To:

The United States Senate Committee on Finance
Committee on Finance
Washington, DC 20510 – 6200

From:

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Willis Towers Watson Mental Health RFI Response

Background:

Willis Towers Watson is submitting this response to the Mental Health RFI ("RFI") released by the U.S. Senate Finance Committee on September 21, 2021. The RFI requested input from stakeholders across the health continuum to help the committee better understand how Congress can address the challenges related to mental health and substance use disorders.

About Willis Towers Watson:

Willis Towers Watson is a leading global advisory, broking and solutions company that helps clients (employers/companies) around the world turn risk into a path for growth. We use our deep expertise, research, analytics, and resources across the full spectrum of health benefits to provide employers with strategic insights, innovative solutions and value for their business and employees.

Context for Willis Towers Watson's RFI Response:

Our RFI response reflects the predominant perspectives of our clients who offer health benefits (including mental health and substance use disorder coverage) to their employees. If requested, we welcome the opportunity to provide testimony and additional context to the committee.

Our response to the respective portions of the RFI starts below:

Strengthening Workforce:

The shortage of mental health providers places a significant barrier to access for employees and their families. Potential solutions to increase the supply of mental health providers include:

i. Allowing licensed mental health providers to provide counseling and therapy across state lines.
ii. Reimbursing mental health providers adequately to increase provider participation rates in insurance networks.

iii. Increasing the supply of mental health providers through scholarships and other means.
iv. Provider funds required for training and continuous education on evidence-based therapies to increase treatment efficacy.

Increasing Integration, Coordination and Access to Care

It is estimated that roughly 10% - 20% of the general population will consult a primary care provider (PCP) for a mental health issue; however, a troubling 30% - 50% of all patient referrals from primary care to a specialist mental health provider are declined by the patient.[1] Potential solutions to increase integration, coordination, and access to care include:

i. Increase incentives-based reimbursement for providers with higher rates of care coordination who participate in government health care programs (Medicare, Medicaid, TRICARE, SCHIP, VHA, IHS). Adoption of this standard by federally funded programs will move the commercial health care insurance companies (who administer employer-sponsored medical benefits for most companies) to adopt similar approaches.
ii. Create provider reimbursement incentives (through government-sponsored health plans) for PCP practices with over five practitioners to embed behavioral health professionals into their practice to deliver on-site or virtual care.

Ensuring Parity

Ninety three percent of employers say behavioral health is a priority over the next three years in the 2021 Willis Towers Watson Emerging from the Pandemic Survey.[2] Our experience is that most employers want to enhance mental health benefits and they support continued efforts to ensure mental health parity.

i. While employers are supportive of mental health parity, most will appreciate greater clarity from federal agencies regarding compliance requirements for the recent Consolidated Appropriations Act, 2021, (CAA) which amended the Mental Health Parity and Addiction Equity Act. For example:
    a. There is a perception that the specific CAA mental health parity expectations are only clear in retrospect after receipt of DOL audit requests. This makes it difficult for employers to ensure in advance that programs are fully compliant with CAA guidance.
    b. Self-funded employers leverage the networks and plan administration services of Third-Party Administrators (TPAs) or medical carriers – which means the employer's ability to ensure parity on Non-Quantitative Treatment Limits (NQTLs) primarily depends on their respective TPAs.
ii. The current parity guidance does not explicitly support employers who want to offer mental health/substance use disorder coverage that may be richer than medical/surgical. Some employers perceive current parity regulations as imposing not just the floor on benefits but also what is seen as the ceiling.
    a. As an example, this is explicitly seen with employers' inability to reduce out-of-pocket expenses for employees enrolled in High Deductible Health Plans with a Health Savings Account (HDHP with HSA). Mental health providers are more likely to be out-of-network and collect more than traditional medical providers for office visits. Employees enrolled in HDHP with HSA plans face significant out-of-pocket expenses for the cost of mental

health treatment before their deductible is met, and this deductible is often twice as high for care received from out of plan providers. Employers would like to ease that burden by providing additional subsidies for mental health visits. However, IRS rules on tax advantaged Health Savings Accounts and fears that treating mental health care more generously than other medical care may limit the ability to do so.

Expanding Telehealth

With nearly all employers already offering tele-behavioral services today (94%),[2] we have also witnessed a dramatic increase in the use of virtual care during the pandemic – with eight in 10 employees (79%) regarding virtual care as good as face-to-face consultations, and one in four (25%) rating it better.[3] Despite the encouraging increase in the adoption of telehealth, the following opportunities exist to expand telehealth access.

i. For instance, new and emerging Employee Assistance Programs (EAPs) emphasize a higher number of free therapy sessions (e.g., 15 – 25 sessions per user) and primarily provide care via telehealth. However, employers are hesitant to adopt some of these new solutions out of concern that the EAPs may no longer meet the definition and criteria of an "excepted benefit" as defined by IRS Notice 2013-54.[4] Therefore, employers need greater clarity from regulatory agencies or Congress on whether a high session limit EAP can remain an excepted benefit. To be clear, employers are generally supportive of providing an EAP therapy benefit (i.e., a free benefit) that treats people fully during their period of crisis. Today the "excepted benefit" definition without clarity, elaboration or exception, prevents many employers from offering a more robust benefit.

Improving Access for Children and Young People

The 2019 Youth Risk Behavior Survey[5] reported that

> *suicide is the second leading cause of death among high school-aged youths 14–18 years after unintentional injuries… During 2009–2019, prevalence of suicide attempts increased overall and among female, non-Hispanic white, non-Hispanic black, and 12th-grade students. Data from 2019 reflect substantial differences by demographics regarding suicidal ideation and behaviors. For example, during 2019, a total of 18.8% of students reported having seriously considered suicide, with prevalence estimates highest among females (24.1%); white non-Hispanic students (19.1%); students who reported having sex with persons of the same sex or with both sexes (54.2%); and students who identified as lesbian, gay, or bisexual (46.8%).*[5]

Less than half of the 7.7 million children in the United States with an identifiable mental health condition receive services from any mental health provider.[6] The US is currently facing a severe shortage of pediatric psychiatrists. The American Academy of Childhood and Adolescent Psychiatry states that we need to increase pediatric psychiatry by a factor of four. Also, that distribution is highly concentrated in urban areas leaving some pediatric patients with no regional access to behavioral health care. Counties in the United States with lower levels of income and education particularly struggle to meet demand.

We recommend the exploration of these potential solutions:

1. Growing the workforce to address shortages. Consider government initiatives that would repay student loans, offering a four-year residency program as an alternative to the typical 5-year postgraduate training program.
2. Reinstate the Health Education Assistance Loan (HEAL) program with loan forgiveness for psychiatrists serving in Mental Health Professional Shortage Areas.
3. Enhance reimbursements (as above) to better align with the complexity of working with a pediatric population, and the additional skills this entails.
4. Allow Pediatric Behavioral Health Providers to work across state lines
5. Subsidize the creation of integrated clinical and behavioral health systems, like the Collaborative Care Model for the Pediatric population.
6. Support funding for public school programs focused on behavioral health to remove stigma and encourage access of BH benefits.

Applied Behavioral Analysis (ABA)

As the awareness and diagnosis of Autism Spectrum Disorders (ASD) has risen in the US, we have expanded use of ABA therapies. About 1 in every 59 children is diagnosed with autism, according to the Centers for Disease Control and Prevention, up from 1 in very 150 in 2000. Within the past 2 years limits on ABA therapies by patient age, or time of diagnosis have been lifted as the clinical evidence mounts that regardless of age diagnosed or length of treatment, pediatric members may continue to show benefit from ABA therapies.

A new study shows that there is a shortage in ABA therapists[7]. So, diagnoses are increasing, benefit coverage is expanding, the Affordable Care Act ensures ASD treatment is affordable for patients, and yet we have again, an issue of provider scarcity.

We recommend the exploration of these potential solutions:

1. Support the creation of telehealth guided ABA therapies.
    a. The creation of coding and billing arrangements for such therapies (as has been done during COVID).
2. Fund the creation of national support groups for families and caregivers who can share resources and information for internal support.

Thanks for your consideration.

Sources:

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2. Willis Towers Watson; Emerging from the Pandemic Survey (U.S.); 2021. Available from: https://www.willistowerswatson.com/en-US/Insights/2021/02/2021-emerging-from-the-pandemic-survey

3. Willis Towers Watson; Global Benefits Attitudes Survey (U.S.); 2020. Available from: https://www.willistowerswatson.com/en-US/Insights/2021/02/2020-global-benefits-attitudes-survey

4. See IRS Notice 2013–54 (available at http://www.irs.gov/pub/irs-drop/n-13-54.pdf) and DOL Technical Release 2013–03 (available at http://www.dol.gov/ebsa/newsroom/tr13-03.html), Q&A 9. See also CMS Insurance Standards Bulletin–Application of Affordable Care Act Provisions to Certain Healthcare Arrangements (available at http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/cms-hra-notice-9-16-2013.pdf)

5. Suicidal Ideation and Behaviors Among High School Students — Youth Risk Behavior Survey, United States, 2019. MMWR Suppl 2020;69(Suppl-1):47–55. DOI: http://dx.doi.org/10.15585/mmwr.su6901a6

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