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TESTIMONY OF ERIC A. CIOPPA
SUPERINTENDENT OF INSURANCE
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DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION
In support of L.D. 1
"An Act To Establish the COVID-19 Patient Bill of Rights"
Presented by President Troy Jackson
Before the Joint Standing Committee on Health Coverage, Insurance & Financial Services
February 23, 2021 at 11:00 a.m.

Senator Sanborn, Representative Tepler, and members of the Committee, I am Superintendent of Insurance Eric Cioppa. I am here today to testify in support of the proposed amendment to L.D. 1.

My testimony addresses Parts A and C of the amended bill, which would make changes to the Maine Insurance Code in response to the public health emergency created by COVID-19. Through emergency powers, I have issued orders imposing certain coverage requirements related to COVID-19, including some contemplated by this bill, for the duration of the public health emergency.

This bill would incorporate COVID-19 coverage requirements into the Code that would apply beyond the public health emergency.

Part A would require carriers offering health plans in Maine to cover COVID-19 screening and testing, except when the screening and testing is part of a "surveillance testing program," as defined in the bill. Part A would also require carriers to cover any COVID-19 vaccine licensed or authorized under an Emergency Use Authorization by the U.S. FDA that is recommended by the U.S. CDC Advisory Committee on Immunization Practices for administration to a health plan enrollee.

If a bill proposes to mandate coverage for a specific health care service, the Insurance Code requires the Bureau to review and evaluate the social and financial impact and medical efficacy of the proposed mandate before it can be enacted.[1] A bill, however, may exempt a proposed mandate from this review. Also, beginning in 2014, the Affordable Care Act (ACA) requires states to defray the costs of all mandates that are included in Qualified Health Plans, unless those mandates are required as part of the essential benefit package. States must make payments either to the individual enrollee or to the insurer.[2] Generally, any mandate adopted by a state after December 31, 2011 has been excluded from the essential benefit package by federal regulators and thus is subject to the requirement for the state to defray the cost.

In this case, however, the ACA already requires coverage for specified preventive services, and the Insurance Code was recently updated to mirror this

[1] *See* 24-A M.R.S. § 2752.
[2] *See* 45 CFR § 155.170, implementing ACA § 1311(d)(3)(B).

ACA requirement.[3] Specified preventive services include immunizations that have a recommendation from the U.S. CDC Advisory Committee on Immunization Practices, as well as evidence-based services that have an A or B rating in the recommendations of the United States Preventive Services Task Force. If COVID-19 screening, testing, and vaccines receive recommendations from these entities, then they would be required as part of the essential benefit package and may not be subject to defrayal.

Additionally, Part A specifies that, for purposes of the coverage requirements imposed on carriers, a bill for out-of-network COVID-19 screening or testing is a bill for out-of-network emergency services under Section 4303-C of the Insurance Code (we note that vaccines are not included in this provision). This means that a carrier would have to reimburse an out-of-network provider for COVID-19 screening and testing at the greater of the carrier's median network rate paid for that service by a similar provider in the enrollee's geographic area **or** the median network rate paid by all carriers for that service by a similar provider in the enrollee's geographic area as determined by the Maine Health Data Organization all-payer claims database. This also means that the Bureau's independent dispute resolution process for bill disputes would be available for out-of-network COVID-19 screening and testing bills.[4]

The Committee may also want to consider prohibiting out-of-network providers from balance billing health plan enrollees for out-of-network COVID-19 screening and testing when a carrier does not pay the full amount charged by an out-of-network provider. Title 22 does this for out-of-network emergency

[3] *See* Public Health Service Act (PHSA) § 2713(a) (42 U.S.C. § 300gg-13(a)); 24-A M.R.S. § 4320-A.
[4] *See* 24-A M.R.S. §§ 4303-C(2)(E) & 4303-E; Bureau of Insurance Rule Chapter 365.

services.[5] Otherwise, health plan enrollees could still receive balance bills from out-of-network providers for COVID-19 screening and testing.

Part A also would require carriers to cover any administrative or facility fees associated with COVID-19 screening, testing, and vaccine administration. Further, coverage must be provided without prior authorization requirements or cost-sharing requirements for health plan enrollees. However, a carrier would be allowed to make coverage without cost-sharing dependent on the use of a network provider if an enrollee is offered those services by a network provider without additional delay, and the enrollee instead chooses to receive the services from an out-of-network provider. Part A also gives discretionary rulemaking authority to the Superintendent to adopt routine technical rules to align the coverage requirements with any applicable federal requirements.

Relatedly, although not in the Insurance Code, Part A would add a provision to Title 22 requiring health care providers to give individuals certain information regarding costs and reimbursement for COVID-19 testing and screening before providing those services.

Lastly, Part C of the bill would amend a section of the Insurance Code[6] that requires carriers offering health plans in Maine to cover telehealth services. First, Part C would remove language that currently excludes the use of audio-only telephone from the definition of telehealth, as well as provisions specific to telephonic services. The bill then adds a provision that would allow audio-only telephone in limited cases when an enrollee is unable to participate in an audio and

[5] *See* 22 M.R.S. § 1718-D.
[6] 24-A M.R.S. § 4316.

visual interaction, and audio-only telephone is medically appropriate and the only available option for delivering needed care. It appears that this provision would give carriers the discretion to decide when audio-only telephone is appropriate.

Second, Part C would add a new provision to the parity requirements for telehealth services that would prohibit a carrier from providing a lower reimbursement rate for a service provided through telehealth than would be provided to the same provider through in-person consultation. The Bureau takes no position on the substance of this proposal. Thank you, I would be glad to answer any questions now or at the work session.