MAINE ASSOCIATION OF HEALTH PLANS

Testimony of Katherine Pelletreau
to the Joint Standing Committee on Health Coverage, Insurance and Financial Services

Neither For Nor Against

LD 1 An Act to Establish the COVID-19 Patient Bill of Rights

February 23rd, 2021

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

My name is Katherine Pelletreau and I am the Executive Director of the Maine Association of Health Plans (MeAHP). MeAHP has five members including Aetna, Anthem Blue Cross and Blue Shield, Cigna, Community Health Options and Harvard Pilgrim Health Care. Collectively, MeAHP's members provide or administer health insurance coverage to over 600,000 Maine people. The organization's mission is to improve the health of Maine people by promoting affordable, safe and coordinated healthcare.

This bill puts into statute several patient protections that have been established by carriers and others during the COVID-19 pandemic. **While our Plans are supportive of the goals of this legislation, I am testifying For/Nor because we oppose several provisions as written and urge the Committee to consider changes.**

Health Plans have the responsibility to ensure their members get the care they need when they need it. During the pandemic, they have stepped up to protect and help their members every step of the way by:

- Covering tests to diagnose COVID-19 at no cost to patients
- Working with doctors, hospitals, and other providers to ease administrative processes, provide equipment and expand capacity
- Expanding telehealth access and capacity to ensure that people continue to receive needed care
- Providing premium relief to those struggling to help them keep their coverage
- Expanding access to prescriptions to ensure that enrollees have what they need when they need it

This bill seeks to provide protections to patients that, for the most part, they are already receiving. Health plans, government and others have appropriately taken many special emergency-

driven actions to protect people in this terrible COVID-19 pandemic. Caution should be taken in locking requirements into state statute that may be redundant, not align with federal law and regulation, and that would apply well beyond the COVID-19 pandemic.

Part A

Part A of the proposal requires coverage of COVID-19 testing and vaccinations without cost shares.

We oppose relying on private health insurance for widespread public health testing. Carriers have been covering COVID-19 testing without cost shares since the pandemic started, and before they were required to. However, we have concerns about purchasers of private health insurance bearing the costs of broad-based public health testing. Two MeAHP member Plans report that they are seeing approximately 900 tests per month and that the charges for these tests range widely by provider.

The amended language that removes the requirement for coverage of "surveillance testing" does not go far enough. Under this language, carriers would still be required to cover routine testing for employers and schools, and "lifestyle" testing for routine travelers. Once the pandemic emergency has passed, carriers should only have to cover these tests when medically necessary. If COVID testing is rolled into the U.S. Preventive Services Task Force recommendations, it will be covered as a preventive service under essential health benefits without cost share. These tests and vaccinations should not have their own special protocols but, once the emergency is over, should be treated like any other routine preventive care.

We oppose the requirement that facility fees for COVID vaccinations be covered. Facility fees are not typical for vaccines. Currently, carriers pay fees associated with administration of the vaccine but the vaccine itself is made available to the public by the federal government at no charge. In future years, this strain of coronavirus will likely be incorporated into seasonal flu vaccines and subject to preventive health coverage without cost share as an essential health benefit. For children up to age 19, Maine's universal access to childhood vaccines program, a public private partnership program with funding from health insurers, provides coverage for CDC recommended vaccines to all Maine children without cost share. Locking in a requirement for the long-term that is inconsistent with the current process for how vaccines are covered is not the best approach. If the Committee feels something must be in statute, it should coordinate well with existing practice.

The bill also requires coverage for "all associated costs such as processing fees and clinical evaluations". What is meant by this? Is this intended to permit some type of COVID-specific expanded billing? We urge the Committee not to establish new standards for broader billing unique to COVID-19.

PART B

Part B provides for expanded prescription drug coverage of up to 180 days during a state of emergency declared by the Governor.

We oppose the expansion of prescription drug coverage to 180 days. 90 days makes better sense. Our carriers are already providing expanded prescription drug coverage during the pandemic but typically 90 days (3 months) rather than 180 (6 months). We want to ensure that our members get the coverage they need but also avoid wastage for people who may switch drugs or carriers or doctors during that time.

If the concern is about people getting to the pharmacy to pick up their prescriptions, there are solutions already available that carriers and others are encouraging. All carriers have mail-order options, often at lower cost, and widely available pharmacies such as Hannaford and CVS are offering free or low-cost delivery services, including same-day, in store service areas. The availability of these options makes drugs accessible to those not wanting or unable to leave their homes.

We would urge the Committee to reduce 180 days to 90 days to provide expanded coverage while avoiding the cost and wastage of unused medications being prescribed and picked up but, for whatever reason, not taken. This requirement could mean that a carrier is paying for 5 months of medication for someone who is no longer a member. Adopting a 90-day standard would be consistent with what many states and carriers are already offering and what is provided by the CARES ACT for Medicare Plan enrollees upon request.

In light of the coronavirus pandemic, a provision in the CARES Act requires Part D plans (both stand-alone drug plans and Medicare Advantage drug plans) to provide up to a 90-day (3 month) supply of covered Part D drugs to enrollees who request it during the public health emergency. [1]

PART C

Part C expands telehealth coverage to include audio only telephone services. Over the past year the pandemic has driven tremendous growth in the use of telehealth services and in some cases audio only telephone services. There are now at least three new codes for different time increments for evaluation and management audio only telephone services.

These services, when clinically appropriate, make sense, especially in situations such as during a stay-at-home order as we've experienced during COVID, to facilitate services being provided to people in domestic violence situations, and to provide behavioral health services, particularly for those without good internet access. However, audio only telephone is not appropriate for everything as it cannot replace the visual aspects of in-person or audio-visual telehealth.

We oppose parity for audio only telephonic services. Given the differences between an audio only telephone session and an in-person visit, we do not believe payment parity is appropriate. As a policy, it does a disservice to our members and consumers more broadly to create a system that essentially incentivizes audio only care. It is important to understand that someone with a high deductible health plan is going to bear the full cost of the visit whether audio or a regular office visit. We want technology to benefit access to care but this seems like an overreach.

There are a number of telehealth bills coming before the committee to address matters of audio only telephone services. We would suggest that all of these bills, including this portion of LD 1, be worked together.

Thank you for your consideration of these comments.

[1] https://healthlaw.org/ensuring-people-have-access-to-prescription-drugs-during-the-covid-19-pandemic/