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The Honorable Mariannette J. Miller-Meeks, M.D.
The Honorable Mike Kelly
The Honorable H. Morgan Griffith

Congress of the United States
Washington, DC 20515

Submitted via: Kendyl.Wilcox@mail.house.gov

March 4, 2022

Subject: Request for information regarding the utilization of wearable technologies, the expansion of telemedicine and the digital modernization efforts in the US healthcare system

Dear Dr. Miller-Meeks, Mr. Kelly and Mr. Griffith:

Mercer welcomes the opportunity to provide input to the Modernization Subcommittee of the Healthy Future Task Force in the US House of Representatives on the expansion of telemedicine and the digital modernization efforts in the US healthcare system.[1]

Mercer provides healthcare and group benefits consulting, brokering, and actuarial services to approximately 3,000 US companies – of all sizes with varying employee demographics – sponsoring healthcare benefits for approximately 38 million American workers and family members. Mercer is a business of Marsh McLennan (NYSE: MMC), the world's leading professional services firm in the areas of risk, strategy and people, with 81,000 colleagues and annual revenue of over $19 billion.

Private sector employers provide healthcare benefits to approximately half of the US population.[2] In aggregate they spent $521.3 billion just in the form of contributions for health insurance premiums in 2020.[3]

The unique and urgent demands of the COVID-19 pandemic have accelerated the use of telehealth and expanded novel care models based in telehealth (such as the hospital-at home), all of which have proven to be a crucial resource in making healthcare available. The ability for

[1] Many of our responses are drawn from our collaboration with the American Benefits Council and Catalyst for Payment Reform on a white paper and infographic, *Telemedicine in the Post-COVID-19 World*, that was drafted to raise awareness of how telemedicine has evolved and offering suggestions for both employers and policymakers on how to best leverage telemedicine to support employer-sponsored health program strategies.

[2] U.S. Census Bureau, Health Insurance Coverage in the United States: 2020.

[3] CMS National Health Expenditure Data, NHE Fact Sheet, Table 5-1 Private Business Sponsor Expenditures: Calendar Years 1987 – 2020.

patients to access care and for providers to provide care remotely helped to reduce transmission, preserve personal protective equipment (PPE), and allow continuity of care. Additionally, the pandemic exposed – in the harshest possible light – disparities in health and health outcomes that have long existed. Telehealth has demonstrated it can be an important tool in addressing these disparities by improving access to care and health outcomes.

Both Mercer and its employer clients are committed to improving healthcare quality, affordability and accessibility for US workers and their families. We believe that the expansion of telehealth is an important component of that effort as discussed in our responses below.

Permanently revive and extend telehealth flexibilities created under the COVID-19 Public Health Emergency

Mercer and numerous stakeholder groups are urging Congress to address the expiration of pandemic-related relief allowing HSA-qualifying high-deductible health plans (HDHPs) to cover telehealth, telebehavioral healthcare[4] and other remote care services on a pre-deductible basis.[5] The relief – provided in the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) – permitted HSA-qualifying HDHPs to cover telehealth and other remote care services before individuals satisfied their deductible, without jeopardizing their eligibility to make or receive HSA contributions. Similarly, an otherwise HSA-eligible individual could receive coverage for telehealth and other remote care services from a stand-alone vendor outside of the HDHP before satisfying the HDHP statutory minimum annual deductible and remain eligible to make or receive HSA contributions. Unlike some other pandemic-related flexibilities provided to health plans, this relief was not tied to the ongoing public health emergency or national emergency, and expired at the end of the plan year that began in 2021 (e.g., Dec. 31, 2021 for calendar-year plans).

In addition, Mercer and employer groups are asking Congress to make permanent and expand the temporary telehealth policy provided by regulators during the ongoing public health emergency that allows telehealth and remote care services to be treated as an excepted benefit, and thus avoid having to comply with many ERISA and ACA group health plan mandates (e.g., first-dollar coverage of ACA-mandated preventive care, out-of-pocket maximums, prohibition on annual and lifetime dollar limits for essential health benefits). Under the temporary policy, employers can offer excepted telehealth arrangements to employees and their families who are not eligible for any other group health plan coverage offered by that

[4] An important component of employers' strategies to address mental health channels during the pandemic was allowing first dollar coverage to telebehavioral healthcare for those enrolled in an HSA-qualifying HDHP. The expiration of this relief set employers' behavioral health strategies back.

[5] Alliance for Connected Care, Letter to Congressional Leaders urging Congress to reinstate virtual care access for individuals with HDHP-HSAs, January 21, 2022, https://connectwithcare.org/more-than-100-organizations-urge-congress-to-reinstate-virtual-care-access-for-individuals-with-hdhp-hsas/.

employer.[6] This population often includes part-time or seasonal workers. We encourage Congress to make this relief permanent, and to extend excepted benefit status to telehealth programs, regardless of the population it aims to cover.

Remove state barriers to telehealth care

Mercer recommends that Congress remove a thicket of state barriers to telehealth, including a requirement in many states that the patient and provider reside in the same state, limiting telehealth to specific technologies, and requiring that patients have a pre-existing relationship with the provider. In addition, Mercer urges Congress to reject any mandates relating to telehealth that would impede employers' flexibility to innovate and pursue value-based care. Pending legislation would, for example, require ERISA health plans and insurers to cover telehealth services for any service that is covered in person, as well as mandate that payment for those services be the same whether provided via telehealth or in person. (We discuss payment parity in more detail below.)

Removing barriers to telehealth could greatly improve access for individuals in underserved locations, while also giving more flexilibity to employers and health systems to expand healthcare offerings. Here are a few examples:

- **Behavioral health.** Telebehavioral healthcare – virtual behavioral health coaching, therapy, and psychiatry – addresses longstanding access issues and navigation challenges seen with in-person behavioral healthcare. It is also destigmatizing in nature, in that people receive care in the privacy of their homes without the need to get to and from a physical office space. A growing body of literature indicates that telebehavioral health is in fact working. Some studies suggest that it is just as effective as in-person care and that retention rates are higher.[7] Easing state barriers to telebehavioral healthcare could provide a lifeline to the many Americans who are experiencing greater depression, anxiety, stress, burnout, and substance use.
- **On-site clinics.** Multi-state employers who offer an on-site clinic[8] for populations in one location have historically been prohibited from allowing clinic providers to provide telehealth services to patients in a different state. During the pandemic, worksite clinics ramped up

[6] FAQs About Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation Part 43, Q/A #14 , https://www.cms.gov/files/document/FFCRA-Part-43-FAQs.pdf#at-home.

[7] American Psychological Association, How well is telepsychology working?, July 1, 2020, https://www.apa.org/monitor/2020/07/cover-telepsychology,

[8] Thirty-one percent of all US employers with 5,000 or more employees offer an on-site clinic. Mercer's Survey of Employer-Sponsored Health Plans, https://www.mercer.us/what-we-do/health-and-benefits/strategy-and-transformation/mercer-national-survey-benefit-trends.html.

virtual care offerings[9] and use of clinic-based telehealth expanded significantly.[10] Going forward, worksite health services remain the most direct way for employers to influence healthcare delivery and provide convenient, quality services to employees and their families. Employers have found that worksite clinics can be an asset in a healthcare strategy that seeks to make healthcare more affordable (by providing low-cost or free primary care[11]) and more cost-effective (by steering patients to value-based providers in the community). When designed and managed correctly, a worksite clinic can deliver high value to both employer[12] and employee. Removing telehealth requirements that patient and provider reside in the same state would allow multi-state employers to expand access to these high-value services.

- **Expand access for underserved populations.** Legislative and regulatory changes have expanded access to telehealth to many across the country. However, for those living in many rural and underserved areas, the lack of broadband connectivity and access to the right technology remains an impediment to expanding telehealth coverage. Addressing these technology-related barriers would be an enormous help for Americans who struggle to access healthcare due to provider shortages,[13] healthcare facility closures and travel time and expenses. Allowing patients to more easily receive telehealth services could open up access to a network of high quality providers that wasn't previously accessible.

Mercer encourages Congress and policymakers to issue laws and regulations that eliminate state barriers to care. The current patchwork of state laws restricts access to high-quality, high-value healthcare. We are aligned with the policy proposals being advanced by the American Benefits Council and the principles for model legislation[14] proposed by The ERISA Industry Committee (ERIC) that includes the following, in part:

- Apply the same standard of care to in-person visits and telehealth visits,

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[9] Specialty services offered via telehealth by our survey respondents include behavioral healthcare (30%), disease management (54%), lifestyle management (44%), and physical therapy (10%). 2021 Worksite Health Centers Study, https://www.mercer.us/what-we-do/health-and-benefits/strategy-and-transformation/worksite-health-center-2021.html.

[10] The majority of employers (65%) responding to our 2021 Worksite Health Centers Study, reacted to COVID-19 by expanding access to virtual care. The use of clinic-based telehealth expanded significantly, rising to 78% in 2021 from just 21% in 2018.

[11] Existing IRS rules governing health savings accounts can pose challenges for worksite clinic sponsors who offer and would like to expand virtual care services to employees that elect an HSA-eligible health plan. Although the rules are less than crystal clear, current IRS guidance states that having access to a worksite health clinic that provides significant medical benefits for free or at a reduced cost may prevent an employee from making or receiving HSA contributions. Since both HSAs and worksite clinics are seen as positive ways to control healthcare spending, Mercer supports legislative efforts that would make it easier for employers to offer both HSAs and worksite clinics.

[12] Among those that have measured ROI, 43% of respondents reported an ROI of 1.5:1 or greater and 31% reported an ROI of 2:1 or greater. 2021 Worksite Health Centers Study.

[13] Over the next five years 21% of family medicine, pediatric and OB/GYN, and other primary care physicians will move into retirement age. Yet, demand for primary care physicians will grow by over 4% during the same time period. There will be a 10% increase in demand for mental health workers by 2026. During this time, 400,000 are anticipated to leave the occupation entirely, resulting in twenty-seven states that will be unable to meet hiring demands for skilled and semi-skilled mental health workers. Mercer's 2021 External Healthcare Labor Market Analysis, https://www.mercer.us/content/dam/mercer/assets/content-images/north-america/united-states/us-healthcare-news/us-2021-healthcare-labor-market-whitepaper.pdf.

[14] The ERISA Industry Committee, Telehealth Model Legislation, https://www.eric.org/uploads/doc/health/Updated%20Telehealth%20Model%20Legislation%20-%20Handout_Feb%2014%202017.pdf.

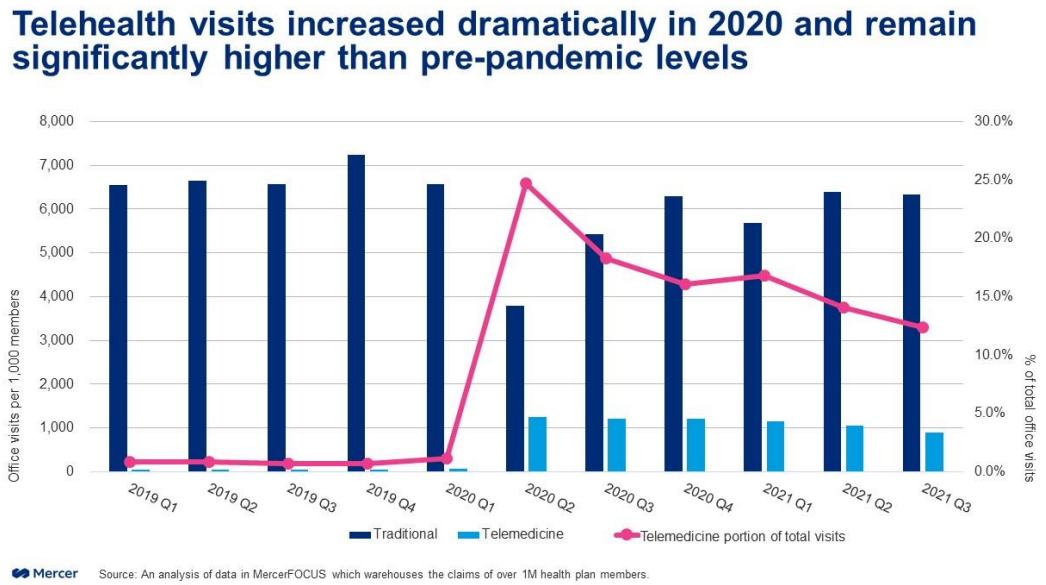
- Allow prescribing via telehealth,
- Do not require reimbursement for telehealth visits to be at the same rate as reimbursement for in-person visits, and
- Apply the same informed consent requirements to in-person visits and telehealth visits.

ERIC's principles for model legislation call for encouraging interstate practice among providers, including recognizing reciprocity for out of state providers and signed interstate compacts that do the same. The most level path to addressing both interstate licensure and multiple jurisdiction licensures would be to have a federal licensing rule immediately usable anywhere in the US, specifically for telehealth. We believe that addressing these current telehealth barriers has the potential to improve access to high-quality, affordable healthcare for all Americans.

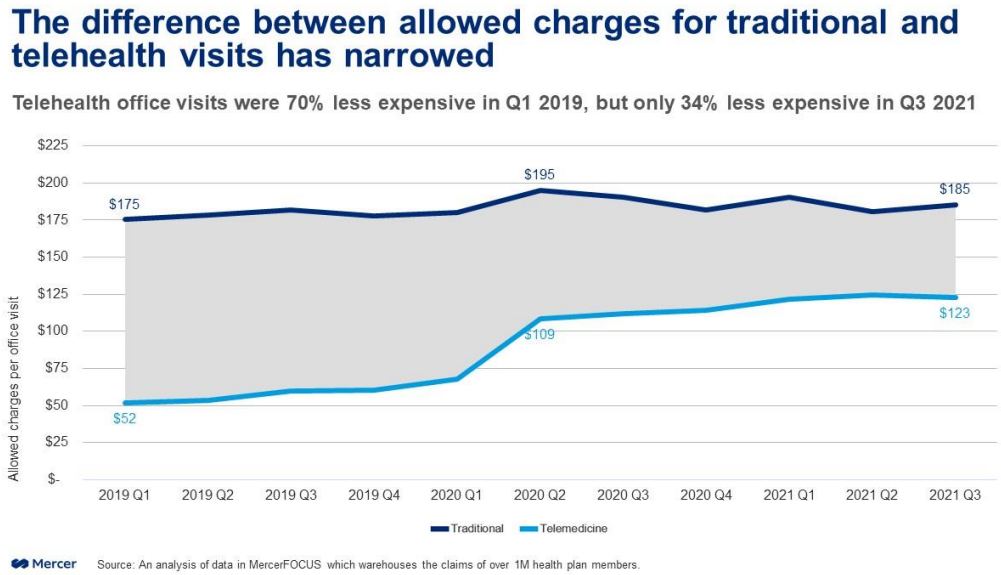
Reject mandates that would require parity in payments

Congress and the Centers for Medicare and Medicaid Services have set reimbursement for virtual care visits at the same rate as for in-person visits. While this may have been necessary to support the need for providers to quickly ramp up virtual services, it is not sustainable over the long term. If virtual visits continue to be billed at the same rate as in-person visits, not only will we fail to realize savings from virtual care, but total healthcare spending will rise.

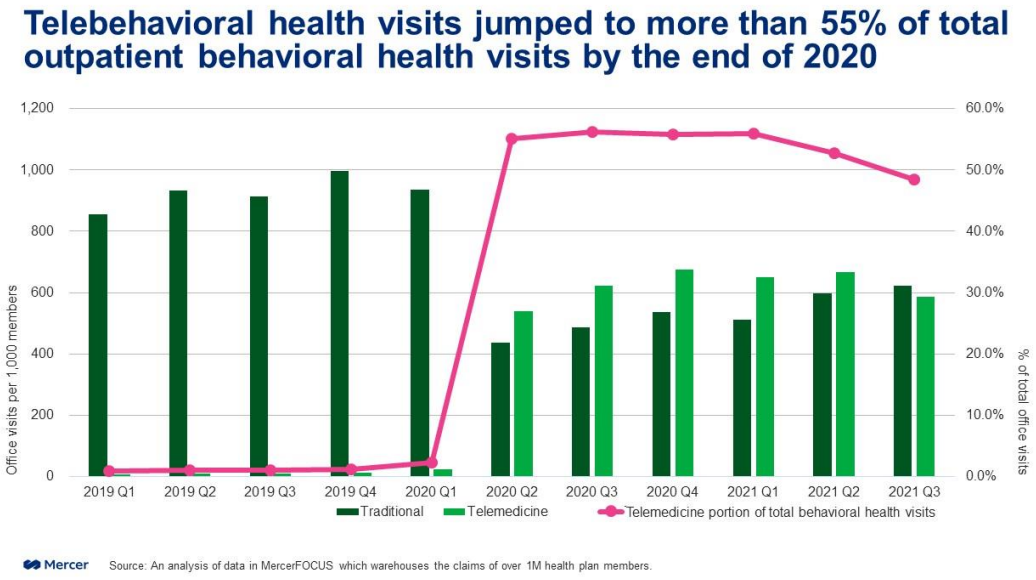
An analysis of data in MercerFOCUS, which warehouses the claims of over one million health plan members, found office visits fell dramatically in Q2 2020, but rebounded to fairly typical levels by Q3 2020. Beginning in Q2 2020, telehealth visits increased dramatically from less than 1% of total office visits to almost 25%. Although telehealth visits peaked in Q2 of 2020, they remain significantly higher than pre-pandemic levels.



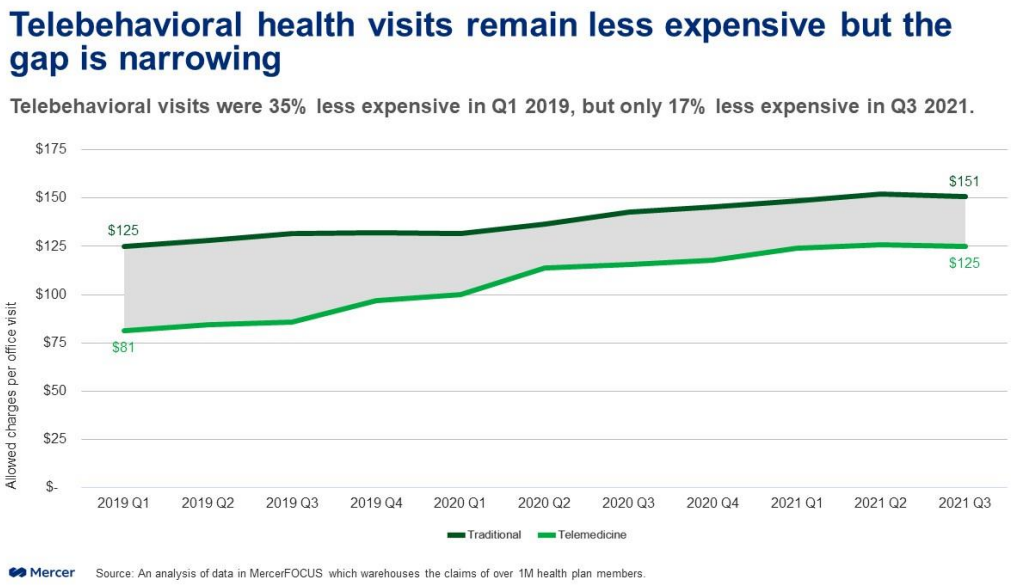
Overall, allowed charges for office visits remained stable through the time period, with costs for both traditional and telehealth increasing. The difference between traditional and telehealth office visits has narrowed – they were 70% less expensive in Q1 2019, but only 34% less expensive in Q3 of 2021.



Our analysis found that that the portion of total outpatient behavioral healthcare encounters conducted via telebehavioral health jumped from just 1% in 2019 to more than 55% by the end of 2020. We did see a slight decline in 2021, but in Q3 that number was still over 48%. This stunning change is a result of both a decrease in traditional behavioral health office visits and an increase in telebehavioral health visits.



From a cost perspective, telebehavioral health visits remain less expensive than traditional, although the gap is narrowing from 35% less expensive in Q1 2019 down to 17% less expensive in Q3 of 2021 – a similar result as seen above for overall telehealth office visit costs.



As we're starting to see the costs of telehealth visits increase, we urge Congress and policymakers to reject mandates that would require parity in payments to providers for virtual and in-person services and thereby impede employers' flexibility to innovate and pursue value-based care. Some considerations:

- While virtual care requires physician practices to expand the ways that they provide care, it does not require the costly infrastructure of brick-and-mortar facilities, and typically, less work is required of a doctor and staff because the patient is not physically present. Virtual care does not typically justify equal payment.
- Existing medical codes reimburse a provider for performing a whole range of services that may occur in an office setting, including a physical examination. Using these existing codes for virtual care may result in payment for services that a provider cannot perform virtually.
- It is important to keep in mind that Medicare reimbursement is much lower than reimbursement to providers for patients covered in the commercial market. Health policy designed for Medicare may result in cost shifting to the commercial market.
- The greater ease and convenience of virtual care – for both the provider and patient – make it likely that virtual visits will not substitute for some in-person visits on a one-to-one basis, but rather that the combined number of virtual and in-person visits will increase.

Unlock the value of telehealth

Mercer's Health on Demand[15] research shows that 72% of employees used telehealth or other types of virtual care (e.g., virtually-assisted physical therapy, video chats with a diabetes coach) during the pandemic and 8 of 10 of those employees plan to continue to use it after the pandemic. In the ongoing shift to more virtual modes of working and conducting business, it is natural employees would expect those efficiencies to translate into healthcare delivery.

Visionary plan sponsors, health plans and provider organizations see telehealth and virtual care as a promising new development in improving the delivery and quality of healthcare. A hybrid model that creates a virtuous cycle – more virtual care, balanced with the appropriate level of in-person care – leading to better outcomes, lower healthcare costs, and greatly improve monitoring patients with chronic conditions would generate greater value to both the plan sponsor and to the patient.

Virtual healthcare often encompasses new capabilities like artificial intelligence (AI) triage to screen symptoms and direct a patient to a care access point or to self-care. We view AI as a powerful tool that can combine large data sets, reduce inefficiences and improve health outcomes. However, AI must be used responsibly to avoid increased racial and gender-based bias in healthcare. We believe the following risks must be properly managed:

- **Diversity and bias.** AI works with data that has been influenced by humans for years and reflects human biases. Machine-learning programs that use and analyze this data ultimately make decisions or produce outputs that will reflect those biases. One way to address this unintended consequence is to work with a more diverse field of AI experts. While more women and people of color have begun working in AI, there is still a long way to go. In addition,there are biases built into the data collected. Most of the data we have comes from those who access care the most. This may further health disparities, since people of color receive less specialty medical care than whites.[16] In addition, there is more data about people who are sick (e.g. ICU patients) than on people who are healthy. This could also influence outcomes. Better data is needed to ensure unbiased AI.
- **Ethics.** Ethical considerations must be paramount in all healthcare AI initiatives to ensure patient privacy, confidentiality, and safety are not compromised. Importantly, liability for AI mistakes has not yet been established – does it fall on the provider, the developer, or both?

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[15] The survey captures what employees want from their employer when it comes to the personalization and delivery of health and well-being solutions. The survey was conducted across Asia, Latin America, Europe, the US and Canada, including representative samples of 14,096 adult employees aged 18-64 years. https://www.mercer.com/content/dam/mercer/attachments/private/gl-2021-mmb-health-on-demand-global-report.pdf.

[16] Cai C, Gaffney A, McGregor A, et al. Racial and Ethnic Disparities in Outpatient Visit Rates Across 29 Specialties. JAMA Intern Med. 2021;181(11):1525–1527. doi:10.1001/jamainternmed.2021.3771

This open question along with issues about bias in the data could hamper trust in AI-operated systems.

- **Transparency.** Clinicians must have transparency into the process that AI uses to make decisions and recommendations; but since AI-influenced processes are ever-evolving and learning, continuous education is both necessary and challenging.

Just as virtual visits can replace some office visits, healthcare AI can replace some virtual visits. Finding the right balance will be the key to unlocking the value of virtual care.

The pandemic has made it clear that we would all benefit from having healthcare resources that can meet the needs of our communities in a crisis. We need planning, connectivity and a ready capacity. Telehealth and virtual care can play a vital role in expanding primary care access and building a stronger, more resilient healthcare system – but only if all stakeholders treat it as a means to reduce healthcare spending, increase value and drive better health and only if we have laws and regulations that enable those outcomes.

We would be more than happy to participate directly in any further conversation on this topic, or answer any questions that you may have.

Sincerely,

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