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Analysis of LC 23.0547.0200 Relating to Health Insurance Coverage of Telehealth

Prepared for the North Dakota Legislative Council
Pursuant to North Dakota Century Code 54-03-28

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Table of Contents

I. Evaluation of Proposed Mandated Health Insurance Services

The North Dakota Legislative Council (NDLC) was asked to perform a cost benefit analysis of LC 23.0547.0200 (Draft Bill) for the standing Legislative Assembly pursuant to the North Dakota Century Code (NDCC) 54-03-28. This Draft Bill amends and reenacts section 26.1-36-09.15. As proposed, the Draft Bill adds clarification for providing medically necessary health services through telehealth and requires policies that provide health benefits coverage for behavioral health provide the same coverage and reimbursement for medically necessary health services for behavioral health services through both telehealth and in-person means.

NovaRest, Inc. has been contracted as the NDLC's consulting actuary, and has prepared the following evaluation of medically necessary telehealth services.

This report includes information from several sources to provide more than one perspective on the proposed mandate to provide a totally unbiased report. As a result, there may be some conflicting information within the contents. Although we only used sources that we considered credible, we do not offer any opinions regarding whether one source is more credible than another, leaving it to the reader to develop his/her conclusions.

We note the proposed bill does not define behavioral health services. There may be differences between insurers in the definition of behavioral health services.

NovaRest estimates the impact on requiring behavioral health services to be reimbursed at the same rate for telehealth and in-person ranges from 0.1% to 0.3% on a percentage of premium basis, and $0.62 to $1.73 on a per member per month (PMPM) basis.

The Draft Bill does not appear to require new services or an expansion of services, and therefore we do not believe it will result in defrayal costs to the state. However, this is not a legal interpretation, nor should it be considered legal advice.

II. Process

NovaRest was charged with addressing the following questions regarding this Draft Bill:

- The extent to which the coverage will increase or decrease the cost of the service;
- The extent to which the coverage will increase the appropriate use of the service;
- The extent to which the coverage will increase or decrease the administrative expenses of insurers, including health maintenance organizations, or other organizations authorized to provide health benefit plans in the State, and the premium and administrative expenses of policyholders and contract holders; and
- The impact of this coverage on the total cost of health care.

III. Coverage of Telehealth Benefits

26.1-36-09.15 of the North Dakota Century Code currently requires medically necessary health services delivered by telehealth be the same as in-person, if services are currently covered and reimbursed in-person. The proposed amendments include:

1. Providers are not required to provide services using telehealth if they determined telehealth is inappropriate or patient chooses not to receive services through telehealth.
2. Insurers may require providers to demonstrate safety and efficacy if the insurer does not currently cover that service through telehealth.
3. Insurers may establish medical management if not unduly burdensome or unreasonable for a service.
4. Insurers may require documentation or billing practices to protect from fraudulent claims if not unduly burdensome or unreasonable for a service.
5. Insurers are not required to cover audio-only unless it was a scheduled appointment and service can be met through audio-only.
6. Insurers may not require patient to pay a fee to download software to facilitate telehealth.

We do not believe these proposed amendments will have a significant impact on premiums. The addition of medical management may lower premiums, but we do not have data on the use of the medical management that is currently used by insurers and cannot estimate the premium savings if medical management is not currently used. Additionally, restrictions on audio-only may have an impact on premiums, however, we do not have data on the use of audio-only services if they are currently covered and cannot estimate an impact.

The Draft Bill also requires that insurers that provide behavioral health services must provide the same coverage and reimbursement for medically necessary behavioral health using telehealth as in-person

1. Insurers may not limit or deny reimbursement based solely on providing telehealth instead of in-person.
2. Insurers may not limit or deny reimbursement based solely on technology used if it is appropriate for a service.
3. Insurers or providers are not prohibited from entering into a contract that includes value-based reimbursement arrangement that may include telehealth.
4. Behavioral health through telehealth must be covered through audio-only if a scheduled appointment is not possible, i.e. emergency or crisis.

Unlike other telehealth services, the Draft Bill specifies reimbursement for behavioral health services provided through telehealth must be the same as in-person, which we believe will have a slight premium impact.

Prevalence of Coverage

Per 26.1-36-09.15 of the North Dakota Century Code, medically necessary health services are currently delivered by telehealth same as in-person, if services are currently covered and reimbursed in-person. We do not believe the Draft Bill would add health services that are not currently covered, instead it adds clarification around telehealth services and requires medically necessary behavioral health services provided via telehealth be reimbursed at the same rate as in-person.

Insurer Comments About Bill Language

1. No insurer indicated any material benefits or savings due to the Draft Bill.
2. The Draft Bill would not allow insurers to offer behavioral health services provided by telehealth at more favorable cost-sharing to members. Currently some behavioral health services provided by telehealth are provided at lower cost-sharing for members. Consider modifying bill to allow insurers to provide behavioral health services provided by telehealth at more favorable cost sharing for members.
3. Allowing providers and plans to negotiate reimbursement can result in savings to consumers. By establishing reimbursement requirements for behavioral health services delivered via telehealth, this bill may not allow for those savings.
4. Demand for behavioral health services – in-person and virtually – has been and will continue to be at a very heightened state. Due in part to a lack of providers in this practice area, members and patients are experiencing wait times to see these providers. The current landscape of providers and other access barriers must be noted in scoping the larger context of this legislative proposal.
5. Two sets of criteria (one for behavioral health and another for non-behavioral health) for audio-only as included in the Draft Bill could cause confusion.
6. Audio-only medical visits are not the same level of care as an in-person visit. Exceptions for audio-only should include when patient and provider are having connectivity issues or where there is medical evidence that indicates that an audio-only visit will meet the patient's needs. There are fraud/waster/abuse concerns with audio-only.

Questions Concerning Mandated Coverage for Public Employee Fertility Health Benefits

The extent to which the coverage will increase or decrease the cost of the service.

Mandating a service or product increases the demand for that service or product, which typically increases the cost of the service, where allowed. Insurers can offset this upward pressure on price by contracting with providers and/or using managed care protocols.

Medically necessary health services are already covered via telehealth if provided in-person. Implementation of medical management and additional criteria around audio-only services may cause a decrease in the usage of services, however, we do not believe the decrease will be significant enough to change the cost of a service.

The Draft Bill will require medically necessary behavioral health services to be reimbursed at the same rate for telehealth and in-person, which will increase the cost of behavioral health services for insurers that currently do not reimburse at the same rate, which is most of the market.

Insurers in the data call noted they did not believe there were benefits or savings from the Draft Bill. They also noted mandating reimbursement limits the potential savings to consumers related to negotiating telehealth reimbursement.

The extent to which the coverage will increase the appropriate use of the service.
The Draft Bill will allow insurers to implement medical management techniques if not unduly burdensome or unreasonable for a particular health service. We are not clear on how unduly burdensome or unreasonable is determined, although it appears to be written to allow insurers to reduce inappropriate use of services.

If reimbursement rates for behavioral health services delivered by telehealth are required to increase to meet the in-person reimbursement rates, we expect higher out-of-pocket member costs could decrease use of the service, although this may be offset by the reduction in transportation costs members pay for in-person visits.

There is insurer concern about fraud/waste/abuse with audio only visits. Also, because audio only requirements vary between behavioral health and non-behavioral health services, there is concern this will cause confusion.

The extent to which the coverage will increase or decrease the administrative expenses of insurers, including health maintenance organizations, or other organizations authorized to provide health benefit plans in the State, and the premium and administrative expenses of policyholders and contract holders.
Depending on the level of medical management techniques implemented, there may be an increase in administrative costs, although there is no requirement that medical management is used so we cannot estimate the cost.

Requiring behavioral health services to be reimbursed at the same rate for telehealth and in-person may decrease negotiation time with telehealth providers but may increase negotiation time with in-person providers so we cannot estimate any cost impact. Additionally, increasing reimbursement may increase the number of behavioral health claims which may impact claims processing administrative costs, but we do not believe that the increase will be significant.

The impact of this coverage on the total cost of health care.

Changes to the cost of the service or utilization of the service would impact the total cost of health care, some of this cost may be offset by the use of medical management. Increasing the reimbursement for telehealth behavioral health services will cause the largest increase in the total cost of health care as estimated below.

NovaRest Estimate

Data

- 2021 National Association of Insurance Commissioners (NAIC) Supplemental Health Care Exhibit (SHCE) for insurers in North Dakota
- Plan year 2023 Unified Rate Review Template (URRT) for insurers in North Dakota
- Data call to North Dakota insurers regarding current behavioral health telehealth reimbursement and expectations regarding the Draft Bill.

Assumptions

- Percentage of total health spending for behavioral health services is between 4.4%[1] and 8.2%.[2]
- Assume inpatient medically necessary behavioral health services could not be provided through telehealth.
- 20% of behavioral health services are inpatient.[3]
- Percentage of outpatient behavioral health provided through telehealth is between 36%[4] and 40%.[5]
- Average reimbursement for medically necessary behavioral health services provided through telehealth is approximately 93% of in-person reimbursement.[6]
- Assume an 83% loss ratio.[7]
- An annual trend factor of 5.5% was applied to both incurred claims PMPM and premiums PMPM.[8]
- Assume copay or coinsurance % would not change for behavioral health as a result of the proposed benefit.
- Assume in-person reimbursement will not decrease to match telehealth impact.

[1] https://www.nationalalliancehealth.org/www/initiatives/initiatives-national/workplace-mental-health/pathforward/milliman-report
[2] https://www.axios.com/2022/09/14/mental-health-spending-rises-chart
[3] https://store.samhsa.gov/sites/default/files/d7/priv/bhsua-2006-2015-508.pdf
[4] https://www.kff.org/coronavirus-covid-19/issue-brief/telehealth-has-played-an-outsized-role-meeting-mental-health-needs-during-the-covid-19-pandemic/
[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9412131/
[6] Based on insurer data call responses
[7] Medical loss ratio threshold for individual and small group ACA is 80%, while the medical loss ratio threshold for large group is 85%. Our assumption of 83% is a members weighted average based on market size.
[8] Projected Private Health Insurance Spending Per Enrollee 2021. National Health Care Expenditures: Table 17 Health Insurance Enrollment and Enrollment Growth Rates.

Methodology

- Percentage of total health spending related to behavioral health applied against the market average incurred claims provides the estimated claims related to behavioral health.
- Removing inpatient behavioral health and applying the percentage of outpatient behavioral health delivered through telehealth to the estimated claims related to behavioral health provides the estimated behavioral health claims delivered through telehealth.
- Increase behavioral health claims delivered through telehealth by the difference between the reimbursement for telehealth versus in-person behavioral health services to determine the claim impact of increasing reimbursement for behavioral health services provided through telehealth.
- Apply loss ratio to determine premium impact of increasing reimbursement for behavioral health services provided through telehealth.

Cost

We estimate the Draft Bill would increase premiums by an average of 0.1% to 0.3%, or $0.62 PMPM to $1.73 PMPM. We note that this impact will vary by insurer, based on reimbursement levels and usage of behavioral health services delivered through telehealth.

Insurers Estimate

Insurers included in our data call estimated an impact of 0.0% to 0.2% of fully insured premium.

Difficulties in insurers providing estimates included the timeframe of the data call and the Public Health Emergency which permitted flexibility in provider coding for telehealth services making it difficult to estimate claims, utilization, and financial trends on currently or recently available claims data.

IV. Other State Telemedicine Laws

Forty-three states and the District of Columbia, require "service parity" requiring commercial insurers to cover telehealth.[9] This includes North Dakota. The only states without a reference to service parity are Alabama, Idaho, North Carolina, Pennsylvania, South Carolina, Wisconsin, and Wyoming.[10] This, however, does not require services provided by telehealth be reimbursed at the same rate as services provided by in-person means, which we call "payment parity."

[9] "Understanding The Case For Telehealth Payment Parity", Health Affairs Blog, May 10, 2021. DOI: 10.1377/hblog20210503.625394

[10] "Private Payer Parity." CCHP. https://www.cchpca.org/topic/parity/ . Accessed January 4, 2023.

Compared to service parity only 27 states offer some form payment parity.[11] Of these states, Connecticut, Maryland, New York, and Vermont are offering payment parity for a temporary amount of time.[12] Additionally, of these 27 states: Arizona, Illinois (after a temporary period), Iowa, Massachusetts, Nebraska, and Utah all appear to require payment parity only for behavioral health services or mental health services consistent with the Draft Bill. [13]

V. Limitations

NovaRest has prepared this report in conformity with its intended use by persons technically competent to evaluate our estimate regarding the Draft Bill. Any judgments as to the data contained in the report or conclusions about the ramifications of that data should be made only after reviewing the report in its entirety, as the conclusions reached by review of a section or sections on an isolated basis may be incorrect. Appropriate staff is available to explain and/or clarify any matter presented herein. It is assumed that any user of this report will seek such explanations as to any matter in question.

NovaRest did not have access to actual insurer claims data by service type or reimbursement rates. NovaRest has developed projections in conformity with what we believe to be the current and proposed operating environments and are based on best estimates of future experience within such environments. It should be recognized that actual future results may vary from those projected in this report. Factors that may cause the actual results to vary from the projected include new insurance regulations, differences in implementation of the required coverage by insurer, changes in medical treatments and practices, accounting practices, changes in federal and/or local taxation, external economic factors such as inflation rates, investment yields and ratings, and inherent potential for normal random fluctuations in experience.

VI. Reliance and Qualifications

We are providing this report to you solely to communicate our findings and analysis of the Draft Bill. The reliance of parties other than the North Dakota Legislative Council (NDLC) on any aspect of our work is not authorized by us and is done at their own risk.

To arrive at our estimate, we made use of information provided by insurers included in the data call and other public sources. We did not perform an independent investigation or verification. If this information was in any way inaccurate, incomplete, or out of date, the findings and conclusions in this report may require revision.

This memorandum has been prepared in conformity with the applicable Actuarial Standards of Practice.

We have no conflicts of interest in performing this review and providing this report.

[11] Ibid.
[12] Ibid.
[13] Ibid.

We are members of the American Academy of Actuaries and meet that body's Qualification Standards to render this opinion. We meet the Qualification Standards promulgated by these professional organizations to perform the analyses and opine upon the results presented in this Actuarial Report.

Appendix A: Definitions

a) "Distant site" means a site at which a health care provider or health care facility is located while providing medical services by means of telehealth.

b) "Health care facility" means any office or institution at which health services are provided. The term includes hospitals; clinics; ambulatory surgery centers; outpatient care facilities; nursing homes; nursing, basic, long-term, or assisted living facilities; laboratories; and offices of any health care provider.

c) "Health care provider" includes an individual licensed under chapter 43-05, 43-06, 43-12.1 as a registered nurse or as an advanced practice registered nurse, 43-13, 43-15, 43-17, 43-26.1, 43-28, 43-32, 43-37, 43-40, 43-41, 43-42, 43-44, 43-45, 43-47, 43-58, or 43-60.

d) "Originating site" means a site at which a patient is located at the time health services are provided to the patient by means of telehealth.

e) "Policy" means an accident and health insurance policy, contract, or evidence of coverage on a group, individual, blanket, franchise, or association basis.

f) "Store-and-forward technology" means asynchronous electronic transfer or transmission of a patient's medical information or data from an originating site to a distant site for the purpose of diagnostic and therapeutic assistance in the care of a patient.

g) "Telehealth":

1) Means the delivery of health services or consultations through the use of real-time two - way interactive audio and visual communications to provide or support health care delivery and facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care.

2) Includes the application of secure video conferencing, store-and-forward technology, and synchronous interactions between a patient located at an originating site and a health care provider located at a distant site.

3) Includes audio-only communication between a health care provider and a patient as authorized under this section.

4) Does not include communication between health care providers which consists solely of a telephone conversation, electronic mail, or facsimile transmission.

5) Does not include communication between a health care provider and a patient which consists solely of an electronic mail or facsimile transmission.

6) Does not include telemonitoring services.

h) "Telemonitoring services" means the remote monitoring of clinical data related to the patient's vital signs or biometric data by a monitoring device or equipment that transmits the data electronically to a health care provider for analysis.

Telemonitoring is intended to collect a patient's health-related data for the purpose of assisting a health care provider in assessing and monitoring the patient's medical condition or status.