MPHA
Maine Public Health Association

Testimony of the Maine Public Health Association In Support of:
LD 1 - An Act To Establish the COVID-19 Patient Bill of Rights

Joint Standing Committee on Health Coverage, Insurance and Financial Services
Room 220, Cross State Office Building
Tuesday, February 23, 2021

Good morning Senator Sanborn, Representative Tepler, and distinguished members of the Joint Standing Committee on Health Coverage, Insurance and Financial Services. My name is Rebecca Boulos. I am a resident of South Portland and executive director of the Maine Public Health Association. I am here to provide testimony in support of LD 1 – An Act To Establish the COVID-19 Patient Bill of Rights.

MPHA is the state's oldest, largest, and most diverse association for public health professionals. We represent more than 500 individual members and 30 organizations across the state. The mission of MPHA is to improve and sustain the health and well-being of all people in Maine through health promotion, disease prevention, and the advancement of health equity. As a statewide nonprofit association, we advocate, act, and advise on critical public health challenges, aiming to improve the policies, systems, and environments that underlie health inequities – but which also have potential to improve health outcomes for all people in Maine. We are not tied to a national agenda, which means we are responsive to the needs of Maine's communities and we take that responsibility seriously.

This bill expands insurance coverage for COVID-19 testing and immunization and prohibits cost-sharing for consumers. It also extends pharmaceutical drug prescription period to 180 days during states of emergency and expands access to telehealth, such that audio-only telephone is a covered service.

We support the expansion of insurance coverage and prohibition of cost-sharing. The inability to pay for healthcare is a barrier to accessing care. Several studies have shown that cost-sharing reduces the demand for care.[1,2] The RAND Health Insurance Experiment showed that higher cost-sharing leads to a decrease in demand of care with no effect on health – except for those with the lowest income and poor initial health.[3] As we have seen with COVID-19, a state of emergency can lead to loss of income, heightening the financial burden of healthcare, and decreasing the likelihood that people with low income will seek care due to other basic need expenses – such as heat, electricity and food. These provisions in the bill will make testing and vaccination more accessible, without increased cost burden, thus promoting individual and community health.

The extended prescription drug benefit is particularly important because it allows patients to limit their travel during a state of emergency. This clears roads, in cases where the state of emergency is due to a natural disaster, making it safer for emergency responders. It also helps minimize the transportation barrier many Mainers experience, particularly those living in rural areas. We support the amendment that clarifies that opioid medication is not included in this extended pharmacy benefit.

The inclusion of coverage for audio-only telehealth is also important and a matter of health equity. According to *The National Law Review*, "…technological and geographic restrictions that, amongst other things, have

inhibited the provision of telemedicine services in rural areas where a lack of adequate broadband connectivity to support audio-visual telemedicine technology can be a significant impediment to the use and expansion of telehealth technology."[4] This month, the RAND Corporation published an article in *JAMA* about audio-only telehealth during the COVID-19 pandemic, a service popular in rural areas. According to the study, for primary care visits, 48.1% occurred in person, 48.5% via telephone and 3.4% via video. Comparatively, for behavioral health visits, 22.8% occurred in person, 63.3% via telephone and 13.9% via video. Telephone visits peaked in April 2020, comprising 65.4% of primary care visits and 71.6% of behavioral health visits.[5] These data underscore the reliance on telephone-based care among rural populations that may have limited access to broadband, reliable transportation, or other barriers, such as mobility or health status. Ensuring continued coverage for audio-only telehealth is an effective strategy for keeping patients connected with their health care providers, ensuring continuity of care, and reducing health disparities.

This bill is supportive of public health and the advancement of health equity for people in Maine because it reduces barriers to health care access, particularly for populations already experiencing disparities. We appreciate the efforts set forth in this bill, and respectfully ask you to vote "Ought to Pass." I am happy to answer any questions.

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[1] McGuire TG. Chapter Five - Demand for Health Insurance1. In: Pauly TGM MV, Pedro PB, editors. Handbook of Health Economics, vol. 2. Amsterdam: Elsevier; 2011. p. 317–96.
[2] Cutler DM, Zeckhauser RJ. The anatomy of health insurance. In: Handbook of health economics, vol. 1. Amsterdam: Elsevier; 2000. p. 563–643.
[3] Newhouse JP, Group RCIE. Free for all?: Lessons from the RAND health insurance experiment. London: Harvard University press; 1993.
[4]The National Law Review. 2021. "The Permanency for Audio-Only Telehealth Act: A Matter of Healthcare Equity?" Volume XI, Number 47. https://www.natlawreview.com/article/permanency-audio-only-telehealth-act-matter-healthcare-equity.
[5] Uscher-Pines L, Sousa J, Jones M, et al. Telehealth Use Among Safety-Net Organizations in California During the COVID-19 Pandemic. *JAMA.* Published online February 02, 2021.