network access to behavioral and mental health professionals.

Expanding Telehealth Services

P4ESC believes the time is ripe to modernize laws to increase access to telehealth services as patients, health providers, and coverage plan sponsors continue to adapt to and comply with remote working and social distancing measures. We support: 1) treating telehealth services as an excepted benefit which would enable employers to offer this type of coverage to part-time and variable workforces, and other employees not enrolled in the employers' medical plan; 2) reforming licensure requirements to enable services to be offered across state lines; 3) establishing a national set of standards for

[1] https://www.shrm.org/hr-today/trends-and-forecasting/research-and-surveys/documents/shrm%20cv19%20mental%20health%20research%20presentation%20v1.pdf

telemedicine services to address state-based requirements that have not kept pace with technology, practice site and remote working advances, including eliminating originating site and prior provider relationship requirements; and 4) clarifying that CARES Act telemedicine provisions are effective for plan years on or after January 1, 2019 (employer plan years vary between non-calendar and calendar year basis).

The pandemic has offered employees the ability to receive behavioral and mental health care services via telemedicine, and we strongly support making this access permanent. As noted in testimony for today's hearing[2], James Gelfand of the ERISA Industry Committee (ERIC) stated "[w]hen COVID-19 caused many employers to shift to remote work or reduced employee presence onsite, many worksite clinics went virtual, offering mental and behavioral health via telehealth. Some clinics expanded eligibility to other employees in the same state, who may not be based at the same site. This helped create continuity for employees undergoing care, and a new access point for many others."

Further, in an op-ed published in *THE HILL*[3] on May 28, 2020, SHRM's Emily M. Dickens, Chief of Staff, Head of Government Affairs & Corporate Secretary, wrote "[g]reater access to telemedicine, including telepsychiatry, will provide the resources for employees to navigate all health care options and privately seek the help that they need. The convenience of this offering will benefit employers and their employees because such services can be received at home and after work hours during a time when personal and professional schedules are anything but definite for so many workers."

In the employer benefits space, telehealth services come in different forms, such as: the ability for employees to be treated by a health provider or practice, with whom they already have a relationship, in a telemedicine setting instead of through a traditional in-office visit; and access to a telehealth service vendor which is included in a benefits package offering, similar to a dental or vision plan, that is separate from the medical plan but provides the ability to be connected to a physician or health professional for a consultation. In the later example, the separate telehealth vendor program can legally be provided to full-time employees enrolled in the employer medical plan but not to other groups of the workforce. Part-time and seasonal employees and full-time employees who declined the employer medical plan cannot access the telehealth vendor program because this type of stand-alone benefit would violate the coverage rules under the Affordable Care Act's (ACA) employer mandate. P4ESC would like the availability of these telehealth services to legally be offered to all employees, regardless of their eligibility for or enrollment in an employer's medical plan.

Addressing Network Access/Provider Availability

Employers and employees face challenges in finding available and affordable behavioral and mental health care providers. Some behavioral and mental health providers – particularly those in rural areas – decline to participate in health insurance networks. In the case of most self-insured plans under the Employee Retirement Income Security Act of 1974 (ERISA), employers rent insurance carriers' provider networks. The decision to join a network lies with the provider, subject to network standards.

[2] 04-15-21 ERIC Testimony - E&L Mental Health Hearing [Final].pdf
[3] https://thehill.com/opinion/healthcare/500017-assist-mental-health-of-workers-by-increasing-access-to-telemedicine

PARTNERSHIP FOR EMPLOYER-SPONSORED COVERAGE

Because so many behavioral and mental health providers choose not to go in-network, employees can often face large out-of-network bills for care sought. It is important to stress that efforts to evaluate the availability of behavioral and mental health providers in health insurance networks must also consider whether these providers make themselves available and affordable to employees. Coverage requirements and civil monetary penalties on employers and insurance carriers are counterproductive, particularly regarding access and affordability, unless there is a countervailing requirement enforced by equal penalties for providers to participate in one or more networks.

***

The Partnership for Employer-Sponsored Coverage welcomes the opportunity to provide input and speak in further detail about ensuring access to behavioral and mental health services to Americans, especially during the pandemic. Benefits offerings and coverage plans in the employer-sponsored system are as diverse as employers themselves. There is no one-size-fits-all employer plan, and the functionality of a business is centered around a productive, thriving, and healthy workforce. As a coalition representing businesses of all sizes, we have the unique ability to provide operational input across the full spectrum of the employer system – from the smallest family business to the largest corporation.

American Health Policy Institute
American Hotel & Lodging Association
American Rental Association
Associated Builders and Contractors, Inc.
Associated General Contractors of America
Auto Care Association
Business Group on Health
The Council of Insurance Agents & Brokers
The ERISA Industry Committee (ERIC)
FMI – The Food Industry Association
HR Policy Association
National Association of Health Underwriters
National Association of Wholesaler-Distributors
NFIB – National Federation of Independent Business
National Restaurant Association
National Retail Federation
Retail Industry Leaders Association
Society for Human Resource Management

[Questions submitted for the record and the responses by Ms. Bendat follow:]

April 23, 2021

Meiram Bendat, J.D., Ph.D.
Founder
Psych-Appeal
7 West Figueroa Street, Suite 300, PMB #300059
Santa Barbara, CA 93101

Dear Dr. Bendat,

I would like to thank you for testifying at the April 15, 2021 Subcommittee on Health, Employment, Labor, and Pensions hearing entitled "*Meeting the Moment: Improving Access to Behavioral and Mental Health Care*."

Please find enclosed additional questions submitted by Committee members following the hearing. Please provide a written response no later than Friday, April 30, 2021, for inclusion in the official hearing record. Your responses should be sent to Mariah Mowbray and Daniel Foster of the Committee staff. They can be contacted at 202-225-3725 should you have any questions.

I appreciate your time and continued contribution to the work of the Committee.

Sincerely,

ROBERT C. "BOBBY" SCOTT
Chairman

Enclosure

Health, Employment, Labor, and Pensions Subcommittee Hearing
"*Meeting the Moment: Improving Access to Behavioral and Mental Health Care*"
Thursday, April 15, 2021
10:15 a.m. (Eastern Time)

Chairman Robert C. "Bobby" Scott (D – VA)

1. Dr. Bendat, consumers have certain rights to appeal adverse benefit determinations by health plans and insurers, including the right to external review. What are some of the challenges that consumers face in utilizing the external review process under current law? What particular issues are prevalent with respect to self-insured ERISA plans? What steps can be taken to address these problems through either legislative or regulatory efforts?

PSYCH
APPEAL
Safeguarding Mental Health Care

April 29, 2021

The Honorable Robert C. "Bobby" Scott
Chairman, Committee on Education and Labor
United States House of Representatives
2176 Rayburn House Office Building
Washington, DC 20515-6100

Re: Health, Employment, Labor, and Pensions Subcommittee Hearing
Meeting the Moment: Improving Access to Behavioral and Mental Health Care (April 15, 2021)

Dear Chairman Scott:

This letter is in response to your April 23, 2021 request for additional testimony relevant to the April 15, 2021 Health, Employment, Labor, and Pensions ("HELP") Subcommittee hearing on access to mental health care. You specifically asked me to address the following:

> Dr. Bendat, consumers have certain rights to appeal adverse benefit determinations by health plans and insurers, including the right to external review. What are some of the challenges that consumers face in utilizing the external review process under current law? What particular issues are prevalent with respect to self-insured ERISA plans? What steps can be taken to address these problems through either legislative or regulatory efforts?

External Review Processes Under ERISA

Although ERISA provides participants and beneficiaries of non-grandfathered group health plans the right to external reviews of adverse benefit determinations,[1] the external review process operates differently with respect to group health plans that are fully-insured and those that are self-funded. Since health insurance issuers offering group

[1] 29 U.S.C. § 1185d, incorporating 42 U.S.C. § 300gg-19(b).

7 West Figueroa Street • Suite 300 • PMB #300059 • Santa Barbara • CA • 93101
Tel (310) 598-3690 • Fax (888) 975-1957 • www.psych-appeal.com

health insurance coverage are subject to concurrent state and federal regulation, their adverse benefit determinations based on medical necessity[2] are generally subject to the "state external review process."[3] The state external review process requires states to directly select, assign cases to, and oversee so-called Independent Review Organizations ("IRO"s).[4] External reviews of adverse benefit determinations by health insurance issuers offering group health insurance coverage in states[5] without an external review process are subject to either the "federal external review process"[6] or the "alternative, federally-administered external review process."[7] While states may permit self-funded ERISA group health plans to participate in their external review process,[8] self-funded group health plans overwhelmingly participate in the federal external review process. Under the federal external review process, health insurance issuers offering group health insurance coverage (in jurisdictions without a state external review process) and self-funded group health plans, primarily through their fiduciaries (*i.e.,* claims administrators), are permitted to privately contract with IROs.[9]

Conflicts of Interest Undermine the Independence
of the State and Federal External Review Processes

Outside the state and federal external review processes, health insurance issuers and claims administrators often also contract with the same IROs that conduct external reviews to perform internal reviews when in-house personnel are unavailable. IROs that serve as internal review agents operate to support the business needs of health insurance issuers and claims administrators. Thus, even if internal and external reviews are not assigned to the same IRO in any given case, IROs are conditioned to view health insurance issuers and claims administrators—not consumers—as their clients. In fact, URAC, which accredits IROs, defines "Client" to be "A business or individual that purchases services from the [IRO].[10] As the National Association of Independent Review Organizations ("NAIRO") rightly admits, "The fact that IRO's may perform independent reviews at levels 'internal' to a health plan poses potential conflicts of interest for IRO's."[11]

---

[2] 29 C.F.R. § 2590.715-2719(c)(2)(i).
[3] 29 C.F.R. § 2590.715-2719(c).
[4] 29 C.F.R. § 2590.715-2719(c)(2)(vii)-(viii).
[5] https://www.cms.gov/CCIIO/Resources/Files/external_appeals
[6] 29 C.F.R. § 2590.715-2719(d)(1)-(3).
[7] 29 C.F.R. § 2590.715-2719(d)(4).
[8] 29 C.F.R. § 2590.715-2719(c)(1)(ii).
[9] 29 C.F.R. § 2590.715-2719(d)(2)(iii)(A)(2).
[10] 2011. *Independent Review Organization: External Review Standards*. 5th ed. Washington, D.C.: URAC, pp.14-36, 73-75.
[11] n.d. *Preserving the Integrity and Viability of Independent Medical Review.* [online] NAIRO, p.6. Available at: https://www.nairo.org/assets/docs/NAIRO-White-Paper-Preserving-the-Integrity-and-Viability-of-Independent-Medical-Review.pdf [Accessed 26 April 2021].

Mental Health Challenges

Under the federal external review process, the client-vendor conflict skews the framing of disputes and precludes relief for parity violations. Because the federal external review process directly tasks claims administrators with assigning external reviews to IROs,[12] claims administrators holding the purse strings routinely instruct IROs to exclusively opine on whether disputed services are medically necessary or experimental/investigational, despite current regulations directing IROs also to determine whether adverse benefit determinations based on medical judgment apply parity-compliant medical management techniques.[13] By improperly limiting the scope of external reviews, even when parity concerns are expressly raised by consumers, claims administrators evade review of systemic and potentially discriminatory nonquantitative treatment limitations. Simultaneously, they also avoid costs associated with the use of legal experts, which IROs are permitted (but routinely fail) to engage.[14] This gamesmanship is entirely consistent with a 2005 URAC/NAIRO survey of IROs' primary review methodologies, finding that "client preference" was the leading determinant of primary review basis for internal reviews and was a close second (to regulatory requirements) with respect to external reviews.[15]

The lack of transparency under the federal external review process poses additional challenges for ERISA health plan participants and beneficiaries. Current regulations simply require health insurance issuers and claims administrators to contract with IROs of their choice without subjecting either party to routine governmental oversight. Consequently, alarming coverage trends for mental health care easily evade detection by federal regulators charged with enforcing MHPAEA. For example, data from California's external review process identified that out of 13,000 requests for external reviews based on medical necessity, external reviews overturned more mental health denials than for any other type of medical condition, and found that health insurance issuers improperly denied coverage of mental health services in 48 percent of all cases.[16]

Additionally, absent governmental oversight of the federal external review process, health insurance issuers, claims administrators, and IROs are not required to

[12] 29 C.F.R. § 2590.715-2719(d)(2)(iii)(A).
[13] 29 C.F.R. § 2590.715-2719d(1)(i)(A). Ironically, the regulation does not require group health plans and their fiduciaries, including claims administrators, to automatically produce evidence concerning relevant nonquantitative treatment limitations to IROs. Unsurprisingly, this information is neither volunteered by claims administrators who operationalize nonquantitative treatment limitations nor requested of them by their contracted IROs.
[14] 29 C.F.R. § 2590.715-2719(d)(2)(iii)(B)(1).
[15] *Preserving the Integrity and Viability of Independent Medical Review*, *supra*, n.11, at pp.10-11.
[16] Wagner, L. and Escamilla, F., 2016. *State Finds Mentally Ill Improperly Denied Coverage for Treatment Nearly Half the Time*. [online] NBC Bay Area. Available at: https://www.nbcbayarea.com/news/local/state-finds-mentally-ill-improperly-denied-coverage-for-treatment-nearly-half-the-time/136786/ [Accessed 26 April 2021].

disclose data concerning their compliance with external review timeframes and notice requirements. This lack of transparency is particularly troubling with respect to expedited external reviews, which by definition are intended to avert jeopardy to life or health.[17] In fact, under the federal external review process, IROs are permitted to terminate external reviews and automatically reverse adverse benefit determinations when health insurance issuers and claims administrators fail to provide timely and complete information.[18] Yet it remains entirely unknown whether, how often, and with respect to which health insurance issuers and claims administrators IROs exercise this discretion (if at all).

Of further concern is that, despite ERISA expressly providing for the identification of medical or vocational experts whose advice was obtained on behalf of a health plan in connection with an adverse benefit determination,[19] IROs routinely conceal the identities of external reviewers from consumers. This practice violates the spirit, if not the letter of the law, and precludes consumers from vetting external reviewers' representations about their qualifications and independence, which are not always accurate or complete. Considering that judges are perfectly capable of making independent, high stakes, and sometimes unpopular decisions with full disclosure of their identities, there is simply no compelling justification for external reviewers to remain anonymous.

Recommendations for Reform

Only the alternative, federally-administered external review process established by the Department of Health and Human Services ("HHS")[20] and state external review processes operated by regulators such as the California Department of Managed Health Care ("DMHC")[21] come close to insulating consumers from the conflicts of interest and lack of regulatory oversight described above. This is because these regulators exclusively contract with IROs that do not accept direct business (including internal review assignments) from health insurance issuers and claims administrators in any market segment. Under these regimes, health insurance issuers and claims administrators are unable to influence or game the external review system. The only caveat is that the alternative, federally-administered external review process does not require its contracted IRO to disclose external reviewer identities, placing consumers at a serious informational disadvantage.

---

[17] 29 C.F.R. § 2590.715-2719(d)(3)(i). Problematically, 29 C.F.R. § 2590.715-2719(d)(3)(ii) requires claims administrators to "immediately" conduct preliminary reviews of requests for expedited external reviews without specifying an exact time limit in which to complete any such review. Additionally, 29 C.F.R. § 2590.715-2719(d)(3)(iii)(A) requires claims administrators to assign expedited reviews to IROs pursuant to the requirements for standard review, suggesting that health plans may take up to 5 business days in which to transmit required data, albeit via an expeditious method such as fax or email.
[18] 29 C.F.R. § 2590.715-2719 (d)(2)(iii)(B)(3).
[19] 29 C.F.R. §2560.503-1(h)(3)(iv).
[20] https://externalappeal.cms.gov/ferpportal/#/home.
[21] https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/rules-and-regulations/public-comments/1210-28876/00025.pdf

In light of the above, I urge Congress to pass legislation or require amended regulations that: 1) prohibit IROs that conduct internal reviews for health insurance issuers or claims administrators from participating in any state external review process, regardless of whether they adjudicate internal and external reviews in any given case; 2) abolish the federal external review process; 3) require self-funded ERISA health plans to participate in the alternative, federally-administered external review process operating under governmental oversight; and 4) mandate disclosure of external reviewer identities under any external review process sanctioned by Congress.

Sincerely,

Meiram Bendat, J.D., Ph.D.

7 West Figueroa Street • Suite 300 • PMB #300059 • Santa Barbara • CA • 93101
Tel (310) 598-3690 • Fax (888) 975-1957 • www.psych-appeal.com

[Questions submitted for the record and the responses by Mr. Gelfand follow:]

April 23, 2021

Mr. James Gelfand
Senior Vice President, Health Policy
The ERISA Industry Committee
701 8th Street NW, Suite 610
Washington, D.C. 20001

Dear Mr. Gelfand,

I would like to thank you for testifying at the April 15, 2021 Subcommittee on Health, Employment, Labor, and Pensions hearing entitled "*Meeting the Moment: Improving Access to Behavioral and Mental Health Care*."

Please find enclosed additional questions submitted by Committee members following the hearing. Please provide a written response no later than Friday, April 30, 2021, for inclusion in the official hearing record. Your responses should be sent to Mariah Mowbray and Daniel Foster of the Committee staff. They can be contacted at 202-225-3725 should you have any questions.

I appreciate your time and continued contribution to the work of the Committee.

Sincerely,

ROBERT C. "BOBBY" SCOTT
Chairman

Enclosure

Health, Employment, Labor, and Pensions Subcommittee Hearing
"Meeting the Moment: Improving Access to Behavioral and Mental Health Care"
Thursday, April 15, 2021
10:15 a.m. (Eastern Time)

Ranking Member Rick W. Allen (R – GA)

1. Mr. Gelfand, I understand the importance of price transparency and using every dollar wisely. Employees enrolled in high-deductible health plans with health savings accounts are rightly cost-conscious and seek to make health care choices that work best for their families and their budget. The CARES Act allows employees participating in such plans to benefit from first-dollar coverage of telehealth, but only through 2021. Can you explain further how first-dollar coverage of telehealth services helps these patients? Why should Congress consider making this temporary provision permanent?

QFR Response: James Gelfand, The ERISA Industry Committee (ERIC)

Ranking Member Rick W. Allen (R – GA)

1. Mr. Gelfand, I understand the importance of price transparency and using every dollar wisely. Employees enrolled in high-deductible health plans with health savings accounts are rightly cost-conscious and seek to make health care choices that work best for their families and their budget. The CARES Act allows employees participating in such plans to benefit from first-dollar coverage of telehealth, but only through 2021. Can you explain further how first-dollar coverage of telehealth services helps these patients? Why should Congress consider making this temporary provision permanent?

Thank you for the question, Rep. Allen. The rules for high-deductible plans (HDHPs) were developed in 2003, and have not been significantly altered or updated since that time. However, our understanding of how to drive value in health care has changed a great deal in the intervening two decades. Employers know that high-value care, like telehealth, should be made readily accessible to employees without barriers or gatekeeping. The CARES Act recognized this, and allowed employers to try moving telehealth to 1st-dollar coverage, in front of the deductible. Employers embraced this change, because we know that telehealth can offer quality care at a low price-point, speeding access to care, and improving choice and competition for our beneficiaries.

Based on reports from ERIC member companies, the results of this policy were good. Patients used telehealth services, and got care they needed, because they didn't have to pay the full price prior to hitting their deductible. Fears related to over-utilization and higher costs were not realized; numerous studies of the use of telehealth during COVID have shown that while some care was substituted via telehealth instead of in-person, telehealth benefits did not lead to any significant volume of unnecessary care. Meanwhile, patients report satisfaction with easier access to medical providers.

Employers believe there are numerous changes Congress should consider to HDHPs, giving employers more flexibility to offer 1st-dollar coverage for high-value services. In particular, one easy change that closely aligns with the CARES Act's telehealth provision, would be to allow 1st-dollar coverage of worksite health centers. Many of these clinics have gone virtual during COVID, offering expanded care to beneficiaries in the region, even beyond those at the specific worksite where the clinic is physically located. But the telehealth provision should be one that Congress can easily act on, because it was previously approved in a strongly bipartisan manner.

If this provision from the CARES Act is allowed to expire, tens of millions of people will suddenly have a new barrier to getting mental and behavioral health care, that they don't have today. Congress should act as soon as possible to ensure that this does not take place.

[Questions submitted for the record and the responses by Dr. Moutier follow:]

April 23, 2021

Dr. Christine Yu Moutier, MD
Chief Medical Officer
American Foundation for Suicide Prevention
199 Water Street, 11th Floor
New York, NY 10038

Dear Dr. Moutier,

I would like to thank you for testifying at the April 15, 2021 Subcommittee on Health, Employment, Labor, and Pensions hearing entitled "*Meeting the Moment: Improving Access to Behavioral and Mental Health Care*."

Please find enclosed additional questions submitted by Committee members following the hearing. Please provide a written response no later than Friday, April 30, 2021, for inclusion in the official hearing record. Your responses should be sent to Mariah Mowbray and Daniel Foster of the Committee staff. They can be contacted at 202-225-3725 should you have any questions.

I appreciate your time and continued contribution to the work of the Committee.

Sincerely,

ROBERT C. "BOBBY" SCOTT
Chairman

Enclosure

Health, Employment, Labor, and Pensions Subcommittee Hearing
"*Meeting the Moment: Improving Access to Behavioral and Mental Health Care*"
Thursday, April 15, 2021
10:15 a.m. (Eastern Time)

Chairman Mark DeSaulnier (D – CA)

Even before the pandemic, there was a gap between the number of people who experience mental illness and those who seek out and are able to receive care. And for those that do seek care, there can be long delays before they receive treatment. What are some of the causes of delayed treatment and what are the consequences of delaying treatment until after the onset of mental health symptoms?

American Foundation for Suicide Prevention

April 30, 2020

The Honorable Robert Scott
Chairman
Education and Labor Committee
U.S. House of Representatives

The Honorable Mark DeSaulnier
Chairman
Health, Employment, Labor, and Pensions Subcommittee
U.S. House of Representatives

Dear Chairmen Scott and DeSaulnier,

Thank you for hosting the critically important Subcommittee hearing "*Meeting the Moment: Improving Access to Behavioral and Mental Health Care*" and for inviting me to testify and share the perspective of the American Foundation for Suicide Prevention.

I appreciate Chairman DeSaulnier's additional question for the record:

> "Even before the pandemic, there was a gap between the number of people who experience mental illness and those who seek out and are able to receive care. And for those that do seek care, there can be long delays before they receive treatment. What are some of the causes of delayed treatment and what are the consequences of delaying treatment until after the onset of mental health symptoms?"

Delays in receiving mental health treatment are unfortunately the norm[1] rather than the exception. There are many causes for significant delays in treatment - from discriminatory practices in workplaces[2] and schools, to mental healthcare workforce shortages, to lack of accessible, affordable, and culturally competent mental healthcare. Quite often, the public does not always know the signs of deterioration in mental health or what would warrant evaluation and consideration of treatment. Many individuals turn to their primary care provider or an emergency department, neither of which are not equipped to triage mental illness and refer to mental health providers. Boarding of psychiatric patients in emergency departments[3] has become a major concern for patient advocates and health professionals. Of those who die by suicide, 40% have been seen by primary care in the week prior to their death, but in most instances their mental health and suicide risk was not even detected during that visit, let alone addressed. Even when connections to treatment are made, insurance coverage for mental health needs is often problematic for the average American, as out of network costs can be prohibitive; and when providers are in-network or affordable, many providers are not taking new patients or the wait to be evaluated can be long, sometimes taking months.

---

[1] New Study Reveals Lack of Access as Root Cause for Mental Health Crisis in America (National Council for Behavioral Health, 2018): https://www.thenationalcouncil.org/press-releases/new-study-reveals-lack-of-access-as-root-cause-for-mental-health-crisis-in-america/
[2] Joint Statement: Supporting Clinician Health in the Post-COVID Pandemic Era (American College of Emergency Physicians, 2020): https://www.acep.org/globalassets/new-pdfs/ac_stmt_jsmh_physicians-mh_06202.pdf
[3] Emergency Department Crowding: High Impact Solutions (American College of Emergency Physicians, 2016): https://www.acep.org/globalassets/sites/acep/media/crowding/empc_crowding-ip_092016.pdf

American Foundation *for* Suicide Prevention

Many areas of the country face extreme geographical challenges, particularly in rural areas.[4] Few mental health providers take insurance or are on insurance panels and mental health professionals who take Medicaid and/or Medicare are in extremely short supply. There is an overall shortage of mental health professionals, especially mental health professionals who specialize in children/adolescents.[5] Compounding these challenges is the extreme shortage of culturally competent mental health professionals for communities from minoritized races/ethnicities and other marginalized communities such as LGBTQ populations. Without improvement in this area, many communities of color will continue to experience barriers for seeking mental health treatment while the rate of Black youth suicide is rising, exceeding that of white youth ages 5-11.[6]

During the Covid-19 pandemic, the CDC has been conducting a Household Pulse Survey[7] every several weeks, surveying 60,000-90,000 American adults about issues of health, mental health, and access to health care. In August 2020, 9.2% of American adults said they needed therapy but could not access it. By December 2020 that unfortunately rose to 12.4% of the American adult population reporting an inability to access mental health care. Pre-pandemic 2019 data from the CDC had demonstrated 4.3% of American adults could not access mental healthcare, so while telehealth services have provided greater access to care, the number of adults seeking mental healthcare rose and outpaced available services.

The consequences of delaying treatment are significant – individual suffering is prolonged, families are in anguish, and many feel desperate for professional guidance. Mental illness often worsens when symptoms are left untreated, developing into more severe symptoms and disability. Delaying treatment can worsen long term prognosis[8] because the brain becomes less amenable to treatment and improvement back to a healthy baseline when symptoms are left to worsen and set in. For example, for each recurrence of psychotic symptoms early in the course of schizophrenia[9] or bipolar disorder, the less likely treatment is to return the patient's mental health to a healthy baseline.

---

[4] Rural Mental Health Training: an Emerging Imperative to Address Health Disparities (Springer Link, 2018): https://link.springer.com/article/10.1007/s40596-018-1012-5

[5] Beyond A Bigger Workforce: Addressing the Shortage of Child and Adolescent Psychiatrists (Pediatrics Nationwide, 2020): https://pediatricsnationwide.org/2020/04/10/beyond-a-bigger-workforce-addressing-the-shortage-of-child-and-adolescent-psychiatrists/

[6] Ring the Alarm: The Crisis of Black Youth Suicide in America (Congressional Black Caucus, 2019): https://watsoncoleman.house.gov/uploadedfiles/full_taskforce_report.pdf

[7] Mental Health Care: Household Pulse Survey (National Center for Health Statistics, 2021): https://www.cdc.gov/nchs/covid19/pulse/mental-health-care.htm

[8] Early-Onset Bipolar Disorder and Treatment Delay are Risk Factors for Poor Outcome in Adulthood (National Library of Medicine, 2010): https://pubmed.ncbi.nlm.nih.gov/20667291/

[9] Relapse Duration, Treatment Intensity, and Brain Tissue Loss in Schizophrenia: A Prospective Longitudinal MRI Study (National Center for Biotechnology Information, 2013): https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3835590/

American Foundation for Suicide Prevention

The average length of time to receive treatment following the onset of symptoms for bipolar disorder is ten years.[10] During this period of time, individuals with bipolar disorder often suffer extreme consequences of their illness including occupational disability, financial ruin, and relationship loss. Suicide risk is most definitely increased when mental illness goes untreated[11] for periods of weeks, months, or years. The societal cost of mental illness[12] is enormous, financially, as well as emotionally for families, communities, workplaces, and schools.

I thank you for your dedication to investigating solutions to these critical mental health issues facing our communities across the nation. Enforcing mental health parity, educating the American public to increase mental health literacy, ensuring that discriminatory practices within healthcare, schools and other industries are eliminated, and increasing the numbers and cultural competency of the mental healthcare workforce are all key strategic solutions. We at the American Foundation for Suicide Prevention stand ready to work with you to continue this important work to increase access to mental health care.

Sincerely,

Christine Yu Moutier, M.D.
Chief Medical Officer
American Foundation for Suicide Prevention

[10] Exploring factors of diagnostic delay for patients with bipolar disorder: a population-based cohort study (BMC Psychiatry, 2020): https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-020-2483-y
[11] Suicide and psychiatric diagnosis: a worldwide perspective (National Center for Biotechnology Information, 2002): https://pubmed.ncbi.nlm.nih.gov/16946849/
[12] Scaling-up treatment of depression and anxiety: a global return on investment analysis (The Lancet Psychiatry, 2016): https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(16)30024-4/fulltext

[Whereupon, at 12:30 p.m., the subcommittee was adjourned.]

○