BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

1310 G Street, N.W.
Washington, D.C. 20005
202.626.4800
www.BCBS.com

November 16, 2021

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 35 independent, community-based and locally operated Blue Cross and Blue Shield (BCBS) companies (Plans) that collectively provide health care coverage for one in three Americans. For more than 90 years, BCBS companies have offered quality health care 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 efforts to realize the promise of telehealth to improve health care access[1], bend the cost curve[2] and promote positive health outcomes.[3] Our member Plans have been doing their part during this unprecedented time. In March 2020, BCBS Plans announced a policy to expand access and coverage for telehealth services to enable social distancing and promote public health during the initial 90 days of the public health emergency (PHE).[4] Many have extended access beyond 90 days and are evaluating their programs to meet the needs of their communities post-PHE.

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

In our September 2021 comment letter, we recommended applying three guiding principles to the development of telemedicine models. BCBSA believes the TARA model law should: (1) ensure access and efficiency; (2) maintain flexibility; and (3) make consumer trust paramount. The principles are outlined in greater detail in our previous comments.

As the committee continues its work on the model, we respectfully ask that you consider our recommendations below as we share your goals of supporting the need to have clear guidelines to ensure consumer access while protecting consumers as they have come to expect. Additionally, we 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. 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."[5]

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 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

[5] Id.

negotiations conducted by the insurer with providers in the same manner as the insurer establishes payment for covered services delivered by in-person means.[6] 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.[7]

**Recommendation: If Sec. 4 (D) is retained, BCBSA recommends amending it to track more closely with our guiding principle of maintaining flexibility.** A more flexible approach would be 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; this section aligns with our guiding principle of ensuring access and efficiency. 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 redress 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**.

**Section 6. Network Adequacy and Limitation**

---

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

[7] http://www.kslegislature.org/li_2020/b2019_20/statute/040_000_0000_chapter/040_002_0000_article/040_002_0213_section/040_002_0213_k/

Section 6 (a) prohibits an insurer from using telemedicine or telehealth to satisfy applicable network adequacy requirements with regard to a health care service. Section 6 (b) prohibits an insurer from limiting coverage only to services delivered by select third-party telemedicine or telehealth organizations.

**Recommendation: BCBSA opposes Section 6 as it does not adhere to our guiding principles of ensuring access and efficiency by maintaining flexibility; we recommend the section be stricken**. Just as this model facilitates new ways for insurers to cover health care services through telehealth, states and insurers should have flexibility in network design to reflect patient preferences and utilization patterns for care delivery and to leverage the increasing number of providers who serve patients through telehealth. While we are proud that BCBS Plan's networks are frequently the largest and most stable of all health plans, given the realities of provider shortages, telehealth providers may be needed to fill gaps in certain areas where in-person care is difficult to access, particularly for behavioral health care services. As the U.S. Government Accountability Office recently reported to Senate Finance Committee, one-third of Americans already live in an area with behavioral health provider shortages; tying states and insurers hands through this network adequacy limitation may only make these shortages worse as the model removes a potential flexibility to increase network capacity to reflect new care delivery.[8] BCBSA, therefore, believes that health plans and regulators need the flexibility to respond to local circumstances without being hemmed in by a national standard.

This policy also runs counter to the flexibility provided by the Centers for Medicare & Medicaid Services (CMS) in the Medicare Advantage (MA) program which allows MA organizations to receive a 10% credit towards the percentage of beneficiaries that must reside within required time and distance standards when they contract with telehealth providers in 12 specialties, including psychiatry.[9] CMS explained it took this action in recognition that providers who provide telehealth services add value to a contracted provider network, while setting the telehealth credit level proportionate to the role that telehealth providers have in a contracted network.

With respect to plan certification standards for qualified health plans offered on the federal exchanges, CMS intends to issue new network adequacy regulations, likely through the forthcoming 2023 annual Notice of Benefit and Payment Parameters, in response to the *City of Columbus v. Cochran* decision. Such standards may address the extent to which telehealth providers can satisfy network adequacy standards or be included in plans' provider directories. In light of this activity, we believe the most appropriate course is for the NCOIL TARA model to stay silent on this topic, by striking Section 6, as it would preclude state regulators from providing telehealth credit is premature and could run counter to federal policies.

---

[8] https://www.gao.gov/assets/gao-21-437r.pdf

[9] The 12 specialties are Dermatology, Psychiatry, Cardiology, Otolaryngology, Neurology, Ophthalmology, Allergy and Immunology, Nephrology, Primary Care, Gynecology/ OB/GYN, Endocrinology, and Infectious Diseases. CMS, "Medicare Program; Contract Year 2021 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program" Final Rule, 85 FR 33796 (June 2, 2020).

We welcome the opportunity to discuss our comments with you and your staff and would be happy to provide additional details on our principles and recommendations. If you have questions, please contact Randi Chapman, managing director, state relations, at Randi.Chapman@bcbsa.com or Lauren Choi, managing director for health data and technology policy, at Lauren.Choi@bcbsa.com.

Sincerely,

Clay S. McClure
Executive Director, State Relations