

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE
TAMPA, FLORIDA
DECEMBER 10, 2020
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health Insurance & Long Term Care Issues Committee met at the Tampa Marriott Water Street Hotel on Thursday, December 10, 2020 at 1:45 P.M. (EST)

Assemblywoman Pam Hunter of New York, Chair of the Committee, presided*.

Other members of the Committee present were (* indicates virtual attendance via Zoom):

Rep. Deborah Ferguson (AR)*	Sen. Paul Utke (MN)
Rep. Martin Carbaugh (IN)	Rep. George Keiser (ND)*
Rep. Matt Lehman (IN)	Sen. Shawn Vedaa (ND)
Rep. Peggy Mayfield (IN)*	Asm. Kevin Cahill (NY)*
Rep. Joe Fischer (KY)	Sen. Bob Hackett (OH)*
Rep. Jim Gooch (KY)*	Rep. Wendi Thomas (PA)*
Rep. Derek Lewis (KY)*	Rep. Tom Oliverson, M.D. (TX)*
Rep. Bart Rowland (KY)	Del. Steve Westfall (WV)*
Rep. Michael Webber (MI)	

Other legislators present were:

Sen. Mike Gaskill (IN)
Rep. Joe Schmick (WA)*

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel
Tess Badenhausen, Assistant Director of Administration, NCOIL Support Services, LLC

QUORUM

Upon a motion made by Rep. Matt Lehman (IN), NCOIL President, and seconded by Rep. Martin Carbaugh (IN), the Committee waived the quorum requirement without objection by way of a voice vote.

MINUTES

Upon a motion made by Rep. Matt Carbaugh and seconded by Asm. Kevin Cahill (NY), NCOIL Treasurer, the Committee voted without objection by way of a voice vote to approve the minutes from the Committee's September 26, 2020 meeting.

CONSIDERATION OF NCOIL VISION CARE SERVICES MODEL ACT

Sen. Bob Hackett (OH), sponsor of the NCOIL Vision Care Services Model Act (Model), stated that both sides have worked very hard on the Model but the best decision right now is to table

the Model. The Model is based on legislation that was enacted in Ohio but this Committee is not quite there yet in terms of being ready for a vote since both sides remain far apart from reaching a consensus on the Model. Accordingly, Sen. Hackett stated he would like to table the Model for now and perhaps re-introduce it at a later meeting.

CONSIDERATION OF NCOIL TRANSPARENCY IN DENTAL BENEFITS CONTRACTING MODEL ACT

Asw. Hunter thanked Rep. George Keiser (ND) for introducing the Model last year. Since that time, Rep. Deborah Ferguson (AR), Vice Chair of the Committee, has acted as lead sponsor of the Model. Rep. Ferguson stated that the Model starts on page 106 of the legislative binders and noted that the Committee has come a long way with the Model since it was first introduced. The Model actually started out with five substantive sections but in a great show of compromise among everyone involved, it has been narrowed to three substantive sections: network leasing; prior authorizations; and virtual credit cards.

Rep. Ferguson stated that these issues are very important to her as a dentist and she is confident that the language before the Committee meets the ultimate goal of transparency – transparency in dental insurance and dental care is the ultimate goal which is why that word is in the title of the Model and has been the focal point of discussions. The provisions are important for dentists but ultimately important for patients because they are the ones left absorbing the costs. Rep. Ferguson stated that before final comments on the Model are heard, she would like to announce a few changes she has made to the Model since it was released in the 30 day materials.

First, the definition of “pre-treatment estimate” has been removed since that term is not in statutory language and to underscore that the Model is focused on prior authorizations, not pre-treatment estimates – they are two distinct terms. Next, the word “written” has been included in the definition of “prior authorization” as under the current text oral communications could technically be considered prior authorization, which would be an impractical outcome in the real world. Next, in Section 1B. the words “sold” and “leased” are deleted to make that section consistent with the rest of the Model. Next, in the same section the second sentence starting with “A provider...” has been changed to “If a provider opts out of lease arrangements, this shall not permit the contracting entity to cancel or otherwise end a contractual relationship with the provider” – that change is to clarify the intent of that section; also, some of the language in the drafting note below that section making clear that the section doesn’t apply to leasing companies has been moved into the statutory section.

Next, on the same page in Section 1C1. the second sentence starting with “the third party access provision” will be replaced with “If the contracting entity is an insurer, the third party access provision of any provider contract shall also specifically state that the contract grants third-party access to the provider network and, for contracts with dental carriers, that the dentist has the right to choose not to participate in third-party access.” The reason for that change there is mainly that “clearly identified” is open to interpretation which could potentially be an issue if this language is adopted by multiple states and those states enforce different requirements.

Next, the drafting note regarding prior authorizations will be changed to “Dental services are authorized through prior authorizations, not pre-treatment estimates” just to make that language as clear and strong as possible. Next, Section D3 dealing with virtual credit cards will be deleted just to make sure there is no risk of sharing confidential information. Lastly, a Section

will be included at the end of the Model providing the Commissioner authority to promulgate rules that are consistent with the provisions of this Act and the laws of this State.

Chad Olson, Director of State Gov't Affairs at the American Dental Association (ADA), stated that he is glad to see that compromise has been reached on a lot of the issues in the Model. It is also great to see and hear from Rep. Keiser as he is the original sponsor of the Model. Mr. Olson stated that he looks forward to working with the Committee on further dental issues and is happy to answer any questions.

Teresa Cagnolatti, Director of Gov't & Regulatory Affairs at the National Association of Dental Plans (NADP), thanked Asw. Hunter, Rep. Ferguson, Rep. Keiser, and the Committee for the work on the Model thus far. Ms. Cagnolatti also thanked the ADA for being receptive to the NADP's comments on the Model. What has emerged from those conversations is that there is a common goal of ensuring that folks have access to quality and affordable dental care. That is what makes NCOIL such an important organization since it can provide a forum to discuss these issues and find common ground.

NADP is glad to see that the leasing provisions of the Model have taken a thoughtful approach and recognize that leasing benefits a number of parties including consumers, providers and insurers. The language has been modified significantly and everyone agrees that transparency is the most important thing. Dentists should have choices to be able to opt-out of the leasing network and they should be well informed. The Model accomplishes that although there is one remaining concern with the Model as currently written.

In two sections there are requirements during the contract renewal process. One is that a list be given to providers of all third parties in existence every time a contract renews. The other is that dentists be given the opportunity to opt out every time the contract renews. It is worth noting that the contracts generally renew on an annual basis and that systems have been built up to make things easier for the provider and everyone that is involved in administration by having the process occur in an automated manner. Given that the Model already requires that carriers inform providers of all the third parties in existence through a website that is updated every 90 days and notify the providers of any new third parties that are purchasing the network 30 days in advance the Model is achieving the joint goal of making sure that providers are well informed without the requirement of the extra renewal language. Accordingly, NADP would like to see the renewal language removed because of the redundancy.

Ms. Cagnolatti thanked Rep. Ferguson for the amendments she discussed earlier regarding the distinction between pre-treatment estimates and prior authorizations. That is important as an industry to say that the most important thing from their perspective between prior authorization and pre-treatment estimates is that a pre-treatment estimate is a voluntary process and is not binding. It is not a guarantee of payment and is not a determination of the necessity of medical services. The amendment is therefore important to make clear that distinction. Ms. Cagnolatti thanked the Committee again and stated that she is happy to answer any questions.

Brendan Peppard, Regional Director of State Affairs at America's Health Insurance Plans (AHIP), stated that he echoes Ms. Cagnolatti's comments and thanked the ADA for its work on the Model. AHIP shares the concerns noted by Ms. Cagnolatti. AHIP appreciates all of the work on the Model and it's a tremendously improved Model.

Rep. Matt Lehman (IN), NCOIL President, asked what the reason is for requiring the notification relating to renewals. Mr. Olson stated that redundancy on informing providers of new

relationships while the contract itself might not change but new leasing arrangements might have taken place – it would be good to have it both on the website with notification and on renewal. More of these relationships are taking place than ever before. Also, the renewal language is current law in CA, CT, IL, NC, NE and NJ so there is precedent around the country for this.

Upon a Motion made by Asm. Cahill and seconded by Rep. Keiser, the Committee voted without objection to adopt the Model, as amended, by way of a voice vote. Rep. Ferguson thanked Rep. Keiser again for originally introducing the Model.

CONTINUED DISCUSSION ON NCOIL TELEMEDICINE AUTHORIZATION AND REIMBURSEMENT MODEL ACT

Asw. Hunter thanked everyone for their work on the Model thus far and noted that she has had several conversations with insurers, providers, and constituents regarding their concerns about telemedicine. Asw. Hunter stated that she is confident the Model can get to a place where everyone can support it.

JoAnn Volk, Research Professor at the Georgetown University Center on Health Insurance Reforms, thanked the Committee for the opportunity to speak. The use of telehealth has jumped dramatically as one estimate says there have been almost 1 billion visits this year and one insurer stated that they covered more visits in April than all of the previous year. About two dozen states issued temporary bulletins or emergency orders from their department of insurance under their state's public health emergency authority to relax standards that were in place and encourage greater use of telehealth. That was done not just to encourage proper care and reimbursement levels but also to encourage social distancing and keep people safe. Ms. Volk stated that amidst all of this, it was a great time to look at state laws to see how they operated prior to COVID and how they might operate after. With funding from the Commonwealth Fund, a 50 state survey is being conducted and some preliminary data can be shared. Regulators were part of the conversation in 10 states to get their feedback on the bulletins and how telehealth has been operating.

About three dozen states already require coverage of telehealth visits on par with in-person visits generally saying that if it's a covered service and it's provided via telehealth it must be covered or cannot be denied just because it was a telehealth visit. The next most common feature is that about two dozen states require parity and cost-sharing – that the insured cannot be charged more and in some cases they must be charged less for telehealth visits. Less common but still substantial is that about a dozen states require parity in reimbursement to providers – it can be no less than what is provided for an in-person visit. There are a handful of states that have addressed other, smaller issues. For example, you cannot restrict the medium that is used which is where the audio-only comes in; a requirement to have a prior relationship; or limit the point of origin which can be broadly defined as anywhere a patient is in their home can qualify for a telehealth visit.

The temporary orders or bulletins under the state public health emergency authority vary. Some just remind of the laws on the books; some encourage but don't require greater access to telehealth; and about two dozen states either relaxed standards or suspended standards that were law prior to COVID. The common themes for the latter approach were to limit or entirely eliminate cost-sharing for consumers, limit or eliminate the use of prior authorization for telehealth visits, or to remove other conditions that might limit access to telehealth such as requiring a specific platform or medium. That is where several states allowed audio-only visits

as many states had not allowed such prior to COVID. That became a critical piece of state orders in recognizing that not everyone has broadband access or the right devices to do an audio-visual visit. There was also a recognition that there were greater needs for behavioral health during this time and some people felt more comfortable with an audio-only visit for that type of care. Other conditions that were often waived were that you had to have a prior relationship with the provider or some states would limit the requirement to cover telehealth equal to in-person if it was with an in-network doctor or even in some cases was provided through a telemedicine network. Another common feature of the temporary orders was that reimbursement cannot be lower than what is done for in-person visits.

Going forward, studies show so far that where there were temporary measures regarding reimbursement levels, that will need to be addressed by the legislature in terms of making anything permanent. There were a number of states that had it on the books already and it was not an issue but it will be an issue for those states that either implemented something entirely new or different from what was existing law. The audio-only issue also seems to be one that will be made permanent following COVID. There are also a number of ways states are collecting data on these issues to see how they are working out. In a number of states, the legislative efforts that pre-date COVID really were led by state legislators that were often providers in which case there were year to year standing working groups and these updates were included there. One state insurance department reported that they held a data call with insurers to get some data from them about what they are seeing in terms of use. Others tapped into existing working groups whether with primary care providers or coalitions of mental health providers and consumer representatives to hear about the use of telehealth for those communities. The one clear benefit that was heard throughout all reporting was that there were fewer missed appointments with telehealth and it has been a benefit to maintain access for people, particularly those with chronic conditions who need regular visits.

Jennifer DeYoung, Director of Public Policy, Building Blocks of Health Reform at United States of Care (USofCare), stated that USofCare is a non-profit, non-partisan organization with a mission that is both bold and simple – that everyone in the country should have access to affordable healthcare no matter who they are. And specifically, the goal is intentionally twofold: first - expand access to quality, affordable health care in the near term; second - pave a path toward durable, people-centered federal policies that achieve the mission. A key element of strategy is bringing different perspectives to the table to solve problems. USofCare sees its brain trust, its founders council, entrepreneurial council, voices of real life, and bipartisan board of directors as its unique superpower which sets it apart from other organizations working in this space. USofCare also plays a unique role in focusing first on where people are and what they are experiencing in the healthcare system. USofCare takes time to listen and understand what their experiences have been like and then uses that information to help inform the solutions that are put forward to solving pain points in the healthcare system.

Ms. DeYoung stated that this year, USofCare has launched a new body of work focused on virtual care. As we have all seen, COVID-19 has brought to light the longstanding problems with our healthcare system including equity issues around disparities such as how some people like black or Hispanic Americans get unequal access to care. USofCare sees a window of opportunity to make meaningful lasting changes to the healthcare system to make the system work better for all people for the long term beyond the pandemic. With virtual care, which USofCare is defining as including telehealth, remote monitoring and other remote forms of communication, USofCare is interested in learning about how virtual care is much more than just another shiny new tool that's out there but rather how it's helping closing gaps and getting people the access they need. To get at that, USofCare is understanding the patient's

perspective by doing a national listening tour with people, providers and other key stakeholders to learn about their experiences with virtual care. That is going to be paired with what is learned from people and the research evidence that experts know so what's missing with virtual care can be highlighted and what more can be done to ensure virtual care is working for everyone.

Ms. DeYoung stated that if you go to USofCare's website you can see some products that have been offered so far and some that will be offered in the coming months. Ms. DeYoung stated that she is excited to share with the Committee what USofCare is learning from people and from its research all of which is critical to helping inform how to create policy so that we can ensure policy is focused on what people need the most. USofCare recently fielded a national survey at the end of November to 1,000 registered voters where they were asked questions about their experiences with the healthcare system overall and with virtual care specifically. 44% of respondents have received virtual care most doing so as a result of COVID-19. About half of those that received it identified as Republican and half as Democrat. 59% of those with a disability received virtual care. 73% of those who used it said they had a mental health disorder. Overall, it was found that there is wide support for the convenience of virtual care, especially during the pandemic. 87% had something positive to say about the virtual care experience and 72% appreciated the convenience of not having to leave their place of residence to receive care and the ease of scheduling.

However, many respondents have concerns about the accuracy of care and concerns about the technology. That aligns with what was heard in 101 interviews as well. For example, one older adult interviewed said he would not explore virtual care if he had to do it on his computer or any other way than a phone call because then he would need help from other people and he believes healthcare appointments should be private. Additionally, another point that is very insightful is understanding why people are not using virtual care. According to the poll, of the 53% who had not used virtual care, 16% had not done so because they felt it wouldn't be personalized or meet their specific care needs. Focus group participants also questioned whether they would receive subpar or impersonal care if not done in person. Those are important points to consider as virtual care policies are formalized – how can you retain what's working while addressing what isn't.

Ms. DeYoung stated that to compliment its poll, USofCare has also honed the existing research evidence to understand what other researchers are saying about the barriers people are experiencing with using virtual care. Some barriers are shared across populations while some are unique to certain segments. If we are going to take this unique opportunity with virtual care and design it for the long term so that it helps to get people access to care who in the past have struggled to get the care they need then we need to pay attention to these barriers – what's causing problems now so we can address them in permanent policies.

As next steps are considered regarding virtual care including making permanent the existing emergency actions it is critical that policies are evaluated against criteria that places the needs of patients at the center. If we want to see patients get the care when they need it rather than waiting until an emergency, whenever clinically appropriate, patients must have the flexibility to choose how they would like to receive their care whether it is in person or through any of the virtual modalities. Permanent virtual care policies should address barriers people experience in accessing virtual care so that virtual care is viable option for them.

Ms. DeYoung stated that USofCare did submit specific amendments to the NCOIL Model which focus on strengthening the Model to make sure that barriers people experience are addressed. The increased need for virtual care across all populations due to COVID-19 has demonstrated

just a baseline of virtual care's potential capabilities to help achieve better care and address longstanding inequities in access. By putting the patient first, permanent virtual care policy measures have the potential to close gaps in healthcare access.

Mr. Peppard stated that as AHIP has previously testified, health insurance providers are supportive of the appropriate use of telehealth to provide access and to reduce costs for necessary medical services. AHIP is supportive of several provisions of the Model, however, there are some provisions that AHIP is concerned with and AHIP has provided a red-line of the Model with recommended changes.

AHIP believes that health insurance providers should have flexibility in the design of benefits. There is language in the Model that limits that flexibility and that is recommended to be modified or removed. AHIP is also specifically concerned with requiring equivalent telehealth and in-person payment rates. That eliminates the cost-saving potential of telehealth and can create disincentives. There was a recent National Governors Association (NGA) report which includes the perspective that there are efficiencies in telehealth making it a lower cost service and requiring payment parity misses an opportunity to lower costs. Mr. Peppard stated that while AHIP reads the Model to require payment parity, it has heard that there are some that suggest that it does not in fact do so. If there is a belief among Committee members that the Model does not require payment parity and there is a reluctance to remove that language identified AHIP would when request an amendment that specifically states that the Model does not require payment parity.

Kimberly Horvath, Senior Legislative Attorney at the American Medical Association (AMA) stated that the AMA continues to support fair and equitable payments for telehealth which will help advance the investments in telehealth by physician practices across the country. Since the Committee last met there have been some results from a telehealth impact survey of healthcare providers which was performed by the COVID-19 healthcare coalition. The survey provided some findings relating to quality of care, patient experience, cost to professionals and certain barriers. Over 75% of clinicians responding to the survey indicate that telehealth enabled them to provide quality care for their patients for both COVID-19 related care and a whole range of care as well. More than 80% of respondents indicated that telehealth improved the timeliness of care for their patients. A similar percentage of respondents stated that their patients reacted favorably to telehealth. Of importance to the discussion on payment, the biggest challenge respondents indicated for having telehealth was low or no reimbursement and that was identified as the biggest challenge or barrier to maintaining telehealth post-COVID – 73% of respondents indicated that was the case.

That is a key reason why the AMA continues to support equitable payment for services provided via telehealth and that really means that when services are comparable and commiserate with the services provided in-person that the payment should be the same. As we continue to promote innovation and as we continue to see value in telehealth moving forward and as physician practices continue to make significant investments in telehealth there needs to be certainty going forward with reimbursement models. Telehealth has become very important during the pandemic and there is a growing recognition that there are potentially long lasting benefits and value to continued use of telehealth in terms of patient outcomes and access to healthcare as well as the patient and provider experience. The AMA continues to do research in those areas and will share that going forward.

Asw. Hunter stated that Section 5 of the Model talks about allowing out-of-state providers access to compete with in-state providers. Asw. Hunter stated that she has had some

conversations with providers who have said that is not equitable and asked for comments on that issue from the speakers.

Mr. Peppard stated that AHIP believes that Section allows for expansion of access and AHIP believes that is one of the good things that has come out of the pandemic related to emergency orders. It is important to note that when carriers offer telehealth as a benefit they generally already offer the ability to speak to providers who are in-state. Mr. Peppard stated that he is not sure he understands the concern that there wouldn't be availability to speak to providers in-state.

Asw. Hunter stated that the providers are worried that out-of-state practitioners could essentially take in-state physician patients. Mr. Peppard stated that he is not sure AHIP views it that way and that is certainly not AHIP's intent with regard to increasing access. Ms. Horvath stated that the AMA continues to support state-based licensure and the Interstate Medical Licensure Compact as a path forward to helping physicians in particular that are interested in practicing across state lines. There is a really good reason to maintaining state-based licensure such as having various state laws that are already in place continue to be recognized like age of consent so that patients in states are protected and making sure that physicians and other healthcare providers are licensed and have oversight from the board of medicine of the state in which the patient is located.

Asw. Hunter stated that during NCOIL's virtual D.C. fly-in earlier this year, one of the biggest things heard during meetings with telehealth related to infrastructure. Asw. Hunter noted that all broadband access is not the same and presuming that someone has a smartphone doesn't necessarily mean that they have FaceTime or data in order to make them able to have a substantive telemedicine appointment. Asw. Hunter stated that without that broad infrastructure investment then accessibility for telemedicine will not exist for those people who have the biggest barrier to access to healthcare. Ms. DeYoung stated that those points are being brought to light in the research being done and that is why allowing telemedicine visits over the phone is important because some people simply don't have the smartphone capability and that is a barrier. USofCare is part of a larger coalition called the American Connection Project that is aiming to examine and look for a broader broadband access particularly in rural communities.

Sen. Hackett stated that expanding broadband access is important and that is being worked on in Ohio. Sen. Hackett stated that he has had several telehealth visits and they all have gone very well. It is amazing how much telehealth has been used in Ohio. Sen. Hackett stated that he is for coverage parity but stated that almost ever provider he knows except for certain specialties say that telehealth is cheaper so there is a cost savings. So, why should the consumer not share in those cost savings?

Ms. Horvath stated that there is indeed a value to telehealth and what the AMA is trying to do right now is take advantage of this unique opportunity and look at the data and find out what that value is. It is also important to be cognizant of the fact that there is an investment as well for physicians and other healthcare providers as they are implementing this into their practice. There is an investment in electronic health records and making sure that everything meets the standards that are required and that everything is protected. Certainly, the cost in comparing it to in-person visits is again something that the AMA is looking at as well. The AMA is looking for consistency for healthcare professionals as they are providing and implementing these telehealth services as part of the services they provide to their patients. It is important to make sure that they know moving forward that payment will be commiserate with what they receive for in-person services in helping make sure that they can sustain providing services via telehealth.

Sen. Hackett stated that in Ohio they stated that it is up to the plans and the provider to negotiate. Certain specialties do indeed have an investment and they have to do things a little differently but in a lot of the areas of telehealth investment is minimal. Sen. Hackett stated that some of the visits he had with a specialist were just iPhone to iPhone. Sen. Hackett stated that he does not believe total payment parity should be required and also noted that Ohio is not going to codify the telehealth rules until everything settles and things can be examined after the pandemic. Certain specialists should have payment parity because of investments but others will even tell you that telehealth is cheaper for a provider and Sen. Hackett stated that is why payment should be negotiated between the provider and insurer.

Rep. Keiser stated that we sometimes talk like telehealth is brand new and it is at least 30 years old. Companies like Nighthawk have done screens on radiology from India and Australia because radiologists don't want to come in at night or on Holidays. As a result, the following Monday when the radiologist goes in they re-read it and that is only because of billing. Rep. Keiser accepts that accessibility and costs are going to increase dramatically because the system is utilized more but what are we going to do in terms of payment parity to a physician such as a dermatologist that looks at you over the phone and then says you need to come in to take a closer look – do they get billed twice at the same amount? Mr. Peppard stated that such double billing is already being seen in Medicare already.

Rep. Ferguson stated that she is not clear as to why providers say telehealth is cheaper for them. When she talks to providers they are spending the same amount of time for telehealth on all different kinds of office visits. If you look at your EOB they should be charging you at the minimum level for the office visit because they are not able to do exams and tests and those kinds of things that they would do in-person. Rep. Ferguson stated that is why she is for payment parity because they are spending the same amount of time and they should be billing a lower level CPT code. Having said that, going forward everyone needs to not fall in the trap of thinking that everything that was an emergency order during the pandemic is appropriate care going forward. Much of it has been compromised care. Some of it is great but a lot of it is compromised.

Sen. Hackett stated that the percentages of appointments being held are tremendously higher and if you talk to providers they will tell you that. Primary care providers will tell you that telehealth is cheaper and there are no travel issues and patients will show up for the appointments. Rep. Ferguson stated that the doctor is not traveling as those that are doing telehealth are scheduling a telehealth room just like they do for regular appointments so their time is equal so she is not sure how providers are saying it is less expensive.

Asm. Kevin Cahill (NY), NCOIL Treasurer, stated that he would like to see this issue marinate a little bit as we continue to make our way through the crisis and see what happens in terms of further emergency regulations being promulgated and other legislation coming down the pipeline. Certainly, we should continue to offer guidance and determine whether a distinction should be made between audio and audio-visual visits and we need to determine the issues of duplicate billing for the same episode like an initial telehealth visit and then a follow-up.

Asm. Cahill stated that he is mostly concerned about getting right the reimbursement issue as that issue will determine the incentivization of delivery of healthcare and that is what we have to remember. When we make a decision about the economic relationship between entities we are actually making a decision about how those services get provided. Lastly, Section 5 of the Model is troubling. New York takes licensure of professionals very seriously and that is done in

the Higher Education Committee. Competition between providers for scope of practice and protection of title and those sorts of things is very fierce. Asm. Cahill stated that he is not certain that a practitioner in another state would have the same scope of practice or have a title in that state that would match the title in New York and that is something that has to be reconciled. Asm. Cahill stated that he supports using the existing waiver process with telehealth but nonetheless the Model is very important to take up again soon and would urge other Committee members to consider all points raised today.

Asw. Hunter stated that she looks forward to further discussing the Model at the Committee's next meeting in March. It is unlikely that a vote will be taken then as the Committee needs to see how things play out in the states regarding further emergency orders so a vote in July is more likely.

INTRODUCTION AND DISCUSSION OF MODEL ACT REGARDING AIR AMBULANCE PATIENT PROTECTIONS

Rep. Tom Oliverson, M.D. (TX), sponsor of the Model Act Regarding Air Ambulance Patient Protections (Model), stated that he is very proud to sponsor the Model along with Delegate Steve Westfall (WV). The Model is very straightforward and the ultimate goal is to regulate these air ambulance subscription membership products as insurance. We all are familiar with the phrase – if it walks like a duck and quacks like a duck, it's a duck. That is really where he is coming from as sponsor of this Model in attempting to regulate these products as insurance.

Del. Westfall stated that he is very proud to sponsor this Model along with Rep. Oliverson and he completely agree with Representative Oliverson's remarks. Del. Westfall stated that he thinks air ambulance membership products were started with a good intention but the landscape has changed and memberships have become less relevant and at this point have become problematic because patients really don't need them. Membership is supposed to cover the balance billing portion that a patient may receive if their insurance doesn't pay. However, that has become less of a problem because of the gains with network participation. Also, there have been some complaints that they are marketed in a way and sold to people who don't need them. Del. Westfall stated that he looks forward to working on the Model with everyone and looks forward to seeing everyone in person soon.

Chris Myers, Executive Vice President, Reimbursement and Strategic Initiatives at Air Methods Corporation (AMC), stated that AMC supports the Model. AMC serves 49 states with over 400 helicopters and fixed wing aircraft representing over 65,000 time sensitive transport a year. When called by an independent physician for first response AMC has an asset deployed with highly trained clinicians and pilots within less than 15 minutes. The most common conditions treated are trauma, cardiac, stroke, and respiratory arrest where minutes matter to the outcome of a patient. During these unique times, AMC has transported over 4,000 COVID patients as well. As rural hospitals continue to close, AMC is the last line of defense to get patients to the trauma center that can best serve their needs.

Mr. Myers stated that over the last 4 years, AMC has deployed multiple strategies to make the patient-billing experience as transparent and as simple as possible. The guiding principle is to approach any billing concerns with what is best for the patient. To that end, AMC has aggressively pursued in-network agreements with any willing payer which has resulted in having 50% of its privately insured patients covered by in-network agreements with great partners like Anthem, Humana and most state Blues plans. That is up from only 5% 4 years ago. United, Aetna, and Cigna remain the final opportunities for AMC to be 100% in-network. Being in-

network is the best way to remove the financial burden from patients and ease the reimbursement process. Additionally, AMC has deployed patient advocates that are individually assigned to patients with an out-of-network payer and a robust financial assistance policy so that the average out-of-pocket cost for a patient is \$167 and getting lower. AMC does not balance bill patients and only sends patients a bill if they have never provided a payer of record or communicated to AMC to get qualified for financial assistance.

AMC support the Model because it aligns with AMC's patient-centric approach and protects patients from unscrupulous insurance and insurance like products and related practices. Many membership sales tactics feel like being both arsonist and firefighter where consumers are scared into thinking they will have a big bill and therefore need to buy a membership to avoid an imminent peril from the same company that is transporting them. That is the opposite of providers working to truly take the patient out of the middle.

The overwhelming majority of air ambulance transports are from Medicare and Medicaid beneficiaries today who have a defined fee schedule and copay. Medicare patients are disproportionately marketed to with tactics like "senior pricing." The prevalence of these products being solicited to seniors is cause for question about whether regulation is needed. If only 25% of the 3 million air med care memberships are sold to seniors that would make it the second largest Medicare supplement product in the U.S. The lack of regulation of these membership programs today has created financial opportunists like Helimedic which launched a website selling the product but has no verified operations. It claims to cover the entire country in only minutes with only a few helicopters based out of Texas and California. Additionally, when you attempt to call the posted contact number it connects to no one yet they are still trying to sell ambulance memberships at \$500 for an individual or \$1,500 for a family even garnering local news coverage.

Mr. Myers stated that from a utilization perspective there are approximately 360,000 air medical transports a year which represents 0.11% of the U.S. population. Given the extremely low utilization of air medical services one wonders why there are millions of memberships sold each year. Additionally, 80% of AMC transports are covered by a set fee schedule. Given that dynamic, AMC has determined to apply resources to mitigate any patient out of pocket expenses to the patients that actually need it versus those that in all likelihood will never need it. Mr. Myers stated that he will leave it to others to conclude whether memberships are insurance products or not but a simple definition from Black's Law dictionary states "insurance is a contract by which one party, the insurer, undertakes to indemnify another party, the insured, against risk of loss, damage or liability arising from the occurrence of some specified contingency." Borrowing from the Guardian Flight vs Godfread opinion, "if it looks like a duck, swims like a duck and quacks like a duck, a reasonable person can conclude that it is a duck."

Montana, New York, Connecticut and Wyoming have all decided to regulate memberships as insurance and Florida requires licensure and regulatory oversight as an insurance product in order to sell to Florida consumers. Patients and consumers should have full transparency in understanding the product they are purchasing and not have their care compromised or face unexpected bills. The arsonist and firefighter sales tactic utilized to sell air ambulance memberships puts undue pressure on patients and doesn't fully disclose the financial terms of the insurance product they are purchasing or the fact that it isn't needed. Patients have sued membership providers for balance billing them when the patient has received a legal settlement and the membership provider has tried to collect those funds. Uninsured patients may not necessarily understand that per the contract terms of some providers they can be billed the Medicare allowable rate which isn't covering their out of pocket costs. The one point that

contract membership terms make abundantly clear is that they only cover the patient in the scenario that a specific provider transports them. This creates unnecessary and dangerous pressure on the patient to delay their care and wait for the free air ambulance transport. That is a risk that patients that need time sensitive air ambulance transport cannot afford to take. AMC has chosen a decidedly different path to memberships: you do not have to pay a membership fee to do what is best for the patient – it is part of the service provided.

The Honorable Glen Mulready, Oklahoma Insurance Commissioner, stated that the primary concern for the NAIC with this issue is consumer protection. Some consumers do not understand the limitations of the product and they are sold to people who do not need it as they have other coverage such as Medicare. The product is also sometimes sold to folks who cannot use it as they either do not live in the proper area and also they do not understand the cancellation policy. Some consumers also don't understand the need for the product. There is also a lack of review of rates and forms. Some states have acted upon this as North Dakota has banned the product pursuant to a federal judge ruling that states do have the authority to regulate subscription plans as insurance. NY and WY regulate the product as insurance. MT requires certification of the product. There was also legislation passed in TX requiring reciprocity in subscription services but that was vetoed. Other options under consideration in states include: banning the duplication of coverage and/or standardize the plans; regulate sales including disclosures and notifications. The Department of Transportation (DOT) is also looking at this issue.

Several reforms around this product have required disclosures that only participating carriers provide services in certain areas; requiring the patient is told they must be insured and the service must be a covered benefit; clarifying who does not need it such as in-network participants and Medicare and Medicaid enrollees; submission of data; and going through a dispute resolution program. The NAIC believes that the Model is on a good path but the overriding issue is the balance billing problem within the air ambulance industry. There is a bipartisan, bicameral bill that was agreed to in Congress in 2019 that would have set some parameters but it stalled out. The NAIC has not been involved in the debate surrounding the amount insurers should be paid. The NAIC has sent letters supporting the extension of protections to air ambulance consumers and preservation of state surprise billing laws.

The DOT also appointed the Air Ambulance Advisory Committee which was required by the FAA Reauthorization Act of 2018 to look at air ambulance costs and transparency. North Dakota Insurance Commissioner Jon Godfread was appointed as the state regulator representative and the report containing findings and recommendations should come out at some point next year. In addition, the DOT has requested comments on the need and ability of the Department to regulate air ambulance carries under current rules which prohibit abusive practices. The NAIC also submitted comments urging the DOT to act to protect consumers from abusive balance billing practices. There is no timeframe on that for further action.

On behalf of Global Medical Response (GMR), The Honorable Eleanor Kitzman, former South Carolina and Texas Insurance Commissioner, stated that GMR's footprint has expanded greatly since it last appeared before the Committee to discuss the NCOIL Model Act Regarding Air Ambulance Insurance Claims. GMR is very disappointed that said Model has not been adopted in any states and that the surprise balance billing issue is still present. There is surprise billing legislation proposed in Congress and the DOT Advisory Committee will be issuing guidance soon that may include some of the NCOIL Model concepts. As welcome as that will be, balance billing and membership programs are two very different things and GMR believes its

membership programs represent a good value for many consumers and may be an even better option for many consumers.

GMR operates the AirMedCare Network (AMCN) which is the largest membership program in the U.S. with 3.1 million members in 38 states with 320 locations. Memberships ensure that members have no out of pocket expenses if flown by an AMCN participating provider. AMCN does not market in areas where it is not a first or second call provider which means that it is considered a go-to provider based on its service history with the dispatchers and it receives a significant number of transport dispatches in that area. The website coverage map indicates whether coverage is available based on a consumer's zip code.

AMCN memberships are distributed through three channels: direct to consumer which includes mail, digital and attendance at events by sales reps; employer sponsored programs with payroll deduction; and municipal site plans which counties, cities or other local jurisdictions pay to enroll residents for basic coverage which may have defined geographic or other limitations at the discretion of the local jurisdiction purchasing the plan but residents of that area are offered upgraded coverage at a discounted rate. The municipal site plans are currently in 20 states.

Cmsr. Kitzman then discussed AMCN's product membership application form. First, Section 2 asks for the names of all members of the household because a single membership covers all members of the household for the same price. Second, Section 3 contains membership and payment options. Monthly memberships are only \$9 per month and an annual membership is only \$85 or \$65 for seniors which is anyone over 60 years of age. The terms and conditions also state that the membership ensures a patient will have no out of pocket flight expenses if flown by a company providing pre-paid protection against a company's air ambulance costs that are not covered by a member's insurance or other benefits or third party responsibility.

Further, AMCN provider air ambulance services may not be available when requested. Members who have insurance or other benefits that cover the cost of air ambulance services are financially liable for the cost of AMCN provider services up to the limit of any such available coverage. In return for payment of the membership fee, the AMCN provider will consider its air ambulance costs that are not covered by any insurance to have been fully pre-paid. Neither the company nor AMCN will be responsible for payment for services provided by another ambulance service. Additionally, there is an express provision regarding Medicaid that some state laws prohibit Medicaid beneficiaries from being offered memberships or being accepted into membership programs and by applying, members certify to the company that they are not Medicaid beneficiaries.

Cmsr. Kitzman stated that it is important to point out what is not in the application's terms and conditions: any restriction on the number of transports; request for medical information; request for insurance information. That means that every member of a member's household can receive unlimited life or limb saving air transport for as little as \$9 per month whether the member is more likely to require transport based on medical condition or has insurance that could reimburse AMCN for its actual costs of transport. GMR has an average of about 2.5 household members per membership agreement currently.

Cmsr. Kitzman stated that she would like to address some misconceptions and understanding regarding memberships, including the mistaken notion that more in-network agreements with insurers and/or elimination of balance billing is better for consumers than a membership. Any solution to balance billing or in-network wont solve the high deductibles and copays that consumers face. 81% of health plans contain deductibles and 24% of them are high

deductibles. According to Kaiser Family Foundation (KFF) in their 2019 employer health benefits survey, there has been a 36% increase in deductibles in the last 5 years and 100% increase in the last 10 years.

With respect to deductibles and copays there is also an argument that they exist as a means to discourage over utilization and should not be forgiven or waived. Cmsr. Kitzman stated that in her experience that is a concept more common in P&C insurance and is intended by insurers to avoid the administrative expenses of low dollar claims and she is not sure how life and limb saving ambulance services dispatched by a third party could be over utilized by a consumer but she also disagrees with premise. Deductible buy back policies are available for various insurance products. There was also a statement made earlier that many members will delay their care in order to ensure that they are transported by a provider that is covered in their membership agreement. Cmsr. Kitzman stated that she is not aware of any evidence of that. Often these dispatches are when patients are not even conscious and able to make that decision. There was also a reference to cancellation of policies and while it is not clear exactly what that refers to, once a membership fee is paid, GMR's contracts are not cancellable.

Another misconception is that a Medicare enrollee does not need a membership plan because Medicare covers air ambulance services. That is only true if the enrollee has purchased Medicare part B and there is still a 20% copay which based on Medicare's average payment for air ambulance services averages \$1,391 which is 21 times the membership fee for seniors. It is possible that a Medicare supplement policy can cover the copay and AMCN includes a FAQ on its website advising consumers to check their coverage. It is also the case that Medicare has a very strict view of medical necessity and has a higher rate of denial for air ambulance services based on that medical necessity in which event a Medicare supplement policy would not provide coverage.

Additionally, several health and human services offices of inspector general advisory opinions have held that membership subscription agreements are permissible for Medicare enrollees under certain circumstances. GMR believes that AMCN's membership programs provide enormous benefits with little to no downside for consumers. If a consumer is transported by a third party, his or her membership benefit does not apply and he or she is not disadvantaged because of the membership agreement beyond the membership fee. If a member is transported by AMCN and is insured, AMCN pursues payment of the reasonable cost of the transport from the member's insurer only and accepts the ultimate payment by that insurer as full payment of its services. The member will never receive a balance bill. Moreover, AMCN waives payment of the member's deductible or copay which will be far more than the cost of membership. If the member is uninsured, the entire transport is covered by the membership agreement.

The proposed Model seems to categorize air ambulance membership subscription agreements as contracts of insurance and to regulate air ambulance companies that provide service through membership programs as insurers. Returning to the definition of insurance from Black's Law Dictionary, AMCN is not indemnifying the member with respect to the specified contingency, i.e. that the member will need emergency air ambulance services and that AMCN will be dispatched and is able to provide such services. Rather, it agrees to provide the service through one of its participating providers if available. If AMCN is not dispatched or an AMCN participating provider is not available, AMCN has no further obligation under the agreement and AMCN expressly has no liability whatsoever for services provided through another air ambulance service. In the event that the risk of loss, the damage or liability arises from the occurrence of some specific contingency is interpreted as a protection against the risk of a catastrophic billing for the use of

an air ambulance, AMCN would be the entity sending the catastrophic billing which never happens to a member and AMCN would then be indemnifying the member against AMCN.

Cmsr. Kitzman stated that Mr. Myers referenced the Guardian Flight case in which it was ruled that air ambulance subscription membership products were a form of insurance. The judge also stated, however, that it was unclear why ND has chosen to prohibit the practice when there is a clear need to address the affordability of air ambulance services implying that he thought subscription agreements did address the affordability issue. He also noted that MT had taken the opposite approach as had WA, AZ and GA. Several states do regulate air ambulance memberships as insurance and there is range of approaches as to how they do that. AK, NE and CA take a light touch while others have effectively expressly regulated the memberships out of existence.

Cmsr. Kitzman stated that she is not here to argue the legalities of it other than to say that GMR does not believe that the product is insurance and to say that just because a practice may be a form of insurance does not mean that it should be regulated as insurance and the best example of that would be warranty products which seem like insurance since there is a payment in advance for a promise to pay in the future for an event that may or may not occur. FL and a few other states regulate that as insurance but most do not. The goal today is to provide a broader, real world context for membership agreements and illustrate the tremendous value of them and to clear up some misinformation about them. Membership agreements may not be the whole solution to affordability of air ambulance services but they seem to be a good approach until a better complete solution is found which no one seems to have done yet.

Asw. Hunter asked if there have been any cases with state Attorneys General where they have filed suit against any of the companies for falsely selling products that they couldn't deliver on. Cmsr. Mulready said he is not aware of any but is not really qualified to answer that. Mr. Myers stated that he is not aware of any. The Helimed company referenced earlier just popped up in the last couple of weeks so there probably has not been enough time to investigate.

Rep. Derek Lewis (KY) stated that as he is in rural Kentucky in the mountains and accessibility is often an issue, air ambulance membership subscriptions are quite common in his area. Rep. Lewis asked Cmsr. Kitzman if she sees the product closer to an Amazon and should not be regulated as supplemental insurance. Cmsr. Kitzman stated that GMR does not believe that the product is insurance and should not be regulated as such but some states do in fact do so and there is a range of approaches as to how it is regulated. Rep. Lewis then had technical problems with his Zoom connection.

Rep. Jim Gooch (KY) asked Cmsr. Kitzman what percentage of GMR's memberships are Medicaid or Medicare recipients. Cmsr. Kitzman stated that none are Medicaid unless they have not told AMCN that they are. As referenced earlier, in the terms and conditions portion of the application by submitting the application they are representing that they are not a Medicaid recipient. Cmsr. Kitzman stated that she does not know the percentage of Medicare beneficiaries but will get the information and report back.

ADJOURNMENT

Upon a Motion made by Rep. Ferguson and seconded by Asm. Cahill, the Committee adjourned at 3:15 p.m.