Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

I am writing on behalf of the National Association of Health Underwriters (NAHU), a professional association representing licensed health insurance agents, brokers, general agents, consultants and employee benefits specialists. The members of NAHU work daily to help millions of individuals and employers of all sizes purchase, administer and utilize health plans of all types. The health insurance agents and brokers that NAHU represents are a vital piece of the health insurance market and play an instrumental role in assisting employers and individual consumers select health plans that are best for them. These plans include coverage for mental and behavioral health benefits as is required by law. Eighty-two percent of all firms use a broker or consultant to assist in choosing a health plan for their employees[1] and eighty-four percent of people shopping for individual exchange plans found brokers helpful -- the highest rating for any group assisting consumers.[2]

We are pleased to have the opportunity to submit recommendations to the committee regarding your request for information on enhancing behavioral health care. These recommendations were put together with the help of NAHU's Mental Health Task Force, a legislative working group comprised of NAHU members with an advanced understanding of mental and behavioral health services and how they are provided and used in health plans.

Access to mental health services is a crucial component of health care. National discussion has addressed mental health care for years, but often focuses more on physical health. The COVID-19 pandemic has reminded us of the importance of adequate mental health care and exposed a mental health crisis: About 4 in 10 adults in the U.S. have reported symptoms of anxiety or depressive disorder, a share that has been largely consistent, up from one in ten adults who reported these symptoms from January to June 2019[3]. For these reasons it is more vital than ever that consumers can access and afford behavioral health services.

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) created standards for the financial requirements and treatment limitations that a group health plan or group health plan issuer may impose on mental health and substance use disorder (MHSUD) benefits. MHPAEA established those financial requirements (such as copayments, coinsurance) and treatment limitations (such as limits on the number of outpatient visits, or prior authorization requirements) cannot be more restrictive than those that apply to medical and surgical benefits. Regarding financial requirements or quantitative treatment limitations (such as the number of inpatient days covered), a plan cannot impose a requirement or limitation on MHSUD benefits that is more restrictive than what is imposed on two-thirds of the medical and surgical benefits in the same classification.

[1] Kaiser Family Foundation. Employee Health Benefits Annual Survey. October 2013.
[2] Blavin, Fredric, et al. Obtaining Information on Marketplace Health Plans: Websites Dominate but Key Groups Also Use Other Sources. Urban Institute. June 2014.
[3] Kaiser Family Foundation. Adults Reporting Symptoms of Anxiety or Depressive Disorder During COVID-19 Pandemic. 27 September 2021.

Most recently, the Consolidated Appropriations Act of 2021 mandates that employers offering medical, surgical, and mental health and substance use disorder coverage provide comparative analyses and relevant supporting documentation demonstrating compliance with mental health parity requirements to the Department of Labor upon request. Both fully insured and self-funded ERISA plan sponsors are required to comply with the quantitative treatment limits imposed by the Mental Health Parity Act. Complying with the new CAA mandates and in particular the non-quantitative treatment limits reporting is challenging for many employers, who, because of their size, must rely on their intermediaries such as third-party administrators to monitor and comply with network adequacy requirements for access to mental and behavioral health care. In the event of a Department of Labor request, these employers often will need to work with legal counsel to identify treatment limitations and contact multiple providers to request information necessary to complete comparative analyses. This makes compliance particularly difficult for employers who already face other compliance requirements relating to the plans they sponsor for employees. To assist employers in this regard, NAHU recommends that reporting requirements for ERISA plan sponsors be lessened by reducing the number of notices, as well as allowing disclosures to be made electronically.

NAHU also recommends that Congress look at easing certain regulatory burdens to allow employers to create new and innovative mental health benefits for their employees. Employers want their employees to experience the best possible physical and mental health. These healthy employees make the best workers and increase productivity in the workplace. Because each workforce, workplace and community are different and offer different challenges and opportunities, the lack of flexibility in meeting mental health parity requirements can make it difficult and cumbersome for employers to develop comprehensive mental health benefit programs, as there is concern that they could come in conflict with one of the many regulations in this area. NAHU recommends that employers be given greater flexibility to create new mental health benefit programs outside of the current benefits structure. While these benefits programs would still be subject to the ACA, MHPAEA, and other relevant statutes, the establishment of new stand-alone mental health benefit programs separate from group health plans would be of immense value for Americans seeking MHSUD services and could even be expanded to offer access to mental health care to employees who aren't eligible for the employer's health plan(s).

Another way in which Congress can improve Americans' access to mental and behavioral health services is by addressing the shortage of MHSUD providers. While attempts have been made to make improvements in this area, there is still a significant amount of ground to cover. 119 million Americans live in areas designated as "Mental Health Professional Shortage Areas." [4] Often it is difficult for patient to locate a provider that accepts insurance at all, much less participates in their insurer's network. If a provider does participate, that participation may not be consistent resulting in provider directory inadequacy. A survey of privately insured patients found that 53 percent of those that used provider directories found inaccuracies in their insurer's provider directory, often leading them to receive care from out-of-network providers.[5] Additionally, recent American Academy of Pediatrics data shows that there are, on average, just 9.75 child psychiatrists per 100,000 children, and child psychiatrists are disproportionately located in larger urban

[4] Kaiser Family Foundation. Mental Health Care Health Professional Shortage Areas (HPSAs). 30 September 2020.
[5] Busch, Susan, et al. Incorrect Provider Directories Associated with Out-Of-Network Mental Health Care and Outpatient Surprise Bills. *Health Affairs.* June 2020.

centers; more than two-thirds of U.S. counties don't have even a single child psychiatrist.[6] According to the Health Resources & Services Administration, an additional 6,586 providers would be needed to bridge the gap for consumers living in these shortage areas.[7] To enhance access to mental and behavioral health care, strengthening the mental health workforce must be a top priority. NAHU supports workforce development and training programs that aim to increase the amount of MHSUD professionals.

A further source of inefficiency impeding Americans' access to mental and behavioral health is the lack of communication between behavioral health and primary care providers. Since mental and behavioral health is often not integrated with primary care, this leaves patients with undiagnosed or poorly managed mental and behavioral health conditions, even though mental and behavioral health conditions often initially appear in a primary care setting. Currently, primary care clinicians provide mental health and substance use care to many people with mental and behavioral disorders and prescribe the majority of psychotropic medications. NAHU believes that a collaborative care model that incorporates behavioral health and primary care could significantly decrease the weight of other illness, lessen the demand for mental and behavioral health services, and thereby lower medical costs and reduce disparities in identification and the effectiveness of treatment for behavioral health issues. Collaborative care models such as Direct Primary Care arrangements and employer-run Accountable Care Organizations (ACOs) would also assist in improving collaboration between primary care and behavioral health providers.

Another vital area of discussion within the mental health space is tele-behavioral health (TBH). Due to the pandemic, rules related to all aspects of telehealth, including TBH, were loosened. This has resulted in immense increase in the use of tele-behavioral health services, enabling cross-state care which has been critical to underserved areas and rural communities. TBH has the potential to overcome patient stigma and improve access and efficiency of care for mental and behavioral health services.[8] 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 which could lead in a decrease in cost for treatment of an individual over the course of their care.

The Coronavirus Aid, Relief, and Economic Security Act created a telehealth safe harbor in high-deductible health plans (HDHPs), allowing a HDHP to cover telehealth and other remote care services without a deductible, or with a deductible below the minimum annual deductible otherwise required by law. Telehealth and other remote care services also are temporarily included as categories of coverage that are disregarded for the purpose of determining whether an individual who has other health plan coverage in addition to an HDHP is an eligible individual who may make tax-favored contributions to his or her health savings account. However, this safe harbor is set to expire at the end of 2021. To ensure that mental and behavioral health patients continue to be able to utilize TBH to the best of their ability, NAHU recommends that this safe harbor be extended permanently.

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[6] McBain, Ryan, et al. Growth and Distribution of Child Psychiatrists in the United States: 2007–2016. *American Academy of Pediatrics*.
[7] Health Resources and Services Administration. Shortage Areas.
[8] Rheuban, Karen. The role of telemedicine in fostering health-care innovations to address problems of access, specialty shortages and changing patient care needs. *Journal of Telemedicine and Telecare*. 1 September 2006.

Another way that Congress can ensure beneficiaries have greater access to TBH is by addressing inequities in telemedicine. There is still a "digital divide" between urban and rural areas that impedes upon rural consumers' ability to utilize telehealth. As of 2019, one in five rural adults say accessing high-speed Internet is a problem for their family, and without reliable, broadband high-speed Internet access, rural communities are unable to properly reap the benefits of telehealth expansion.[9] NAHU recommends looking at methods to eliminate this "digital divide" so that rural communities can better access all the advantages that come with TBH and telemedicine.

State licensure requirements and cross-state-border restrictions also remain some of the largest, most complex barriers within TBH and the telemedicine space broadly. Due to the COVID-19 pandemic CMS, along with a handful of states, decided to relax regulations around telehealth and state-licensure requirements, temporarily waiving requirements for licensure in the state where the patient was located. This added flexibility was of great benefit to patients across the country, particularly MHSUD consumers. For these reasons, NAHU recommends that Congress look at ways to facilitate reciprocity of state-provided licenses and other ways to ease cross-state-border restrictions on TBH and telehealth generally.

We appreciate the opportunity to provide these comments and would be pleased to respond to any additional questions or concerns of the committee. If you have any questions about our comments or if NAHU can be of assistance as you move forward, please do not hesitate to contact me at either (202) 595-0639 or jtrautwein@nahu.org.

Sincerely,

Janet Stokes Trautwein
CEO, National Association of Health Underwriters

[9] Neighmond, Patti. With Rural Health Care Stretched Thin, More Patients Turn to Telehealth. *NPR*. 7 July 2019.