Questions and Answers for the Record for Tracy Watts

HELP Subcommittee Hearing

"Reducing Health Care Costs for Working Americans and Their Families"

April 26, 2023

10:15 a.m.

What actions have employers taken to comply with the Mental Health Parity and Addiction Equity Act?

In accordance with the requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA), fully-insured and self-funded group health plans continue to take steps to ensure that if the plan covers mental health and substance abuse disorder benefits, it does so in parity with medical/surgical benefits covered under the plan. The numerous and complicated MHPAEA compliance rules include two key testing and evaluation requirements: (i) financial/quantitative treatment limitation testing, and (ii) non-quantitative treatment limitation (NQTL) comparative analysis. Employers that sponsor fully-insured group health plans typically rely on their carriers to ensure compliance with the parity rules as the carriers themselves are subject to the same MHPAEA rules.

Where the plan is self-funded, this generally results in the MHPAEA rules applying directly to the self-funded plan versus the third-party administrator (TPA) that generally administers the plan. Similar to fully-insured plans, employers tend to rely on their TPAs to ensure MHPAEA compliance as the TPAs are often selling benefit designs and related administrative services to employers seeking to sponsor a self-funded plan. Some of the challenges self-funded group health plans face demonstrating compliance with MHPAEA include:

- ***Financial/quantitative treatment limitation testing.*** Many plan sponsors do not have the expertise and/or data needed and must rely on third parties (e.g., third party administrators) to conduct the testing. The methodology used to conduct this testing varies significantly and most TPAs do not use plan level data because they deem the plan level data to not be credible.
- ***NQTL comparative analysis.***
    - TPAs are the entities that implement and administer most of the NQTLs in a plan and they often are the only entities that have the relevant information that must be included in a comparative analysis report.
    - The level of detail and support that TPAs are willing to provide with regard to these NQTLs varies amongst TPAs and employers can only access what TPAs are willing to share.
    - Plan sponsors generally have no way of validating or verifying the information pertaining to most NQTLs provided by the TPA.
    - The enforcing agencies (HHS/CMS, DOL/EBSA, Treasury/IRS) – despite issuing numerous MHPAEA rules and sub-regulatory guidance – have yet to clearly articulate the type and level of detail that must be included in the comparative analysis documentation for it to be deemed "sufficient" [1].

- Enforcement by DOL can be via the National Office and/or regional offices and there are instances where the same plan design/administration will be reviewed by separate offices as part of an audit/investigation, with the offices finding different levels of compliance.
- Due to the lack of prescriptive guidance from the enforcing agencies, inconsistent enforcement/audit standards across the DOL offices and the fact that almost all of the relevant information generally can only be accessed from TPAs that may not be willing to disclose such information, self-funded plan sponsors may not be able to produce a comprehensive NQTL comparative analysis that will be deemed "sufficient" by DOL/CMS despite a plan sponsor's best efforts – including engaging expert counsel – to ensure compliance with MHPAEA requirements.

1. During 2021, the Department of Labor (DOL) requested NQTL comparative analyses from more than 150 plans and issuers. Requests from the Centers for Medicare and Medicaid Services (CMS) went to four nonfederal governmental plans and nine issuers. In their 2022 MHPAEA Report to Congress regulators noted that all of the comparative analyses were insufficient when first received.

What actions have employers taken to enhance access to mental health benefits for employees and their families? What have the results been?

It is well documented that seeking out behavioral health services has historically been stigmatized, causing people to forego care due to feelings of shame or embarrassment. Over the past two years, however, demand for care has been steadily climbing. An analysis of data in MercerFOCUS, which warehouses the claims of over 1 million health plan members, found a substantial increase in the number of people accessing outpatient behavioral health services – from 73 members/1,000 in 2019 to 83 members/1,000 in 2021. It is particularly interesting that telemedicine visits for behavioral health care – essentially non-existent prior to the pandemic – were utilized by 39 members/1,000 in 2021.

Mercer's Survey on Health and Benefits Strategies for 2024 asked employers to rate the effectiveness of actions they have taken within the past few years to increase behavioral healthcare utilization and create a work environment that is supportive of mental and emotional health. Enhancing or expanding the EAP was the most common action taken — over two-thirds of survey respondents have enhanced their EAP services. The majority of employers that have recently enhanced their EAP services believe that doing so has been effective or very effective (59%). The top-rated action was adding a supplemental provider network for virtual or in-person care, which directly addresses the shortage of behavioral health providers and makes it easier for people to get care when they need it. About two-fifths of employers surveyed have added a supplemental network within the past few years; of those, 69% say it has been an effective or very effective strategy.

Effectiveness of actions taken to increase behavioral healthcare utilization or create a more supportive environment

			Of those taking action:	
		Have taken this action within the past 3 years	Has been effective or very effective	Has been fairly effective
1	Added supplemental network for virtual or in-person care	42%	69%	22%
2	Enhanced or expanded EAP	69%	59%	25%
3	Took steps to increase screenings for mental health and/or substance abuse	19%	58%	33%
4	Manager training in recognizing BH issues and steering to resources	36%	49%	30%
5	Conducted campaign to reduce stigma and encourage use of BH resources	49%	46%	33%
6	Added digital or in-person resources for managing stress/building resiliency	58%	44%	29%

Employers with 500 or more employees

Mercer

Mercer Survey on Health & Benefit Strategies for 2024

Would allowing employers to offer telehealth as an excepted benefit result in employers substituting telehealth-only benefits for a comprehensive health plan? Why or why not?

The ACA requires large employers (i.e., employers that average at least 50 full-time and full-time equivalent employees per month in the past calendar year) to offer affordable health coverage that provides "minimum value" to at least 95% of its ACA full-time employees (i.e., those working, on average, 30 or more hours per week) or potentially be subject to a shared responsibility penalty. An "eligible employer-sponsored plan" provides minimum value if the plan covers at least 60 percent of the total cost of medical services for a standard population and includes substantial coverage of physician and inpatient hospital services. Because stand-alone telehealth benefits will not meet the "minimum value" criteria under the ACA, large employers that substituted such benefits for comprehensive health plans could expose themselves to large penalties. In our experience, employers offer comprehensive medical benefits in order to recruit and retain employees, and comply with the ACA's employer-shared responsibility requirements.

At the April 26 hearing, one of the witnesses expressed concerns that individuals would confuse telehealth-only benefits with major medical coverage. Do you share this concern? Why or why not?

Have not seen any evidence to support this concern. In our experience, enrollment communications are very clear on what is covered by the program, how the programs works, including caveats regarding what is not covered. Also, after enrollment, employers typically continue to communicate to plan members about the program – encouraging them to set up an on-line account and reminding them how the benefit can be used. Even the name – telehealth, virtual care, etc. – specifies the type of care.

Increased access to telehealth has transformed the way mental health professionals deliver care. How can establishing a stand-alone telehealth excepted benefit through ERISA help workers struggling with mental health conditions? Why is it important to act in light of the public health emergency ending on May 11?

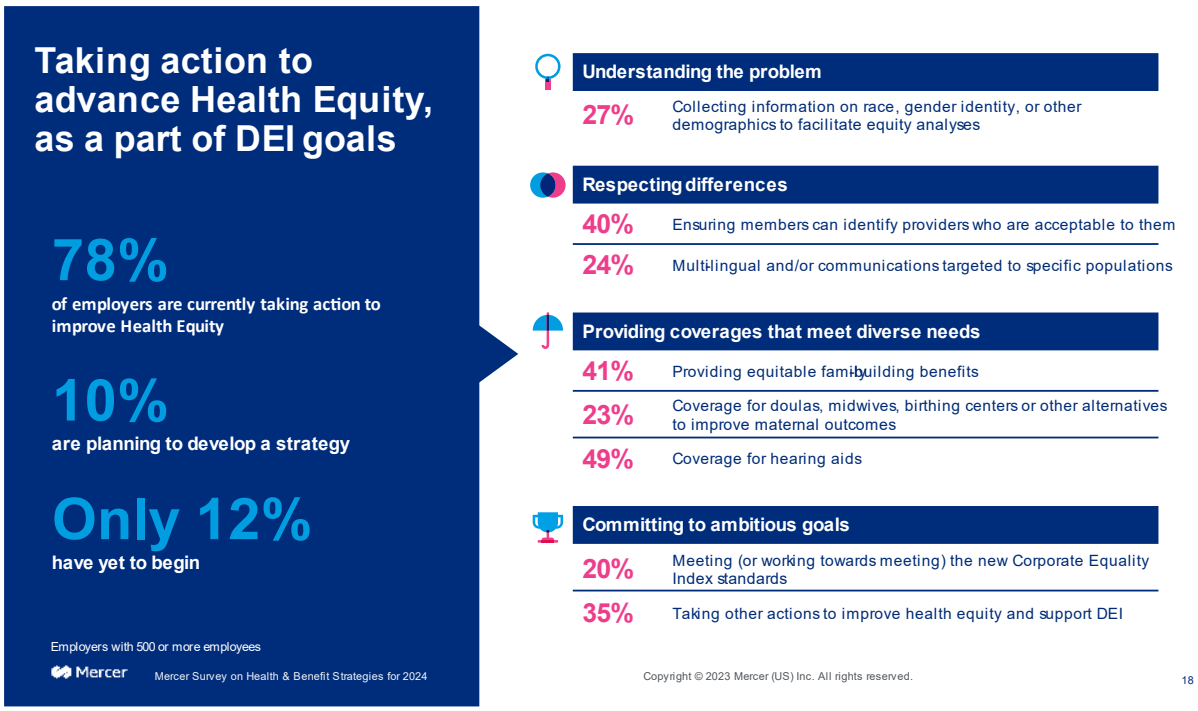
Telehealth, when offered as an excepted benefit, meets a very specific need for certain employers with large numbers of employees who are not benefit eligible – mostly part-time workers in retail, hospitality and healthcare. Because of legislative uncertainty, we saw a decline in employers using this strategy to 7% in 2023, down from 17% in 2022. This is a benefit that is valued by workers – but employers need permanent legislation for this coverage to be restored. As an example, we work with a large restaurant chain that extended telehealth to its part-time population. They view the telehealth benefit as a critical way to provide access to behavioral health services and appropriate medication when an employee who is not enrolled in the health plan gets sick.

Can you discuss why it's so important for employer-sponsored health plans to recognize and address the diverse needs of populations, particularly people of color and members of the LGBTQ population?

The existence of health disparities in the US carries significant business implications for employment. These implications include increased healthcare costs, reduced productivity, higher absenteeism rates, and challenges in attracting and retaining diverse and talented workforce The 2018 economic burden of racial and ethnic health disparities in the US was estimated at $451 billion. Given that employers provide health care benefits for approximately 50% of the American population, they have an opportunity to not only address unmet needs of employees, but to reduce costs for their organization and employees.

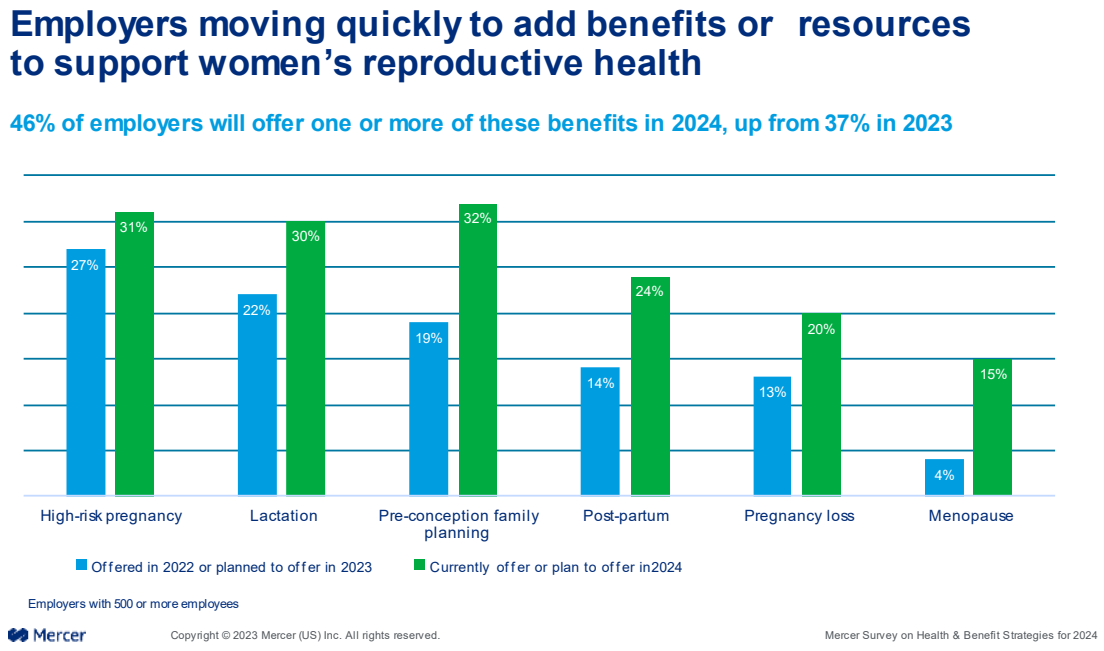
Our research over the past few years has tracked the ways employers are working to align employee benefit programs with their organizations' overarching DEI goals. For Pride month, we put together a round-up of survey results – Health benefits that matter to the LGBTQ+ community: By the numbers – relating to health and well-being benefits of particular importance to the LGBTQ+ community.

Here is a summary of what employers are doing to advance health equity from Mercer's Survey on Health and Benefits Strategies for 2024.



Can you discuss the importance of comprehensive reproductive health care for women, particularly women of color?

Female reproductive health is a big focus area for benefits leaders and companies driven by the impact of the *Dobbs* decision, the spotlight the pandemic put on health disparities and health equity, and the fact that the U.S. sadly underperforms on maternal health issues compared to other high income countries.



Black mothers in the US face disproportionate challenges and adverse outcomes of pregnancy and childbirth. Black women have a 2.9 times higher maternal mortality rate than white women. It's crucial that we shine a light on the issues and explore potential solutions to address these disparities. One example in which employers are addressing black maternal health is by expanding medical benefits to include doula support. Black women are more likely than their white counterparts to want a doula. Studies have indicated that the presence of a doula during childbirth can reduce the likelihood of intervention such as C sections and epidurals. Doulas have been shown to have a positive impact on birth outcomes, particularly for Black mothers. And furthermore, doula support is associated with higher maternal satisfaction with the birth experience. Additionally, some employers are choosing to ensure benefits include access to alternative forms of birthing support or birthing centers. This is an example of how employers are being intentional in their approach to advance health equity.