

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE
INTERIM COMMITTEE MEETING
AUGUST 21, 2020
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health Insurance & Long Term Care Issues Committee held an interim meeting via Zoom on Friday, August 21, 2020 at 1:00 P.M. (EST)

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

Other members of the Committee present were:

Rep. Deborah Ferguson (AR)
Asm. Ken Cooley (CA)
Sen. Jack Tate (CO)
Rep. Colleen Burton (FL)
Rep. Martin Carbaugh (IN)
Rep. Peggy Mayfield (IN)
Rep. Joe Fischer (KY)

Sen. Paul Utke (MN)
Asm. Kevin Cahill (NY)
Sen. Bob Hackett (OH)
Rep. Wendi Thomas (PA)
Rep. Carl Anderson (SC)
Del. Steve Westfall (WV)

Other legislators present were:

Sen. Thomas Alexander (SC)
Rep. Robin Smith (TN)

Also in attendance were:

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

QUORUM

Upon a motion made by Sen. Bob Hackett (OH), and seconded by Rep. Joe Fischer (KY), NCOIL Secretary, the Committee waived the quorum requirement without objection by way of a voice vote.

INTRODUCTORY REMARKS

Asw. Pam Hunter (NY), Chair of the Committee, thanked everyone for joining the meeting and stated that she asked to call this interim meeting because she wanted to make sure that when the Committee meets at the "Summer" Meeting in September, the Committee is not pressed for time such that people feel unduly rushed and topics do not get properly vetted.

Asw. Hunter stated that the Committee will get started today with the final discussion on the NCOIL Short Term Limited Duration Insurance Model Act, sponsored by Rep. Martin Carbaugh (IN). The Model was first introduced at last year's Summer Meeting and the Committee has had extensive discussions and has heard from those on both sides of the issue. Accordingly, today will be a final opportunity for legislators and interested persons to offer comments on the Model

before a vote is taken at the Committee's next meeting in September. Of course, feedback between now and the September meeting is still welcome.

Next, the Committee will discuss the NCOIL Health Care Sharing Ministry Registration Model Act, also sponsored by Representative Carbaugh. This Model was also introduced at last year's Summer Meeting and thus far, opinions on the Model and the issue of health care sharing ministries in general, have varied significantly enough that a formal decision on how to proceed is proper. Therefore, today will be an opportunity to determine if the Committee should move forward with developing the Model, or table it for possible consideration at a later date.

The Committee will next hear from Chris Myers, Executive Vice President, Reimbursement & Strategic Initiatives at Air Methods Corporation (AMC), regarding air ambulance subscription membership products and the legislative and regulatory environment surrounding them. Lastly, the Committee will have an initial discussion on the possible development of an NCOIL Telemedicine Model Act.

FINAL DISCUSSION ON NCOIL SHORT TERM LIMITED DURATION INSURANCE MODEL ACT

Rep. Carbaugh thanked everyone that has worked on this Model and noted that it is almost time for a vote. Rep. Carbaugh stated that he believes very strongly that short term limited duration insurance plans are products that can really help people. This Model is based on the bill that he sponsored in Indiana and upon that bill being signed into law, he thought it was a great opportunity to present it to NCOIL for development of a model act that other states can look at. Rep. Carbaugh noted that since the bill was signed into law, many uninsured people in Indiana have been helped by these plans, and many businesses have come into the state to provide more competition and therefore lower prices. It is important to note that States are free to oversee, regulate, and even ban short-term plans – that is why he included the drafting note in Section 2 of the Model stating: "States are not required to offer short term limited duration insurance plans. For states that choose to offer such plans, this Model is intended to serve as a framework that can be adjusted accordingly to meet each state's needs."

The drafting note is important because opinions differ as to the value of short-term insurance plans, and some states have in fact prohibited their sale. Rep. Carbaugh noted that he of course disagrees with those states and he is a strong believer in the product, but nonetheless, it's important for the Model to be clear that states are not required to offer these plans and the Model is meant to be a framework to build on for those states that do offer such plans.

Rep. Carbaugh then noted some changes that he will be offering in the next version of the Model which will be distributed in the 30 day materials next week. The changes are largely based on the comment letter submitted by Blue Cross dated January 31, 2020. First, a new Section will be added titled "Applicability" and it will read "This Act shall apply to short term insurance plans delivered or issued for delivery to residents of this state, regardless of the situs of the contract or policy; however, nothing in this Section shall invalidate a plan validly delivered in another state."

Rep. Carbaugh stated that such language is important to include to recognize the fact that, in situations such as when short-term insurance plans are delivered to a group or association in one state and then sold to consumers in another state, insurance regulators have jurisdiction to regulate all short-term insurance plans covering residents in their state. However, the language he is proposing makes clear that a short-term plan is not nullified if it is delivered or sold in a

state that permits the sale of such plans, but then resides with the consumer in a state that prohibits such plans. For instance, if someone purchased a short-term plan in Indiana and then moves to a state that prohibits such plans, the plan should not be invalidated only because that person moved to a state that prohibits them. That person may not be able to renew the plan in that state, but the plan should not be invalidated.

Next, a new Section will be added regarding rescissions that will incorporate the same rescission standards as applied to group and individual health insurance coverage. Essentially, an insurer that issues a short-term insurance plan cannot rescind such a plan once the enrollee is covered except for an act or practice that constitutes fraud or intentional misrepresentations of material fact. This is consistent with the requirements in the Public Health Service Act and is an important consumer protection to include in the Model.

Lastly, current Sections 3(c) and 6 will be amended to replace the term “participating provider organization” with “network based plan.” Rep. Carbaugh noted that in the last draft of the Model, he had changed the title of Section 6 from “preferred provider requirements” to “network based plan requirements” so that it applies to network based-plans, including preferred provider organizations, health maintenance organizations and exclusive provider organizations. Accordingly, using the term “network based plan” throughout the Model is appropriate for consistency.

Also, in current Section 6(b)(3)(i), a couple of housekeeping amendments will be made to the citations to the federal code in the form of periods between CFR and the inclusion of the section symbol. Rep. Carbaugh stated that he is open to making some further edits to the Model, but would like to have the Model ready for a vote at the “Summer” Meeting in September.

J.P. Wieske, Executive Director of the Health Benefits Institute (HBI), stated that he has some concerns with the proposed amendment offered by Rep. Carbaugh regarding “Applicability.” There is a concern that in a lot of cases, short-term plans are issued from an administrative standpoint from one state and then sold into other states. It sounds like the language offered by Rep. Carbaugh does not allow consumers to take their plan with them and limits the ability of consumers to buy short-term plans through associations. It might limit the ability of insurers to continue to sell the products in states without directly filing them in all 50 states which could create an administrative difficulty. Mr. Wieske asked Rep. Carbaugh if that is his intent because that is something that Blue Cross has pushed in other states and that would be a concern for HBI. Rep. Carbaugh stated that he does not see the point raised by Mr. Wieske to be an issue but would be happy to discuss it with him once the new language is distributed.

Brian Blase, President & CEO of Blase Policy Strategies, thanked Rep. Carbaugh for the work he has done on the Model and stated that it is good to hear about all the good things happening in Indiana since his bill was signed into law. Mr. Blase noted that he spoke at the 2019 NCOIL Annual Meeting in December on this issue and stated that he served as Special Assistant to President Trump at the National Economic Council from 2017-2019. He also noted that he wrote a piece recently in the Health Affairs Blog on what he believes is the proper role of government regulation of the short-term market. We know exchange enrollment remains well below expectation as there are about 15 million fewer people enrolled in the exchange plans as the coverage is simply unaffordable for most people who don’t receive large subsidies.

Accordingly, short term plans are a crucial option for millions of Americans. Chris Pope, a healthcare economist, conducted a study last year that compared ACA plans with short term plans and found that for equivalent insurance protection, short term plans are much lower – in

some cases half the cost. Unlike the ACA markets, people do have an incentive to obtain high value from short term plans because they are spending their own money. States should allow people to purchase what works best for them. For market innovation and so that plans can best meet people's needs, policymakers should avoid imposing sweeping mandates on short-term plans. Mr. Blase stated that he believes the proposed amendments to the Model largely make sense and many of the Model's provisions are reasonable, particularly those pertaining to robust disclosure of benefits and limitations.

Mr. Blase stated that he believes two sections of the Model do merit further review – Section 6 regarding network requirements and Section 8 regarding restrictions as to how short-term plans can be priced. Those Sections will do more harm than good – particularly section 8 which will reduce choice in plan innovation, increase the number of people without insurance, harm those with pre-existing conditions and lead to more denials of coverage. Mr. Blase urged the Committee to arm consumers with information about short term plans while allowing maximum consumer choice and market innovation.

Rep. Carbaugh stated that he has previously spoken with Mr. Blase about Section 8. With regard to Section 6, it is important as networks are so prevalent and in Indiana, that Section was included as a request from the healthcare folks who have called into questions with some short term plans. Rep. Carbaugh noted that he believes short terms plans are sometimes conflated with other limited benefit health programs such as indemnity type plans but they are not the same thing. Short term plans are a substantial health insurance policy, particularly with a \$2 million minimum annual limit as the Model requires. Further, prior to changes being made in Indiana, a \$250,000 max benefit plan and a \$2 million max benefit plan had very small premium differences which made it appropriate to call for a high minimum benefit in order to provide robust benefits that can be kept for three years. With regard to Section 8, Rep. Carbaugh stated that he would be interested to hear what the Committee's thoughts are as that came out of compromise discussions in Indiana.

CONTINUED DISCUSSION ON NCOIL HEALTH CARE SHARING MINISTRY REGISTRATION MODEL ACT

Rep. Carbaugh stated that the Committee has had three very in-depth discussions on this issue at its past three meetings. Rep. Carbaugh noted that he brought this issue forward to this Committee primarily because of an experience a friend of a friend had with one of the sharing ministries that dealt with her having to pay some health expenses out-of-pocket that she expected to be "shared" within the ministry. Rep. Carbaugh then began to hear and read some other similar stories making news headlines and thought that NCOIL would be a perfect forum to discuss what the current legislative and regulatory landscape surrounding health care sharing ministries is like, and whether any model legislation should be developed.

Rep. Carbaugh stated that if you have been involved in the discussions on this issue here at NCOIL, you know that the opinions on what should be done vary greatly. Accordingly, before NCOIL dedicates more time and resources on this issue, Rep. Carbaugh stated that he wanted to check the pulse of the Committee members and interested persons to determine whether the organization should move forward with developing a Model law, or table the issue and perhaps return to it at a later date. It seems that those who favor the sharing ministries do not want much of anything in the form of regulation while others who are not supportive of the sharing ministries do not want any regulation as that would validate such ministries. Accordingly, the Committee is at somewhat of an impasse. Before opening it up for comments, Rep. Carbaugh stated that he does believe there is a proper role for health care sharing ministries and that they

can provide a lot of value and help for people but at this time it seems like it may be best to table the Model due to the wide array of opinions on the issue.

On behalf of the Alliance for Healthcare Sharing Ministries, Brad Nail stated that the Alliance agrees that this issue could use some more development and discussion. The Alliance has no problem with tabling the Model and the Alliance still sees a benefit to an organization like NCOIL promulgating a Model for states to use. Accordingly, the Alliance may return to NCOIL at a later date and ask for a Model to be developed.

Kevin McBride, attorney for Sharable LLC which is a technology provider for health care sharing, stated that Sharable and many others are working with the IRS on a tax deduction for health care sharing ministries. That issue should be worked through in the coming months and might include a definition of a health care sharing ministry. Therefore, Sharable's request is to table the Model, but not permanently as there may be future developments after the IRS finishes its work that would warrant action by the Committee. Rep. Carbaugh then stated that he would like to table the Model from the Committee's agenda.

DISCUSSION ON AIR AMBULANCE SUBSCRIPTION MEMBERSHIP PRODUCTS

Chris Myers, Executive Vice President, Reimbursement & Strategic Initiatives at Air Methods Corporation (AMC), stated that his goal today is to stress why this is an issue and to request that states regulate air ambulance subscription membership products. Emergency air medical services are extremely rare services, used on average about 350,000 times per year compared to 15 million ground ambulance uses per year. Emergency air medical services do not self-dispatch – they get a call from a medical professional or a first responder following state protocols for emergency services. Air medical services are then off the ground in 15 minutes after receiving the call and they do not know much about the patient other than size and weight to make sure they can fit in the aircraft. The services are essentially a flying ICU – it's not just the speed in which the patient is moved but also the services provided including those of a medic and nurse who have specialty care and can do things most clinicians don't do like intubating or providing drugs during flight. Mr. Myers stated that emergency air medical services largely service rural America. A typical situation is such that a patient in a rural hospital will have a condition like a stroke and they are immediately transported to a Level 1 trauma center with the opportunity to receive proper treatment.

With regard to the current state of the industry, Air Methods saw a history of some billing practices that were not great and asked themselves "how can we change that?" Accordingly, Air Methods essentially adopted four pillars focused on eliminating balance billing and getting the patient out of the middle. The best way to do that is go out and get in-network agreements with payers. Air Methods has done that over the past few years and has gone from less than 10% in network with commercial payers to 50% today. Some remaining payers that have to be brought in are Cigna and Aetna. Despite persistent efforts, no major independent national payers have been willing to go in-network.

Air Methods uses a patient advocacy philosophy so for those patients that are transported that have an out of network payer, as soon as that is understood which is usually about 10 days after transport Air Methods will reach out to the patients and assign them an individual and let them know from the beginning saying, for example: "Hi, my name is Chris. We understand that you have Aetna as an insurance provider. Unfortunately, they are out of network with us and we are going to have a long process to get your claim paid but we are going to work with you throughout that process which will require, unfortunately, you – the patient – to be involved

because your payer won't respond to us as an out of network provider. If you can work with us throughout the process to file appeals and to provide information to them, we will get your claim paid and you will have no balance bill – you will only be responsible for the copay and deductible.” That has been very effective both by reducing out of pocket expenses and balance bills and also just giving patients a sense of comfort during a difficult time.

Mr. Myers stated that the next opportunity for Air Methods is to fix the cost shift in the industry. Today, 70% of the patients that Air Methods flies reimburse at Medicare or less. Medicare reimburses about \$5,800 per transport and the average cost is about \$12,000 per transport. That represents about 30% of their population that is just Medicare. Another 40% pay less than Medicare. So, there is a massive cost shift in the industry that needs to be fixed and Air Methods is working hard with CMS and HHS to allow themselves to do cost reporting so that there can be a Medicare rate that is at least close to their cost.

With regard to air ambulance subscription products, the reality is that Air Methods has been able to have a lot of success without having memberships. Air Methods' average out of pocket cost for all patients, including self-pay, is only \$167. Mr. Myers stated that he paid more than that this morning at the dentist's office. The strategies that Air Methods has deployed have been very effective and they will not stop until they can get rid of all balance bills. 90% of Air Method's patients never receive a balance bill because of the in-network progress that has been made in the commercial space.

Air ambulance membership products were started with a good intention and that intention was that since payers are rejecting more and more claims patients need to be protected from big out of pocket expenses. However, that landscape has changed and memberships have become less relevant and at this point have become problematic. They are 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. Even for those cases that are out of network, Air Methods deploys the patient advocacy strategy so that patients are guided through a balance bill process – and patients don't have to pay for that strategy, nor should they. The other issues with membership products is that they are marketed in a way and sold to people who don't need them. Some marketing materials include “senior pricing” – why would someone with Medicare need a membership when they have a defined copay and deductible. It doesn't make any sense. From Air Method's perspective, the folks that are selling memberships are using fear as a tactic to get them to buy a membership when they don't really need it. Membership products started as somewhat of a backstop but they now have a significant revenue stream where they have whole business models just around the membership program which in Air Method's estimation could generate \$100-\$200 million in revenue.

The problem with memberships is that they get marketed from a standpoint of fear. It shouldn't be that way and from Air Method's patient advocacy perspective, it does many of the things for free that the membership products claim that they will do so patients shouldn't have to pay a membership fee for that. The other thing with the way membership products are sold is that a helicopter will be flown into a county fair and people will be told how great it is but that if they don't want to be stuck with huge balance bills they need to buy membership products. The gist of all of that is to say that there are much more effective ways to do these type of things which involve in network advocacy, patient advocacy and working in ways not to collect dollars from patients but from payers.

Mr. Myers stated that you will see some areas where patients will actually refuse a flight even the doctor has ordered it because they have a membership and they don't know if the aircraft that is going to fly them is a part of that membership program. That has created a dynamic where patients are not getting the care they need because they don't know if the membership that they have will cover things. That creates more confusion which is also exacerbated by selling membership products to the elderly population that don't need them. Mr. Myers stated that Air Methods asks that a solution be developed to protect consumers from memberships. Air Methods believes that they act, look, and sound like an insurance product and therefore should be regulated as an insurance product. The hope is that the confusion and fear that is used to sell membership products is eliminated.

Sen. Bob Hackett (OH) stated that Ohio is working very hard to eliminate surprise billing and a deal that has involved compromise with everything is almost complete. Sen. Hackett asked if Ohio will be a state that allows membership products if surprise billing is no longer a problem. Mr. Myers stated that he does not believe just eliminating surprise billing will get rid of memberships. Memberships will still be sold because they have been marketed as a way to cover a copay and deductible as well – so even though you didn't get a surprise bill you may have a high deductible plan and the membership can solve that. Air Methods believes there are issues with that approach as well because copays and deductibles exist as a means to overutilization and they are not supposed to be routinely forgiven. That is problematic and memberships will still continue despite surprise billing legislation.

Mr. Myers further stated that it is important to note that there is a Committee that the Department of Transportation (DOT) has started – the Air Ambulance Patient Billing Advisory Committee – that is tackling this issue. Mr. Myers stated that he is a member of that Committee and the Committee started its work in January with the goal of recommendations ready by June to give to Congress. Since the pandemic occurred that deadline was not met but meetings have resumed and the goal is to have recommendations ready by the end of the year.

Rep. Deborah Ferguson (AR), Vice Chair of the Committee, stated that she hopes any legislation on this issue would have measures in it to prevent membership products being sold to Medicare and Medicaid patients along with significant penalties for doing so since those are covered services that the patient may not be aware of. Mr. Myers agreed.

Asw. Hunter asked Mr. Myers to discuss what Air Methods is trying to facilitate with CMS on this issue. Mr. Myers stated that Air Methods has engaged CMS to look into membership products. Air Methods knows of no other similar product that is sold and marketed to Medicare and Medicaid beneficiaries. Air Methods has provided a memo to CMS that outlines these concerns with the goal of regulating these products and above all protecting Medicare and Medicaid patients.

Asw. Hunter thanked Mr. Myers and noted that this issue will not be discussed at the upcoming "Summer" Meeting but noted that it may be on the agenda at the Annual Meeting in December with something concrete to discuss such as a draft Model Act or Resolution. Asw. Hunter urged any comments or questions to be directed to NCOIL staff.

DISCUSSION ON DEVELOPMENT OF NCOIL TELEMEDICINE MODEL ACT

Asw. Hunter stated that as we all know, COVID-19 has impacted several different kinds of industries and forced them to adapt to new ways of doing business. One example of that adaptation is the rapid expansion of telemedicine. Telemedicine is not new – in fact this

Committee discussed the issue at length several years ago – but the global pandemic has caused both federal and state telemedicine laws to be examined in order to make sure patients can receive the care they need without any delays; such as when quarantined during a global health emergency like the one in which we find ourselves.

As an example of how significant the expansion of telemedicine has been, CMS reported there was an average of 13,000 telemedicine visits per week prior to the pandemic. But in the last week of April alone, almost 1.7 million Medicare beneficiaries had a telemedicine visit. There appears to be almost unanimous agreement that once we finally return to a sense of normalcy following the pandemic, the expansion of telemedicine is here to stay. Some states have already taken action to enact legislation that would make many of the telemedicine flexibilities expanded during the pandemic permanent. Asw. Hunter stated that she thinks this presents a great opportunity for NCOIL to get involved and provide guidance to states in the form of telemedicine model legislation and she would be proud to sponsor such a model. Asw. Hunter stated that she would like to hear from legislators and interested persons today as to what their thoughts are on what should or should not be in an NCOIL telemedicine model act.

Asw. Hunter stated that she would then like to include a first draft of a model in the 30 day materials for the “Summer” Meeting, which will be distributed next week. The committee will then have an opportunity to discuss the first draft in September. Asw. Hunter noted that during the pandemic she has used telemedicine and has found it to be very easy in a place like Syracuse, NY that is a transportation desert and people don’t have opportunities to get to appointments or are concerned about contracting COVID-19. Telemedicine is a great option to be able to use as a healthcare resource.

Rep. Ferguson stated that if nothing else, this pandemic has really escalated the use of telemedicine. Rep. Ferguson stated that she passed the first telemedicine bill in Arkansas almost six years ago but she still thinks that, despite certain exceptions being made for the pandemic, it still needs to be focused on best practices and the best practice of medicine. Certain things such as waiving copays have been done during this crisis but with regard to establishing a patient-provider relationship, Arkansas law states that it has to be an audio-visual visit. Phone calls are a different thing – Medicare pays for phone calls but if you are really having an audio-visual visit payment parity is important because they are going to follow the same CPT codes and get reimbursed at the same level whether it’s a 15 minute visit or a 30 minute visit. Parity is important.

Rep. Ferguson also stated that she does not want to see telemedicine go the way of pharmacy benefit managers (PBMs) where they gradually start impeding on the practice of medicine like they have with pharmacies. Rep. Ferguson further stated that another thing she sees is that a lot of the telemedicine companies when a patient gets online and fills out a 25 page questionnaire are calling that a medical record and they want that to be store and forward. Store and forward has been around a long time and medical records are exchanged all the time between primary care physicians and specialists. Filling out a questionnaire online is not store and forward because that is not sharing medical record information. Those parameters are important. Some states have discussed the issue of telemedicine licensing but that is not an issue in Arkansas because you can conduct telemedicine in Arkansas if you don’t have a physical location in the state. Rep. Ferguson stated that it is her understanding that in some states it is more difficult to get a license and telemedicine cannot be conducted unless there is a physical brick and mortar location in the state.

Asm. Kevin Cahill (NY), NCOIL Treasurer, stated that the concern he has had all along with telemedicine is some of what was expressed by Rep. Ferguson and some of what has been discussed in the past. We cannot allow telemedicine to become a substitute for in-person healthcare when in-person healthcare is the appropriate means of delivering healthcare. Asm. Cahill stated that he is concerned on both fronts – in terms of insurers trying to incentivize or force consumers into telemedicine and also providers who would perhaps find a way to use those services in lieu of in-person visits when in-person visits are more appropriate. Situations involving Medicaid present a problem because many poor people do not have access to broadband technology and video services. Asm. Cahill stated that the federal qualified health plan in his community in the beginning of the pandemic found it virtually impossible to conduct telemedicine visits so what happened was that people went without healthcare. The rule changed at the federal level allowing telephonic meetings that were not consults but actual full blown office visits.

Asm. Cahill stated that we need to have all of these things in consideration when drafting a balanced model act so that when it gets implemented into states it does not change the nature of healthcare. We also need to recognize, which was brought up several years ago to this Committee, the vast differences from one state to another. Some places have a girth of healthcare in urban areas and none in rural areas and telemedicine is an important tool for that purpose. This is not a piece of legislation that should specifically encourage or discourage the use of telemedicine but it does have to take into consideration all of the competing interests. Asm. Cahill stated that he hopes that an NCOIL model act is consumer centric and has provisions addressing the points that have been raised.

Sen. Hackett stated that years ago he worked hard to get a telehealth bill passed in Ohio but one of the ways that was done is that there was no payment parity – reimbursement was slightly less. Sen. Hackett stated that the expansion of telemedicine has been one of the positive things to come out of the pandemic. He stated that he was just on a Zoom call where a medical hospital system increased their telehealth by over 1,000%. They went from under 500 per month to 30,000 per month. One point to make is that this is working very well in that you are not seeing people run to the emergency room as often as they did in the past. We are also seeing appointments being held with providers. Sen. Hackett stated that he has had several telehealth visits via phone and it works very well. Sen. Hackett stated that he thinks it is a good system and he understands everyone wants their health to be better and telehealth can help people see providers more than they have in the past. It is important to understand that the emergency room system looks like it has been changing for the better in terms of less frequent visits given the expansion of telehealth. Sen. Hackett stated that he has changed slightly in his views towards payment parity and he knows that providers would make more money in this situation but it is a win-win as costs will be better controlled. We want people to be healthier and providers are seeing patients more than they normally would. Accordingly, the system in this country could be changed for the better because of telehealth. Ohio is currently working on further telehealth legislation.

Rep. Robin Smith (TN) stated that in Tennessee with regard to payment parity and making it friendly to existing providers, Tennessee created a definition of provider based telemedicine and contrasted that with what was existing in code of telehealth. Telehealth being facility to facility and provider based telemedicine being a Tennessee practitioner licensed by a governing board whether it be a nurse or a EA, physician, therapist, etc. – provider based telemedicine would fall under that governance and there would have to be an existing relationship with that Tennessee based provider. That would in no way prohibit a contractual in-network pool of a franchise telemedicine/Teledoc/MD live. The legislation permits Tennessee providers to interact with

Tennessee patients. By using CPT codes that currently exist and by putting in code that all of this would be subject to utilization review, Tennessee was able to push payment parity. Rep. Smith stated that she would be happy to work with the Committee to use provisions of the Tennessee law as part of the Model. Tennessee found it was important not to eliminate that which was already in existence which was functioned as telehealth facility to facility – it was just expanded and they made sure that franchise type telemedicine would not be impacted and wouldn't creep into provider based telemedicine which does require a live, virtual visit and the use of store and forward. That is what is eligible.

Rep. Colleen Burton (FL) stated that in 2019, Florida enacted telehealth legislation that relates to the relationship of physicians and patients and other medical practitioners. It is a broad piece of legislation but there is language which deals with out of state providers. There is a process whereby a physician licensed outside Florida can practice. There have been conversations regarding billing but at this point in time no one has moved forward on that issue. Florida is very proud of the legislation enacted and would be happy to work on model legislation with NCOIL.

Rep. Ferguson stated that she wanted to clarify that in Arkansas if there is already an existing patient-provider relationship or if there is access to the medical record then phone calls count but it is important that it is an actual medical record and not just an online document.

Sen. Jack Tate (CO) stated that he was able to carry a telemedicine bill in Colorado and have it enacted. One of the issues that arose at the end was to what degree should the availability of telemedicine clinicians be able to use toward network adequacy requirements. That is a very interesting topic as significant capital investments have been made for brick and mortar locations and this presents a different model. That is a topic that should be discussed further.

Brendan Peppard, Regional Director, State Affairs of America's Health Insurance Plans (AHIP), stated that during the pandemic telehealth has emerged as a tool that improves access by removing traditional barriers to the use of healthcare such as distance, mobility and time constraints and for those individuals who are compromised or for those doctor offices that were closed it has allowed people to access healthcare. Health insurance providers are supportive of the appropriate use of telehealth to provide access and reduce cost to necessary medical services to its members. Prior to this health crisis, telehealth was a growing industry and most health insurance providers offered virtual access to their members but uptick had been low. Trends have begun to change. Access from the government and from health insurance providers have promoted growth. A FAIR Health report showed an 8,000% increase in telehealth visits.

There have been some key areas of increased flexibility during the health crisis including flexibility around originating sites, patient and provider location, increased allowance for the services available, providers eligible to practice via telehealth, and eligible technology. We have also seen rural health clinics and FQHCs being permitted to deliver telehealth. Mr. Peppard stated that in order to move forward following the pandemic, health insurance providers have some recommendations about things that can cement the positive changes we have seen regarding the use of telehealth. First, during the crisis many states lessened restrictions on practicing medicine across state lines. A physician's ability to practice across state lines is determined by a state whenever licensure was granted, potentially restricting the ability of clinicians to deliver virtual care to patients outside the state of their license. AHIP recommends that states allow providers to practice in multiple states to increase access across the entire country and allow for the creation of a national network of providers if that is something that makes sense.

Next, inconsistent state regulations, restrictions or mandates relating to budgets, services or technologies or originating sites may limit health insurance providers ability to design benefits that best meet patient needs. The use of telehealth services should be expanded to provide better access to care for people living in underserved areas. Telehealth can extend the reach of care teams, allow for around the clock monitoring, increase data collection guide an individual's treatment, and may provide more timely responses to crises during treatment. We should leverage telehealth to target services for underserved communities and ensure convenient access to high quality, affordable care. A recent report from Teledoc indicated that half of behavioral telehealth interactions were with men ages 20-35, a notoriously hard to reach demographic. As demonstrated by that example, some populations may be more comfortable using telehealth as a means to receiving services. Requiring equivalent telehealth and in-person payment rates eliminates the cost-saving potential of telehealth.

Mr. Peppard stated that AHIP's recommendations is to allow for flexibility in negotiating appropriate payment rates for telehealth services. The savings from those negotiations can and do benefit the consumer. Payment parity may have made sense during the pandemic as doctor's offices were closed and people couldn't get to doctor's offices when they were open because they may not have been comfortable or because they should not have been going due to compromised immune systems. However, post-pandemic, AHIP believes that payment parity doesn't make sense and it should be left to a negotiation. Telehealth visits don't always require the same type of intensity, the same amount of time, or the same equipment as brick and mortar visits. Therefore, reimbursement parity should not be required. AHIP also believes that telehealth should not become a replacement for needed in-person visits. One of things that we have seen are concerned about is a drop in necessary vaccination rates. Obviously, those cannot be done via telehealth and we have to encourage people to go to their doctors. We don't want to create an inappropriate incentive to substitute a telehealth visit for a necessary in-person visit.

The explosion of telehealth under COVID-19 has provided opportunities and raised new questions. Ultimately, the growth is good. Health insurance providers have been promoting telehealth use for a decade and it is believed that much of what has been seen regarding the increase in utilization is positive. Telehealth has proven useful, especially among underserved and difficult to reach populations and geographies. Telehealth is not inherently most risky than in-person services but with increased volume we need to make sure it is safe, effective, and efficient care. Mr. Peppard thanked the Committee for the opportunity to speak and stated that AHIP stands ready to work with the Committee going forward.

Mr. Wieske stated that in addition to the HBI he represents Horizon government affairs and he previously was deputy Commissioner for the State of Wisconsin and he worked directly on network adequacy issues which is a very important topic to understand in a model act. For consumers, especially in a rural setting, having access to telehealth can provide access to providers to dermatologists and others that are just not practicing in rural settings. That is important to understand. The NAIC network adequacy model act does include provisions as to how telehealth can be used inside a network adequacy model. Mr. Wieske stated that it is also important to be careful as we go through this process that there is a lot to get wrong around telehealth. We have seen the movement of regulations that have increased the availability of telehealth – not just from COVID-19. That indicates the importance of regulatory flexibility. Looking at sites of service is important. Also, licensing is important - in a lot of cases recently it is not just telehealth licensing flexibility but broader licensing issues including moving beyond the compact licensing of medical doctors in this area. It is also important to look at software

issues and not pick winners and losers. In some cases, audio is the only way individuals can access care and there shouldn't be issues surrounding that. In other cases, winners and losers should not be picked between Microsoft, Google and other products. That is something a number of states have looked at.

Emily Carroll, Senior Legislative Attorney at the American Medical Association (AMA), stated that the AMA welcomes the opportunity to work with NCOIL on a telemedicine model act. In the AMA's view, a model act is extremely timely as the pandemic is really pushing stakeholders to realize the value of care provided via telemedicine. For example, telemedicine is allowing patients, especially those vulnerable to COVID-19 complications to continue access to care safely with their physicians. It is also helping physicians maintain their practice and staff during stay at home orders when providing in-person care is not safe or feasible. It has also been an important tool in addressing longstanding inequities although much work remains there to ensure that patients have access to broadband and other technologies. If the Committee decides to move forward with a telemedicine model act, the AMA would love the opportunity to offer a number of recommendations related to access, coverage, payment. The AMA will plan to offer those recommendations in writing and they will focus on advancing telemedicine not as a replacement for in-person care but as a valuable supplement to in-person care to improve coordination of care and ensure vulnerable populations have access to physicians and realize the efficiencies and ROI that come with expanding the means by which care can be provided. The AMA looks forward to working with the Committee on these issues.

Rep. Burton stated that with regard to payment parity, Florida has not considered mandating any particular formulas for payment. Current Florida law is flexible so it leaves those arrangements between the providers of insurance and providers of medical care. That does require a lot of oversight by regulators which can sometimes be a challenge. Florida is excited about telehealth as it is expanding their just like in other states and it was good that Florida was flexible enough to allow for such frequent telemedicine use during the pandemic. There is a lot of rural space in Florida.

Asw. Hunter thanked everyone for their comments and stated that she looks forward to working with everyone going forward.

ADJOURNMENT

Upon a Motion made by Asm. Cooley (CA), NCOIL Vice President, and seconded by Del. Steve Westfall (WV), the Committee adjourned at 2:15 p.m.