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Honorable Heather Sanborn, Senate Chair
Honorable Denise Tepler, House Chair
Joint Standing Committee on Health Coverage, Insurance and Financial Services
100 State House Station
Augusta, Maine 04333-0100

Re: L.D. 1, "An Act To Establish the COVID-19 Patient Bill of Rights"

Dear Senator Sanborn, Representative Tepler, and Members of the Joint Standing Committee on Health Coverage, Insurance and Financial Services:

Thank you or the opportunity to testify at the public hearing on February 23, 2021. This letter is intended to provide further information regarding the concerns expressed with respect to L.D. 1, "An Act To Establish the COVID-19 Patient Bill of Rights."

We certainly understand and appreciate the premise of the bill—to incorporate the current provisions regarding coverage of COVID-19 into Maine law. However, while well intended, the proposed legislation goes beyond what is required today and would permanently place in statute measures required to address temporary situation. I would like to take this opportunity to discuss our concerns with the bill.

1. Requirement to Cover Testing and Screening at no cost share beyond the current State of Emergency

Section A-2 of the proposed amendment would require carriers to provide coverage and screening for COVID-19 testing without cost sharing or prior authorization. Anthem voluntarily implemented those provisions before they were required at either the state or federal level. Both the Emergency Order issued by the Superintendent and the Federal legislation (the Families First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief, and Economic Security Act (CARES Act)), require health plans to cover screening and testing without cost shares and without prior authorization for the duration of the current states of emergency.

Our concern with the proposed amendment is that would extend beyond the duration of the current states of emergency. As a result, L.D. 1 would require that testing and screening for COVID-19 be covered at no cost share in perpetuity. It is not likely that COVID-19 will always be the pandemic we face today. Although well intended, L.D. 1 may have the unintended consequence of treating the screening and testing for COVID-19 more favorably than the testing

for many other health conditions, even after the current pandemic subsides and COVID vaccinations and treatments are more readily available.

Rather than leave the coverage requirement open-ended, we would suggest that taking the same approach as the federal law (requiring during the current states of emergency) or, alternatively, including a provision to sunset the provision in 1 to 2 years, which would afford the Legislature the opportunity to reexamine the issue and determine whether a further extension of the requirement is necessary or appropriate.

To the extent the legislation would require coverage beyond the current state of emergency, it would be a new mandated benefit subject to review by the Bureau of Insurance pursuant to 24-A M.R.S. §2752.

2. Return to work testing

Second, while the proposed amendment specifically excludes coverage for surveillance testing, it does not exclude "return to work" or "return to school" testing. Coverage of "return to work testing" is not required under the Superintendent's Emergency Order or section 6001 of the FCRA. In fact, FAQs issued by jointly by the Department of Labor (DOL), the Department of Health and Human Services (HHS), and the Department of the Treasury (collectively, the Departments) on June 23, 2020 state as follows:

> **Q5. Is COVID-19 testing for surveillance or employment purposes required to be covered under section 6001 of the FFCRA?**
>
> No. Section 6001 of the FFCRA requires coverage of items and services only for diagnostic purposes as outlined in this guidance. Clinical decisions about testing are made by the individual's attending health care provider and may include testing of individuals with signs or symptoms compatible with COVID-19, as well as asymptomatic individuals with known or suspected recent exposure to SARS-CoV-2, that is determined to be medically appropriate by the individual's health care provider, consulting CDC guidelines as appropriate.13 However, testing conducted to screen for general workplace health and safety (such as employee "return to work" programs), for public health surveillance for SARS-CoV-2, or for any other purpose not primarily intended for individualized diagnosis or treatment of COVID-19 or another health condition is beyond the scope of section 6001 of the FFCRA.

(https://www.cms.gov/files/document/FFCRA-Part-43-FAQs.pdf) (emphasis added).

This was reinforced in FAQs issued last week on February 26, 2021, in which the Departments stated:

> **Q2. May plans and issuers distinguish between COVID-19 diagnostic testing of asymptomatic people that must be covered, and testing for general workplace health and safety, for public health surveillance, or for other purposes not primarily intended for individualized diagnosis or treatment of COVID-19?**

> Yes. Plans and issuers must provide coverage without imposing any cost-sharing requirements (including deductibles, copayments, and coinsurance), prior authorization, or other medical management requirements for COVID-19 diagnostic testing of asymptomatic individuals when the purpose of the testing is for individualized diagnosis or treatment of COVID-19. However, plans and issuers are not required to provide coverage of testing such as for public health surveillance or employment purposes. But there is also no prohibition or limitation on plans and issuers providing coverage for such tests. Plans and issuers are encouraged to ensure communications about the circumstances in which testing is covered are clear. To the extent not inconsistent with the FFCRA's prohibition on medical management, plans and issuers may continue to employ programs designed to detect and address fraud and abuse.

(https://www.cms.gov/files/document/faqs-part-44.pdf) (emphasis added).

To require coverage of "return to work" or employment testing goes beyond what is currently required and have significant cost implications for health plans and employers.

Since this would constitute a new mandated benefit, the Committee should refer the bill to the Bureau of Insurance for a mandated benefit review pursuant to 24-A M.R.S. § 2752 in order to understand the costs associated with such a mandate, both premium costs and the potential costs to the State.

3. Requirement to pay administrative and facility fees

The proposed amendment to L.D. 1 would require carriers to pay administrative or facility fees for COVID-19 testing and screening and for administration of the COVID-19 vaccines. We understand "administrative fees" to mean paperwork processing fees and "facility fees" to mean charges for the use of space and staffing resources in a facility—generally a hospital. Under other provisions of the proposed amendment, these associated charges would need to be disclosed to any patient receiving COVID testing or vaccination services and providers would be prohibited from charging these fees to uninsured patients. We believe that the same patient rights this bill is seeking to protect for the uninsured should also be protected for those individuals and businesses that purchase insurance and are already struggling with unsustainable healthcare costs. This inequity should be reason enough to reject the suggestion of proposed surcharges for one segment of the population only, but we have additional concerns we will explain.

First, facility fees are not appropriate for services rendered in office and other non-hospital settings. The resources involved in the administration of a vaccine are not comparable to a those utilized in services where a patient is a registered outpatient in a hospital, such as an ER visit, or admitted to a facility as an inpatient.

Second, this will create a precedent for allowing such fees for the administration of other vaccines, such as the influenza or shingles vaccine.

Third, under the Federal rule, the Medicare payment rates are considered to be reasonable rates for administration of a COVID-19 vaccine; however, Medicare does not pay a facility fee for administration of the COVID-19 vaccine.

Finally, there is no limit on the amount of the fee that could be charged. Under the proposed amendment to L.D. 1, a provider could charge administrative and/or facility fees of any amount over and above the charge for administration of the vaccine, significantly increasing overall costs. Consider the following example: Assume Anthem has approximately 130,000 fully insured members in Maine and 70% of them receive a COVID vaccine. If you then you assume that 70% of those members receive a vaccine requiring two injections and 30% receive a single dose vaccination, if the provider charges a $20 administrative or facility fee, it results in an additional cost of $3 million dollars—increase that facility fee to $100, and it adds nearly $15.5 million in additional cost that would need to be incorporated into premiums. This at a time when many businesses, particularly small businesses are struggling with the cost of health insurance. And this reflects only the potential costs associated with administrative and facility fees for administration of the vaccine—allowing such fees for the testing and screening would result in significantly higher costs.

The FAQs issued by the Departments on June 23, 2020[1] state that if a facility fee is charged for a visit that results in an order for administration of a COVID-19 test, the facility fee must be covered; however, that is not the same as requiring the payment and administrative fees for all COVID testing, screening and vaccinations, which goes far beyond what is required today. As a result, we strongly urge the Committee to delete the references to administrative and facility fees.

4. Treatment of out-of-network providers of screening and testing as an out-of-network emergency service

The proposed section 4320-P(1)(E), in Section A-2 of the bill, provides that bills for out-of-network screening and testing should be treated as bills for out-of-network emergency services. There is no reason to treat an out-of-network COVID test as a bill for emergency services—it will only serve to increase costs by trying to drive up reimbursement and make a non-emergency service subject to the Independent Dispute Resolution process.

5. Prescriptions during state of emergency

Although we are not impacted by the provisions of Part B of the proposed amendment, we did want to share some concerns with the proposal to allow a 180-day supply of a prescription drug during a state of emergency.

First, we recommend no more than a 90-day supply—longer that 90 days tends to result in waste and, therefore, unnecessary costs. In the face of the pandemic, both carriers and the retail pharmacy market has responded to ensure that our members have access to their prescriptions on the schedule they need. Furthermore, there is no requirement that the member be impacted by the

[1] https://www.cms.gov/files/document/FFCRA-Part-43-FAQs.pdf

declared state of emergency, potentially allowing an individual who lives in Portland to obtain a 180-day supply due to an emergency having been declared in Aroostook County.

6. Telehealth audio only and parity in reimbursement

We do not support the expansion of Maine's telehealth mandate but feel the proposed amendment has narrowed the use of audio only telemedicine.

We are concerned about the requirement of parity in reimbursement for the following reasons:

- Requirements to reimburse telehealth visits at the same rate as in-person visits do not take into account that rates are developed, in part, to cover the overhead costs of providing services such as a provider's office equipment and the site of service, costs that are not always present for a telehealth provider.
- Reimbursement parity sets the rates for in-person services for providers who have brick and mortar offices but would create an uneven playing field for providers who chose to only offer services virtually.
- Reimbursement parity requirements can drive up a member's cost-share if the cost of the telehealth visit is required to be the same as an in-person visit. When providers and payers are able to negotiate and enter into innovative, value-based arrangements that incentivize virtual care, providers may be able to better manage care, at lower costs to consumers.
- Certain telehealth services such as Live Health Online have specific negotiated rates ($0 or $49 for Anthem members, depending on the plan design) that are lower to make the services more affordable and more accessible to members—we shouldn't be required to pay the same amount if they contractually agreed to accept a lower rate.
- Providers and payers should be able to negotiate reimbursement for services delivered virtually. As care delivery quickly evolves and consumers get used to engaging in virtual care, the market should be able to offer new and innovate value-based payment models that do not tie rates to an antiquated fee-for-service system.

7. Mandated benefit study

As noted above, L.D. 1 proposes to establish new mandated benefits. As a result, the Committee should refer the bill to the Bureau of Insurance for a mandated benefit review pursuant to 24-A M.R.S. § 2752 in order to understand the costs associated with such a mandate, both premium costs and the potential costs to the State.

8. Application of the requirements

Finally, it is also important to note that these requirements will not apply to self-funded plans—imposing additional costs on business that purchase health insurance that will not be borne by their self-insured competitors or by their competitors in other states.

Thank you for the opportunity to share these comments. I would be happy to answer any questions you may have.

Sincerely,

Kristine M. Ossenfort, Esq.
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