BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

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September 23, 2020

Assemblywoman Pamela Hunter
711 East Genesee Street, 2nd Floor
Syracuse, NY 13210-1540

Submitted via email to William Melofchik (wmelochik@ncoil.org).

Re: NCOIL Model - Telemedicine Authorization and Reimbursement Act (TARA)

Dear Assemblywoman/Committee Chair Hunter:

The Blue Cross Blue Shield Association (BCBSA) appreciates the opportunity to provide comments on the proposed National Council of Insurance Legislators' (NCOIL) "Telemedicine Authorization and Reimbursement Act (TARA)."

BCBSA is a national federation of 36 independent, community-based and locally operated Blue Cross and Blue Shield (BCBS) companies (Plans) that collectively provide healthcare coverage for one in three Americans. For more than 90 years, BCBS companies have offered quality healthcare coverage in all markets across America – serving those who purchase coverage on their own as well as those who obtain coverage through an employer, Medicare and Medicaid.

BCBSA strongly supports the use of innovative technologies, including telehealth, to expand consumer access to care when and where they need it. BCBS Plans are leading the efforts to realize the promise of telehealth to improve healthcare access,[1] bend the cost curve[2] and promote positive health outcomes.[3] BCBS Plans have been doing their part during this unprecedented time. In March, BCBS Plans announced a policy to expand access and coverage for telehealth services to enable social distancing and promote public health during

[1] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.05089

[2] https://www.ajemjournal.com/article/S0735-6757(18)30653-3/fulltext

[3] https://effectivehealthcare.ahrq.gov/sites/default/files/pdf/cer-216-telehealth-final-report.pdf

the initial 90 days of the public health emergency (PHE).[4] Many have extended access beyond and are evaluating the effectiveness of these telehealth programs to meet the needs of their communities post-PHE. In fact, all 36 BCBS Plans and BCBSA have pledged to support the White House's "Pledge to Embrace Technology to Advance America's Health," as we share the same goals of expanding access thoughtfully, with flexibility in coverage and payment, to provide accessible and cost-effective care through telehealth, advancing the ability of all Americans to receive the care they deserve.

As NCOIL considers the TARA model law, we recommend using the following principles as a guiding framework:

- **Ensure Access and Efficiency:** Improved access to care for patients and increased efficiency for providers and plans should be an underlying goal of all telehealth policies. Specifically, Plans should be empowered to use technologies like telehealth to expand access to their members. We also support the efforts to remove arbitrary restrictions, including geographic and originating site requirements, which have no clinical implications or evidence basis to affect quality of care. Additional ways to increase access to care, address provider shortages and create efficiencies include expediting multi-state licensure for both physicians and non-physician practitioners, relaxing established patient relationship requirements, and not limiting care delivery to specific modalities.

- **Maintain Flexibility:** Specific coverage and reimbursement needs may differ across communities and states, so policies should strive for maximum flexibility while preserving patient safety and quality care. While some health plans have provided payment at parity with in-person visits during the COVID-19 emergency to support healthcare providers, opportunities exist to leverage telehealth's cost efficiencies (i.e., better care management, less overhead for office space, staff, time, etc.) once the public health emergency ends. Plans should have flexibility in modalities, rates and sites, based on different markets and different situations and should be encouraged to develop value-based payment arrangements, allowing for service delivery innovations of all stripes. Utilization management techniques that are based on clinical evidence are important to preserve, and coverage of visits or services should be based upon medical necessity.[5]

- **Make Consumer Trust Paramount:** Telehealth policies must assure patient privacy and information security that aligns with the Health Insurance Portability and

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[4] https://www.bcbs.com/press-releases/media-statement-blue-cross-and-blue-shield-companies-announce-coverage-of-telehealth-services-for-members

[5] As one recent white paper written by leading health policy scholars and physicians noted, "In the same way different drugs yield different outcomes, telemedicine may provide health benefits for certain clinical uses. For example, telestroke could save lives. On the other hand, telemedicine visits for the common cold have little clinical benefit." https://www.commonwealthfund.org/sites/default/files/2020-08/Mehrotra_Medicare_Telemedicine_ib.pdf

Accountability Act (HIPAA). Alignment with HIPAA requirements can facilitate easy and open communications between the provider and the patient receiving care through telehealth. Telehealth policies can also build upon consumer protection efforts by focusing on patient safety, quality and clinical appropriateness and by preserving existing payer program integrity tools and processes to prevent and detect fraud, waste and abuse.

We stand ready to work with legislators and utilize these guiding principles in offering constructive feedback as NCOIL works to develop this important, timely model. We support the need to have clear guidelines to ensure consumer access while protecting consumers as they have come to expect. We also must ensure quality services while keeping costs in check to provide affordable products that consumers demand. To that end, we have provided the following recommendations for the Health Insurance & Long Term Care Issues Committee to consider.

Section 4. Coverage of Telemedicine Services

Section 4(D) requires reimbursement to the treatment provider or the consulting provider for the diagnosis, consultation or treatment of the insured delivered through telemedicine services on the same basis as the provision of the same service through in-person consultation or contact.

Reimbursement flexibility helps plans establish high-quality, cost-effective provider networks and keep premiums stable year-to-year. Services provided through telehealth should be no exception, particularly given the breadth of telehealth modalities, the drive to value-based reimbursement strategies and the growing and established infrastructure built by providers and facilitated by both temporary public health emergency policies and potential funding streams implemented before, during and after the public health emergency. A white paper authored by leading health policy scholars and physicians and published by The Commonwealth Fund recognizes that while "implementing telemedicine does require significant investment in the short term, in the longer term a provider's marginal costs for telemedicine visits should be lower than for in-person visits, and reimbursement should reflect those costs.[6] Lower payment rates could also spur more competition through new, more efficient providers. At least for some patients, out-of-pocket costs could be increased for some forms of telemedicine."

While we recognize some states have imposed temporary or even permanent reimbursement parity policies, several others have not, allowing for reimbursement strategies tailored to the circumstances of the specific market, patient community needs, provider base and adaptation to value-based care, set of modalities and covered services, and the rapidly changing and evolving nature of these technologies and practices.

To the extent the Health Insurance & Long Term Care Issues Committee decides to move forward with explicitly regulating the manner of reimbursement for telemedicine services through

[6] Id.

this model, we wish to highlight a few state laws adopted to date, which provides a mechanism to determine reimbursement for telehealth with in-person rates. For example, North Dakota's law specifically authorizes insurers to establish payment for covered telehealth services through negotiations conducted by the insurer with providers in the same manner as the insurer establishes payment for covered services delivered by in-person means.[7] The Kansas law also explicitly retains a market-driven approach to telehealth reimbursement by stating reimbursement for covered services may be established in the same manner as reimbursement for covered services that are delivered via in-person contact.[8]

Recommendation: If Sec. 4 (D) is retained, BCBSA recommends amending it to adopt a more flexible approach to permit payers and providers to negotiate payment terms for telehealth services as is done for other covered services by striking the existing language and replacing instead with the following:

"An insurer, corporation, or health maintenance organization shall establish reimbursement for the diagnosis, consultation, or treatment of the insured delivered through telemedicine services through negotiations conducted by the insurer, corporation, or health maintenance organization with the treating provider or the consulting provider in the same manner as the insurer, corporation, or health maintenance organization establishes reimbursement for covered services delivered by in-person means."

Section 5. Limited Telemedicine License

Section 5 establishes a limited telemedicine license for an individual with a license to practice medicine in another state who meets the conditions in the section. The section treats the limited license holder as subject to the disciplinary jurisdiction for the [state] medical board in the same manner as if the individual held a full license to practice medicine.

Recommendation: BCBSA supports the establishment of a limited telemedicine license. One of the biggest barriers to availability of telemedicine services, regardless of payer, is the requirement that telemedicine providers (e.g., physicians, nurse practitioners, physician assistants, behavioral health providers, and social workers) must be licensed in the patient's state. Expediting multi-state licensure through this provision appropriately reduces this barrier to increase access and address provider shortages, while maintaining state oversight over the care provided to state residents. We recommend ensuring that limited licenses are available to all telemedicine provider types (including non-physician practitioners, nurses and social workers) capable of practicing within the state under the state's scope of practice and supervision laws.

[7] https://www.legis.nd.gov/cencode/t26-1c36.pdf#nameddest=26p1-36-09p15

[8] http://www.kslegislature.org/li/b2019_20/statute/040_000_0000_chapter/040_002_0000_article/040_002_0213_section/040_002_0213_k/

We welcome the opportunity to discuss our comments with you and your staff. If you have additional questions or comments, please contact Lauren Choi, managing director for health data and technology policy, at Lauren.choi@bcbsa.com.

Sincerely,

Clay S. McClure
Executive Director, State Relations