NATIONAL CONFERENCE OF INSURANCE LEGISLATORS
HEALTH, LONG-TERM CARE & HEALTH RETIREMENT ISSUES COMMITTEE
CHARLESTON, SOUTH CAROLINA
FEBRUARY 27, 2015
MINUTES

The National Conference of Insurance Legislators (NCOIL) Health, Long-Term Care & Health Retirement Issues Committee met at the Mills House Wyndham Grand Hotel in Charleston, South Carolina, on Friday, February 27, 2015, at 10:00 a.m.

Assem. Kevin Cahill of New York, Chair of the Committee, presided.

Other members of the Committee present were:
Rep. Ron Crimm, KY
Sen. Joseph Fischer, KY
Sen. Dan "Blade" Morrish, LA
Rep. Scot Simon, LA
Rep. Ken Goike, MI
Rep. Joe Hune, MI
Rep. George Keiser, ND
Assem. William Barclay, NY
Sen. Neil Breslin, NY
Sen. James Seward, NY
Rep. Barbara Sears, OH
Sen. Ronnie Cromer, SC
Sen. Robert Hayes, SC

Other legislators present were:
Assem. Ken Cooley, CA
Sen. William Haine, IL
Sen. Travis Holdman, IN
Sen. Kevin Bacon, OH

Also in attendance were:
Susan Nolan, Nolan Associates, NCOIL Executive Director
Candace Thorson, Nolan Associates, NCOIL Deputy Executive Director
Molly Dillman, Nolan Associates, NCOIL Director of Legislative Affairs
Andrew Williamson, Nolan Associates, NCOIL Director of Legislative Affairs

MINUTES
Upon a motion made and seconded, the Committee unanimously approved the minutes of its November 20, 2014, meeting in San Francisco, California.

TELEMEDICINE REGULATORY APPROACHES
Dr. Gerald Harmon of the American Medical Association (AMA) Board of Trustees stated that the AMA has looked into three particular areas of telemedicine: licensure, reimbursement, and practice standards. He said that the AMA has developed model legislation for each of these three areas. He stated that the association's telemedicine reimbursement act outlines ways in which states can support insurance coverage and payment for telemedicine.

Dr. Harmon stated that reimbursement, or lack thereof, is one of the primary obstacles to implementing telemedicine payment reform. He said that over 40 percent of doctors report having never been reimbursed for telemedicine, and those who received reimbursement have

reported that it's much less than in-person care. In South Carolina, he reported, Medicaid covers telemedicine but private payers are not required to include telemedicine in their policies. He said that the AMA model reimbursement law provides language for a framework to remedy such issues.

Dr. Harmon stated that the proliferation of telemedicine does not mean that practice standards should be changed or modified. He stated that as telemedicine continues to evolve, patients should expect to receive the same type of quality care that they would in face-to-face medicine. He said such innovation is needed to support the future development of telemedicine and ensure patient safety, quality of care, privacy of patient information and protection of the doctor/patient relationship. He stated that the AMA also believes that coordination and follow-up care are essential in order to prevent overutilization and readmission.

Dr. Harmon said that one of the biggest challenges in telemedicine is licensing and oversight and that the AMA needs to work with state licensing boards to ensure that the boards are acting appropriately. He stated that it is the AMA position that when practicing telemedicine, a doctor should be licensed in the state where the patient is receiving care. He said the AMA would also prefer that the patient receiving telemedicine have a preexisting doctor/patient relationship with the physician who is providing the care. Dr. Harmon said that since arriving at the NCOIL Spring Meeting, he had practiced telemedicine three times. He said he had prescribed prescriptions and had scheduled testing but had a pre-existing relationship with those patients. He also indicated that he will not be paid for these services but that his patients will receive the care they need. He said that oversight by both state legislatures and state medical boards is appropriate.

Kristin Schleiter of the American Medical Association (AMA) addressed state-by-state activity regarding telemedicine legislation. She said that so far, over half the states have considered some type of legislation that addresses telemedicine. She advised that much of this legislation addresses telemedicine reimbursement for specific sites such as school-based centers and allows for reimbursement for specific services like hospice care and occupational therapy, as well as for specific specialties such as psychiatry, behavioral health, and dentistry.

Ms. Schleiter reported that many of these bills would allow reimbursement through various plans, such as Medicare, private insurance, and state employee health plans. She noted that many of the bills that have been introduced follow the language of the *AMA's Telemedicine Reimbursement Act*. She said several states are also considering legislation that would establish telemedicine practice standards for physicians and other health care professionals. She stated that the focus of these bills has been largely on requirements establishing a doctor/patient relationship, particularly whether to require an audio only or an audio/visual exam before a patient can be treated via telemedicine. She said that many of the states have aligned with the AMA model legislation that requires both an audio and visual exam before a new patient can be treated. She stated that to date, only a small handful of these bills have been moved out of committee, but the AMA is encouraged by the progress that has been taking place.

Ms. Schleiter stated that the AMA is working with a variety of national specialty societies to establish clinical practice guidelines for the use of telemedicine. She said that whether a doctor/patient relationship exists largely depends on the specialty. She used the example of the American Academy of Dermatology, which has created an online app that is free to any

dermatologist, called Access Durham, that allows a patient to send a picture of a rash to a dermatologist who can then make recommendations to the patient.

In response to a question from Rep. Keiser, Dr. Harmon stated that the AMA has no policy restricting licensure. Ms. Schleiter stated that the AMA has a long history of supporting licensure portability, reciprocity, and uniformity among state standards for medical practice. She said that some states may be considering the Interstate Medical Licensure Compact, which would streamline the process through which physicians can get multiple state medical licenses. She noted that the AMA supports the compact and is coordinating with state medical boards to ensure that the minimum seven states needed for adoption is met this year and that as many states as possible adopt the compact. She said that the AMA would encourage NCOIL to consider the interstate compact as a means to streamline and simplify the licensure process.

In response to a question from Assem. Cahill, Dr. Harmon said that as electronic medical records improve, they will be better able to assist treatment through telemedicine.

NETWORK ADEQUACY UNDER THE AFFORDABLE CARE ACT

Commissioner Monica Lindeen (MT) President of the National Association of Insurance Commissioners (NAIC), reported that the NAIC Regulatory Framework Task Force met to review all existing NAIC models relating to the Affordable Care Act (ACA) in order to determine whether any of the model laws needed amending. She said it became clear during that process that such model laws did indeed need to be updated. She stated this has become a major priority of NAIC over the past year and a half.

Commissioner Lindeen advised that the NAIC has made a significant effort since the Center for Consumer Information and Insurance Oversight (CCIIO) began considering adoption of federal network adequacy rules. She indicated that NAIC is opposed to such rules because they believe that they would not benefit consumers in individual states. She stated that it is difficult to adopt a single standard when it comes to network adequacy. She noted that rural states would have difficulty with any type of federal standard. She said the NAIC had created a network adequacy review subgroup with the Wisconsin Commissioner as chair. She said the subgroup began meeting last year and had received considerable input concerning possible revisions to an NAIC network adequacy model act.

Commissioner Lindeen noted that at the NAIC November meeting last year, a public draft of revisions to the model law had been released for comment, with a January public comment deadline. She stated that in response, more than 100 comments had been received and that the subgroup has been holding weekly conference calls to review them. She said this has been a transparent process, allowing for participation by any interested party. She announced that the subgroup plans to conclude its work by the end of the NAIC Summer Meeting in August, with its product then moving through task force and committee levels with the goal of final changes being made at the Fall Meeting in November.

Commissioner Lindeen related that some of the key issues contained in the comments focused on appropriate standards for determining whether a network is adequate or sufficient and whether it provides the benefits promised; ensuring that consumers have all the information that they actually need; and determining how directories should be updated to ensure accuracy.

She said that none of these issues had been easy and that NAIC appreciates the widespread input it has received.

In conclusion, Commissioner Lindeen reported that a meeting was held yesterday, February 26, in Washington, D.C. among the NAIC Health Insurance and Managed Care (B) Committee and the Market Regulation and Consumer Affairs (D) Committee regulators and the Centers for Medicare and Medicaid Services (CMS), the Department of Labor (DOL) and the Internal Revenue Service (IRS). She reported that the discussion centered on how best to move forward following completion of the second ACA enrollment period, particularly with regard to issues such as communication and oversight and their impact on consumers and companies. She said that regulators were also informed that the Center for Consumer Information and Insurance Oversight (CCIIO) will continue to hold back their federal network adequacy rules and will allow NAIC to continue its process.

In response to a question from Assem. Cahill, Commissioner Lindeen stated that having a single federal standard to fit every market in every state would be counterproductive and disruptive to both consumers and markets. In response to a question from Rep. Sears, Commissioner Lindeen stated that there is an existing NAIC network adequacy law that states have implemented. However, she said that because of the passage of the ACA and new changes to this network adequacy law, she believed that NAIC would be able to develop better standards for the states.

In response to a question from Rep. Keiser, Commissioner Lindeen stated her belief that NAIC has not collected data on whether the system could provide services in a reasonably timely manner under ACA. She noted that Montana was not encountering issues with insureds accessing providers; rather, the problem was that individuals on Medicare were unable to retain their providers because so many providers were dropping Medicare patients.

In response to a question from Howard Goldblatt of the Coalition Against Insurance Fraud, Commissioner Lindeen said NAIC has not seen any evidence of fraud that needs to be addressed.

In response to a question form Assem. Cahill, Commissioner Lindeen stated that the study NAIC is doing is based on the entire range of possible services and not just on the essential benefit standard.

HHS/CMS PARTNERSHIP TO COMBAT HEALTH INSURANCE FRAUD

Howard Goldblatt of the Coalition Against Insurance Fraud reported on a health care fraud prevention partnership. He said the partnership began in 2010 and is comprised of health insurers, the National Insurance Crime Bureau (NICB), and property casualty insurers, as well as HHS and Medicare. He explained that the purpose of the organization is to collaborate on the issue of healthcare fraud. He emphasized that this is important because fraud against private insurers is the same type of fraud that occurs against public insurers.

Mr. Goldblatt said that the Coalition has conducted six studies regarding different types of healthcare fraud and that the savings they observed are in the tens of millions of dollars.

In response to a question from Assem. Cahill, Mr. Goldblatt stated that the nature and degree of the fraud observed by the Coalition varied from area to area.

ELECTRONIC FUNDS PAYMENT TRANSFERS

Dr. Harmon reported that electronic payments move very quickly and that while this speeds up the process, it also creates several opportunities for mischief. He said that virtual credit cards (VCC) were established by the Health Information Protection Accountability Act (HIPAA) as an electronic funds transfer (EFT) standard.

Dr. Harmon said that VCCs were developed by the insurance industry to pay doctors' offices. He said that instead of using an actual credit card or having to submit a claim, the insurance company sends a picture of a credit card by fax, e-mail, or mail. He said a transaction fee is charged and that there is also a percentage-based interchange fee, which means doctors are actually being charged to receive their payment.

Dr. Harmon stated that staff must manually process the payments and that this creates an extra burden. He said that it is important to note that while doctors may opt out of such programs, they may be automatically enrolled without their prior knowledge.

Heather McComas of the American Medical Association reported that the AMA has fielded a growing number of physician complaints over the past few years over VCCs. She said that colleagues in the Federation of Medicine, a specialty society, reported that complaints seem to be increasing as each month goes by. She noted that the AMA has conducted an informal web survey on the topic and found that 68 percent of respondents had been paid via VCCs, 96 percent reported having received VCC payments without prior consent/notification, and 40 percent reported being unaware of the interchange percentage fee associated with VCC payments. She said the study also found that such practices were widespread throughout the country and not geographically isolated as some had suggested.

In conclusion, Ms. McComas stated that the AMA does have a model bill available, titled the *Transparency in Health Insurer Payment Act*, which contains provisions that would protect providers.

ADJOURNMENT

There being no further business, the Committee adjourned at 11:15 a.m.