H 7171 Article 20– Health Care Reform--

Sections 8-12: ACA Consumer Protections

Section 14: Health Spending Transparency and Containment Act

New Budget Article on Telemedicine

Testimony to the
Honorable Senate Finance Committee
from the RI Office of the Health Insurance Commissioner
July 23, 2020

Office of the Health Insurance Commissioner

- § 42-14.5-2. Purpose.

- With respect to health insurance as defined in § 42-14-5, the health insurance commissioner shall discharge the powers and duties of office to:
- (1) Guard the solvency of health insurers;
- (2) Protect the interests of consumers;
- (3) Encourage fair treatment of health care providers;
- (4) Encourage policies and developments that improve the quality and efficiency of health care service delivery and outcomes; and
- (5) View the health care system as a comprehensive entity and encourage and direct insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access.

H7171
Article 20
Sections 8-12
Consumer Protections

- Goal: That all Rhode Islanders have access to high quality and affordable health insurance
- Fact: The ACA is working in RI with the rate of persons without insurance dropping from 11% prior to the ACA to 4% in 2019
- The ACA sets a minimum for access to quality insurance coverage that the state should require regardless of the federal law being maintained
- ACA is in effect—the adoption of these provisions at the state level does not increase state spending or increase premium costs from the current levels
- 2018-2019 Individual Market Stability Workgroup generally supported these provisions, but not others

H 7171 Article 20 Sections 8-12: Consumer Protections

Key Provisions:

- No exclusions for preexisting conditions
- Guaranteed issue and renewability (cannot be denied a policy, even if sick)
- Adds essential health benefits, (e.g. maternity, hospitalization, emergency care, prescriptions drugs, etc.) [individual and small group]
- Adds preventive services with no cost sharing [individual, small group, and large group]
- Adds an open enrollment period for obtaining health insurance

These provisions **DO NOT**:

- Exceed the ACA
- Require new state funding
- Include Medicaid
- Impose new impacts on businesses

Article 20, Section 14
Health Spending Transparency and Containment

RI Cost Trend Project:

- Created in August of 2018
- Funded by the Peterson Center on Health Care through Brown School of Public Health through March, 2021
- A Partnership of OHIC and EOHHS, guided by a Steering Committee of broad stakeholders

- Progress to-date:
  - Agreed on an Annual Spending Target that RI stakeholders will seek to keep spending at or below
  - Tied per capita health care spending to spending on other RI costs Projected Gross State Product
  - Using claims data to analyze spending on health care from all payment sources, identifying the main sources of annual increase

Cost Trends Steering Committee Members

- Angela Bannerman Ankoma, United Way
- Tim Babineau, MD, Lifespan
- Al Charbonneau, RI Business Group on Health
- Tony Clapsis, CVS Health
- Tom Croswell, Tufts Health Plan
- Adriana Dawson, Bank Newport
- Mike DiBiase, RI Public Expenditure Council
- Jim Fanale, MD, Care New England
- Stephen Farrell, United Healthcare of New England
- Diana Franchitto, Hope Health
- Marie Ganim, PhD, Co-Chair, Office of the Health Insurance Commissioner
- Peter Hollmann, MD, Rhode Island Medical Society
- Kim Keck, Co-Chair, Blue Cross Blue Shield of RI
- Al Kurose, MD, Co-Chair, Coastal Medical
- Jim Loring, Amica Mutual Insurance Company
- Peter Marino, Neighborhood Health Plan of RI
- Betty Rambur, PhD, RN, FAAN, University of RI School of Nursing
- Sam Salganik, Esq., RI Parent Information Network
- Nicole Alexander Scott, MD, MPH, Department of Health
- Ben Shaffer, Rhode Island EOHHS
- John Simmons, RI Public Expenditure Council
- Neil Steinberg, RI Foundation
- Teresa Paiva Weed, Esq., Hospital Association of RI
- Larry Wilson, The Wilson Organization, LLC

Article 20, Section 14
Health Spending Transparency and Containment

- Intent: To deliver value to employer groups and tax payers, so that health care does not continue to "crowd out" other expenses.
- Annual public reports and recommendations to General Assembly.
  - How did we do against the target? What policy recommendations can the Legislature consider to curb the identified drivers of spending and increases?
- Sustainability plan: Cost Trends Steering Committee endorsed the assessment methodology proposed in Section 14.
- Technical Amendments to Section 14 add a Sunset on the Assessment

Article 20, Section 14
Health Spending Transparency and Containment--Assessment Methodology

- Modelled on methodology used to fund the State's vaccine program.
- "Contribution enrollee"--an individual for whom an insurer administers or covers healthcare services, unless excepted by law.
- The Assessment is capped at or below $1 per YEAR per enrollee.
- Funds will be assessed in October, collected by end of January into a RRA at EOHHS (estimated up to $.6M per year).
- OHIC and EOHHS will contract for data analysis, project management and report preparation.

New Article: Telemedicine

- Medicaid and Commercial--Expanded Telemedicine is necessary to protect public health during COVID-19
- Continuity of care, reducing infection risk for providers and patients
- Telemedicine via phone is a matter of equity since many people do not have internet access and/or the ability to use it
- Beneficial for behavioral health care with increased need for services, fewer missed appointments, and patients who may otherwise have felt stigmatized seeking care in-person
- CMS: No significant differences by race or ethnicity or age groups among patients who received telemedicine services

New Article: Telemedicine

Includes Medicaid aligned but distinct

- Continues current Telemedicine polices tied to the pandemic until sunset on 6/30/21.
- Continues telephonic visits when appropriate for care, and audio-visual telemedicine for any appropriate service.
- Cost-sharing at parity with in-person care.
- Reimburse in-network providers at parity with in-person care.
- Allows insurers to require prior **approvals for TM,** except in-network primary and behavioral health care
- Data review and stakeholder recommendations due to the Legislature by 12/31/20.
- COVID-19 related care (beyond telemedicine) with no prior approval
- Statutory changes do not prohibit fraud and abuse investigations

New Article: Telemedicine

15 States' Laws Require Telemedicine Reimbursement Parity with in-person office visits:

- Arkansas, Colorado, Delaware, Georgia, Hawaii, Kentucky, Minnesota. Missouri, New Jersey, New Mexico, North Dakota, Tennessee, and Virginia. California and Washington have laws effective in January 2021.

- Other states have legislation pending that ensures reimbursement parity (e.g., Vermont)

CMS Administrator--7/15/20-- *Health Affairs*

- "Telehealth will never replace the gold-standard, in-person care. However, telehealth serves as an additional access point for patients, providing convenient care from their doctor and health care team and leveraging innovative technologies that could improve health outcomes and reduce overall health care spending. ***The rapid explosion in the number of telehealth visits has transformed the health care delivery system, raising the question of whether returning to the status quo turns back the clock on innovation."***

- " Further analysis could be done to determine the level of resources involved in telehealth visits outside of a public health emergency, and to inform the extent to which payment rate adjustments might need to be made. For example, supply costs that are typically needed to enable safe in-person care (for, e.g., patient gowns, cleaning, or disinfectants) and built into the in-person payment rate are not needed in a telehealth visit. ***On the other hand, there are new processes that clinicians must create for telehealth visits, with associated costs."***