

Insurance Committee Hearing
House Insurance Chairman Hank Zuber
Senate Insurance Chairman J. Walter Michel
State Capitol, Room 216

September 20, 2021 – 1:30 pm

Windpool

Tom Quaka, CPCU – Southern Insurance Consulting

Scott Lemon, Chairman - Board of Directors for Mississippi Windstorm Underwriting Association

Joe Shumaker, Manager - Mississippi Ratings Bureau

Hearing Aid Insurance for Children

Rachel Powell, Legislative Chair - Mississippi Speech-Language Hearing Association

Courtney Turner, Audiologist – Mississippi Speech-Language Hearing Association

September 21, 2021 - 9:00 am

Telehealth

Robert Baretta, National Telehealth Consultant - Teladoc Health

David Houghton, MD - System Chair and Medical Director of Telehealth & Digital Medicine, Ochsner Health

Lucius M. (Luke) Lampton, MD - Mississippi Academy of Family Physicians (Past President)

Frank (Finn) Perkins, MD - Mississippi Psychiatric Association

Alan E. Jones, MD - Associate Vice Chancellor for Clinical Affairs - University of Mississippi Medical School

Jay Underwood, MD – Mississippi Independent Physician Practice Association

State Insurance Plan Update

Cindy Bradshaw, State Insurance Administrator – Mississippi Department of Finance and Administration

**House and Senate Insurance Committees Hearing
September 20, 2021**

**Mississippi Windstorm Underwriting Association
(*Windpool*)**

Thomas G. Quaka, CPCU¹

History of Formation and Hurricane Katrina Assessments

- Hurricane Camille, August 17, 1969
 - In 1970, the Mississippi Legislature formed the Mississippi Insurance Underwriting Association (MIUA) to provide property insurance coverage not otherwise available to residents of the Mississippi Gulf Coast.
- 1987
 - Mississippi Legislature adopted statutes creating Windpool (and the MIUA statutes were repealed).
 - Mississippi State Rating Bureau assumed operation and management of Windpool.
 - Windpool operated for 18 years (and its predecessor MIUA for 17 years) with little controversy, oversight or significant impact to the commercial insurance industry – then Hurricane Katrina.
- Hurricane Katrina – August 29, 2005
 - Windpool losses totaled approximately \$720,000,000.²
 - Windpool had \$175,000,000 of reinsurance coverage.
 - Windpool assessed member insurers \$545,000,000.
 - Brierfield Insurance Company's assessment was \$7,000,000.

¹ Tom Quaka retired as Senior Vice President of FCCI Insurance Group on April 15, 2019, after 52 years of service to the insurance industry. During his employment with FCCI, Mr. Quaka served as FCCI's designated representative on the Board of Directors of MWUA. Mr. Quaka is a member of Southern Insurance Consultants, LLC, an independent insurance consulting firm, and frequently serves as an expert witness concerning insurance matters. Any opinions expressed herein are those of Mr. Quaka and not his former employer FCCI Insurance Group or any of its affiliated companies, including but not limited to Brierfield Insurance Company, a Mississippi domestic insurer.

² At that time, the Windpool had 16,155 policies and a Total Insured Value (TIV) of approximately \$1.8 Billion.

- Brierfield incurred direct losses due to Hurricane Katrina in the amount of \$7,000,000, none of which were losses on property located in the coastal area.
 - MWUA received state and federal funding of \$179,981,381.³ The sole purpose of these funds was to defray expenses and costs for reinsurance.
- Legislative amendments – 2007⁴

Nonadmitted Policy Fee⁵

- Nature of surplus lines market (why it exist, who buys insurance in this market).
- Intended purpose of nonadmitted policy fee.
 - The statutorily stated sole purpose of the nonadmitted policy fee is to support the operations and activities of the Windpool **including programs targeted to reduce the number of policies within the association [Windpool]** and no other purposes.⁶
- Beginning in 2018, there have been Legislative takings of \$9,500,000 of nonadmitted policy fees (for purposes other than the operations and activities of MWUA).
 - 2018: \$1,500,000 for Capital Maintenance Fund.
 - 2018: \$4,500,000 for Rural Fire Truck Fund or Supplemental Rural Fire Truck Fund.
 - 2019: \$3,500,000 for Rural Fire Truck Fund or Supplemental Rural Fire Truck Fund.

Current Financial Position

- Admitted Assets: \$353,087,189.
- Surplus: \$316,513,953.

³ Mississippi Insurance Department Report of Examination of Mississippi Windstorm Underwriting Association as of December 31, 2012.

⁴ House Bill No. 1500, 2007 Regular Session, Mississippi Legislature. This legislation continues to be referred to as House Bill 1500.

⁵ The nonadmitted policy fee is imposed on statewide total surplus lines policy premiums. Initially, the nonadmitted policy fee percentage was set by the Commissioner, subject to a minimum policy fee of 5%. The Legislature amended the nonadmitted policy fee provision in 2012 fixed the nonadmitted policy fee percentage at 3%. In 2020, nonadmitted policy fees totaled \$16,581,099. Through June 30, 2021, nonadmitted policy fees have totaled \$9,881,367.

⁶ Such programs would include a comprehensive windstorm mitigation program funded with private money and depopulation plan. Both of which could be done without any legislative action.

- Reinsurance coverage: \$450,000,000.
- Reinsurance premium: \$19,500,000.
- Approximately 13,000 policies (down from 14,854 reported this time last year.)
- Total Insured Value (TIV) of approximately \$1.7 Billion (down from \$2.48 Billion reported this time last year.)

Board Composition

- Majority of the board of directors once consisted of insurance executives.
- Initially, the board consisted of 9 insurers (the holdover board of MIUA).
- The 1987 legislation provided for a board consisting of 5 insurers and 3 agents from the coast area.
- The 2007 legislation provided for a board consisting of 5 insurers, 3 agents (2 of whom being residents in the coast area), 2 coast area resident business leaders and the State Treasurer.

Possible Plans to Reduce Number of Windpool Policies

- Windpool should have formal depopulation plan.
- By contrast, Louisiana and Texas (and possibly other states as well) have formal depopulation plans that have been very successful in reducing the size of their residual markets and returning insureds to the private sector.
- This likely would be ongoing process.
- Estimated time to implement, approximately 12 months.

A stylized graphic of a windmill with multiple blades, rendered in shades of grey and tan, positioned behind the text.

MWUA

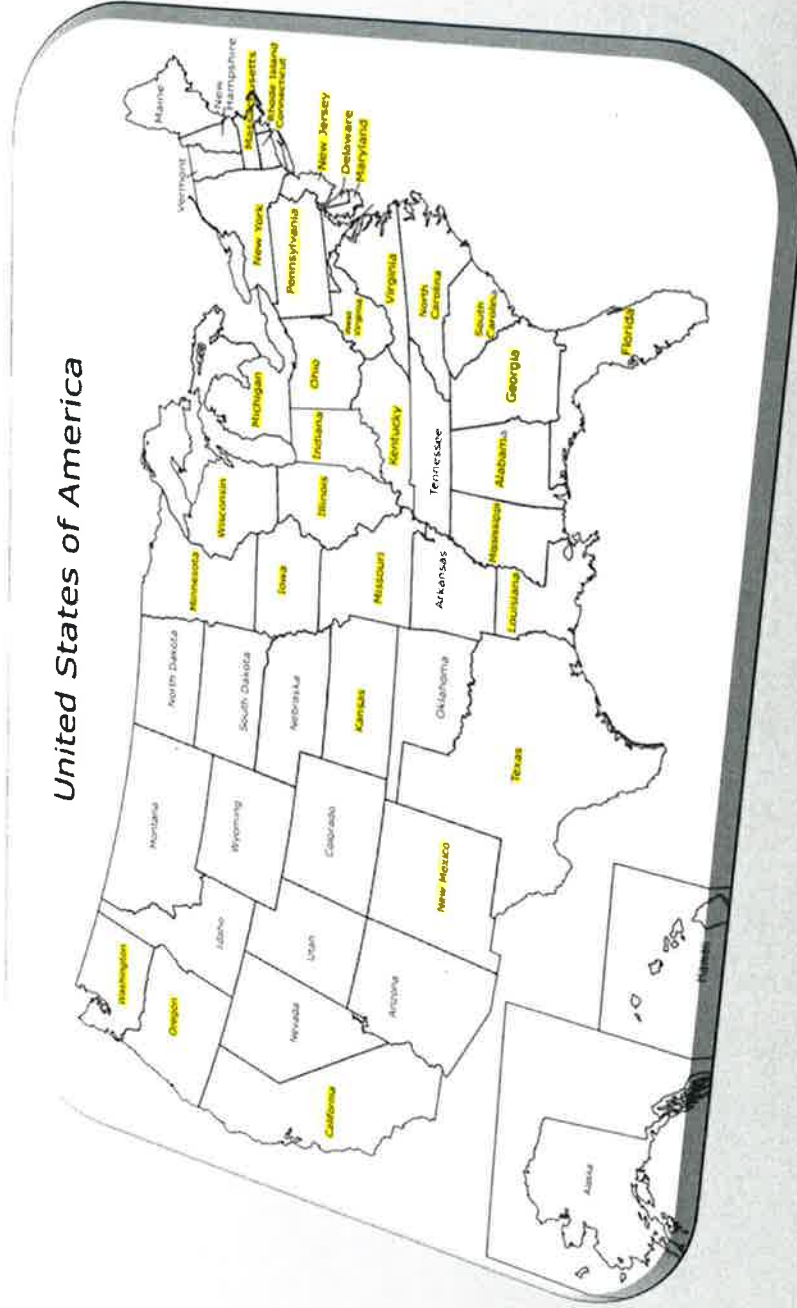
Legislative Insurance Hearing

**A Brief History and status of
the Mississippi Windstorm
Underwriting Association**

Scott Lemon

Joe Shumaker

United States of America



33 States have at least 1 residual plan
36 Total Residual Plans Nationwide

Year end 2020

State	Policies	TIV (Billions)
Florida	573,427	144.8
Massachusetts	209,434	86.2
North Carolina (Wind)	210,735	78.2
Texas	195,453	55.0
North Carolina (FAIR Plan)	198,827	24.7
Louisiana	41,142	6.7
New York	29,625	8.2
South Carolina	16,748	5.2
Alabama	16,321	4.8
Mississippi	14,647	2.4
Georgia	12,872	1.8

Red = increase from prior year
Blue = decrease from prior year

MS COASTAL PLAN CREATION

- **Hurricane Camille in 1969**
- **First Mississippi Residual Plan (MIUA) 1972**
- **Counties - Hancock, Harrison, Jackson Pearl River, Stone, George**
- **MSRB chosen to administer the Plan**

Who is MSRB?

- **MS State Rating Bureau established by SB126 in 1924**
- **Non-profit corporation governed by a Board of Directors**
- **Funded by all MS licensed insurance companies writing property fire policies (currently approx. 700) Surplus Lines carriers not members.**
- **No taxpayer funds or charges to local governments**

Some Key MSRB Functions

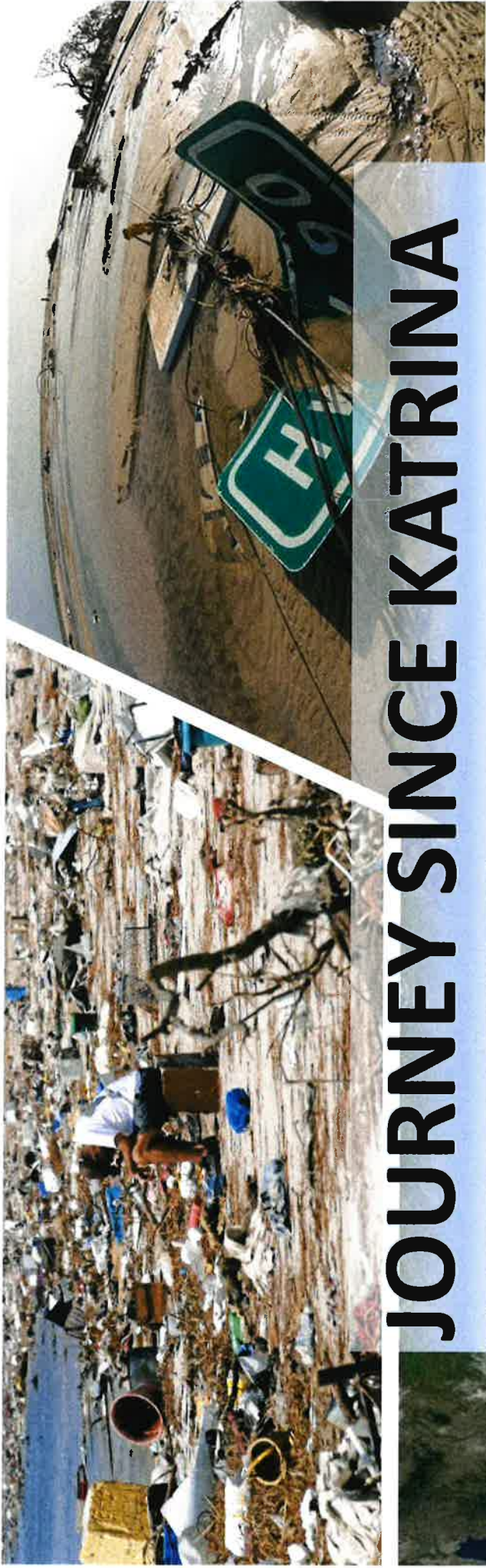
- **On site Property Inspections/Surveys** (4,190 in 2020)
- **Review of Fire Sprinkler designs for code compliance**
- **Actuarial review of loss costs for Commercial and Dwelling fire rates.**
- **Filing with DOI coverage forms, rules and loss cost for all licensed insurance carriers.** (ex: Commercial wind mitigation premium credits per statute effective 7-1-2021)
- **Evaluation of cities and counties fire protection capabilities and establish insurance classification** (792 cities/fire districts currently)
- **Consult with county/city planners, consultants and economic development authorities on fire protection improvement needs for their respective jurisdictions.**
- **Testing of new Fire Trucks to help ensure code compliance and performance** (47 in 2020)
- **Evaluation of cities and counties Building Code enforcement and establish a classification for related insurance credits.** (BCEGS – Building Code Effectiveness Grading Schedule)
- **Maintain an interactive GIS web site to deliver electronic fire classifications to agents and insurance company representatives writing business in Mississippi.** (509,011 web visits in 2020)
- **Provide for administration and operation of two residual pools (MS Windstorm Underwriting Association and MS Residential Property Insurance Underwriting Association – MWUA & MRPIUA)**
- **Oversee the complete operation of both MWUA and MRPIUA through several Hurricanes (including Katrina) and numerous Tropical Storms assuring policyholders claims are adequately and timely paid.**

MWUA CREATION

- **MWUA Created by HB 274 in 1987 (changed MIUA to wind/hail only)**
- **Prior to Katrina completely funded by MS Licensed Carriers (no surplus lines companies)**
- **Unlimited admitted carrier assessments (Katrina \$545M) Surplus lines carriers not assessed.**
- **Revised by HB 1500 (2007)**
- **MWUA is incorporated and shall be a separate and independent entity and operate as a private enterprise as authorized in MS Code 83-34-3.**

MWUA's Mission

- “Assure an adequate market for windstorm and hail insurance in the coast area of Mississippi.”
- Protect policyholders state-wide from unreasonable Windpool surcharges.
- Avoid damaging the state-wide market for property insurance.
- Encourage better building standards and land use in the coast area in order to mitigate wind losses and depopulate the Windpool.
- While accomplishing these goals, try to avoid high rates thus helping the Coast economy revive.



JOURNEY SINCE KATRINA



MWUA KATRINA LOSSES

- 16,155 policies in force
- 18,154 claims
- \$1.8 billion insurance in place
- \$720 million losses (40% Limits in force)
- \$12M Gross annual premium
- 60 years of premium spent on Katrina losses
- \$175 million 2005 reinsurance in place
 - 250 year PML
- The remaining \$545 million in MWUA losses were assessed to and paid by admitted insurance companies.
- Non Admitted Carriers were not assessed

All Admitted Insurance Companies felt the pain of
Katrina assessment

Companies with small statewide market share
experienced large Katrina assessment example:

ABC Insurance Co = 2.3% statewide market paid
\$42.4M Katrina assessment

XYZ Insurance Co = 22.59% statewide market paid
\$12.3M Katrina assessment
*(As an incentive for companies to write coastal properties,
credits are allowed that reduce their MWUA assessment.
However such companies suffered large losses to the policies
they wrote voluntarily.)*

MWUA KATRINA ASSESSMENT EXAMPLE

Katrina Assessments caused a Statewide Insurance concern
not just Coastal Insurance concern

KATRINA LITIGATION ISSUES

- Claims Disputes**
- 18,154 claims / All Disputes settled out of court**
- MWUA Board sued by group of Member Companies. (insufficient reinsurance)**
- Judge dismisses case during trial**
 - **Over \$6M spent in legal costs**
- Group of Member Companies challenge assessment process.**
- Commissioner upholds MWUA process to assess**
- Appeals filed through courts all the way to Supreme court**



Pre HB 1500 (3/07) Motivation For Leaving Mississippi

- ❑ Fear of Catastrophic losses on the coast
- ❑ Shared percentage of MWUA losses
- ❑ Percentage of Participation determined by state wide writings

Post Katrina Accomplishments

- Resolved all Katrina claims - collected assessments – appeals
- HB 1500 stabilized the statewide property insurance marketplace
- MWUA Absorbed 300% growth
- Maintained surcharge protection (reinsurance) while managing rates
- Built reserves to fund retentions and losses of future storms
- Geographic rating tiers
- Updated and modernized coverage forms
- Enhanced exposure data gathering to improve modeling data
- Administrative upgrades – policy management, added staff for claims/ accounting
- Optional Named Storm Deductible Credits
- Flood requirement for A and V zones
- Mitigation Discounts validated by IBHS
- BCEGS (Code enforcement) Discounts
- Commercial Deductible revisions successfully depopulating large blanket policies
- Aggressive Re-Inspection program for proper Insurance to Values
- Overall depopulation resulting in approximately 70% reduction since its peak

MWUA growth since 2005

• **AUGUST 29** • **Peaked 2011** • **Current Aug 21**

2005

• 16,155 polices

• 46,406 policies

• 13,301 policies

• \$1.8 billion insured

• \$7.24 billion

insured

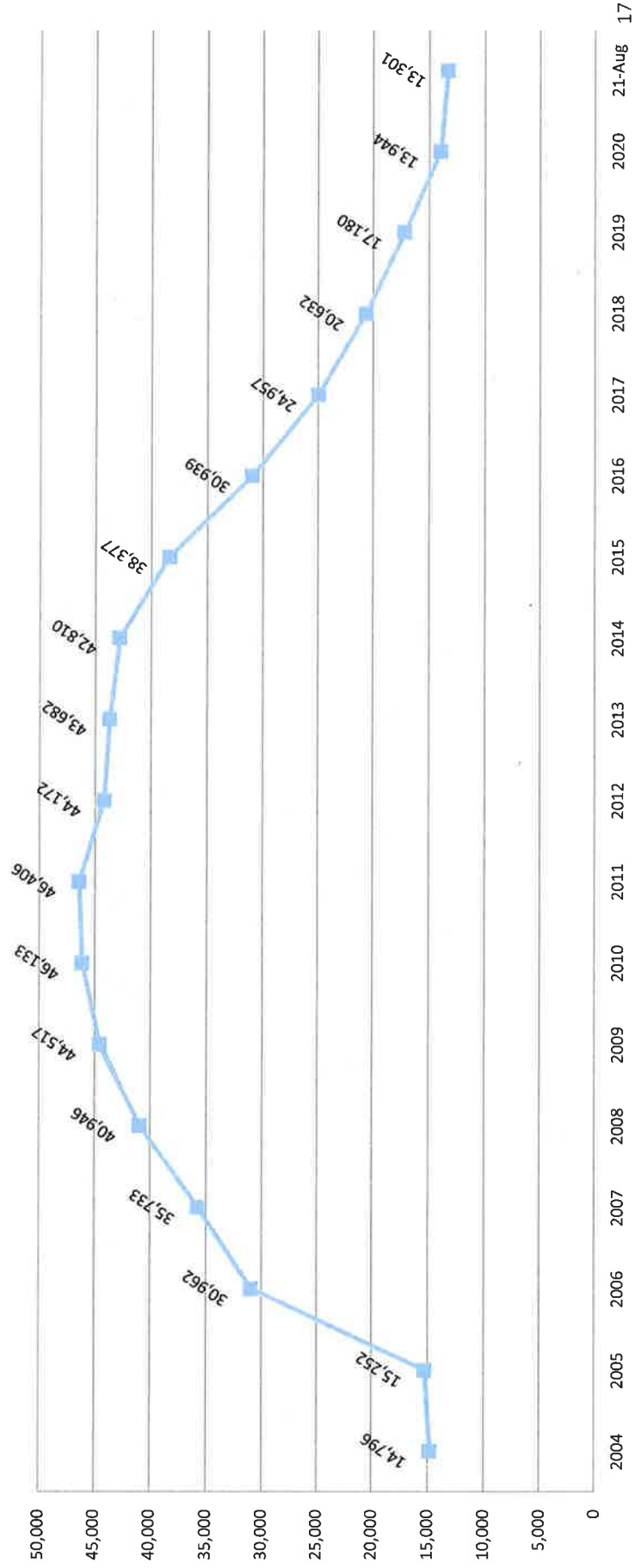
• \$2.35 billion
insured

Windpool Limit in Force Trend Since Katrina



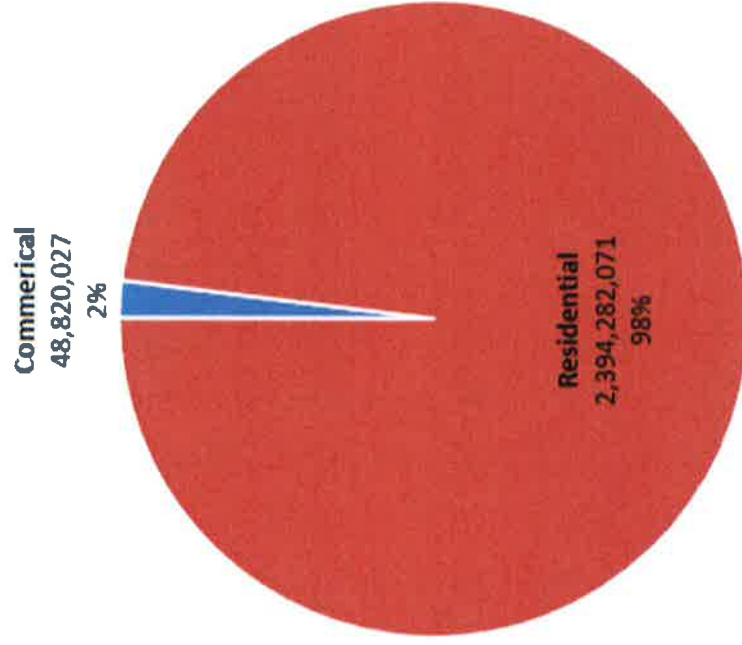
Windpool Policies in Force Since Katrina

MWUA POLICY COUNT



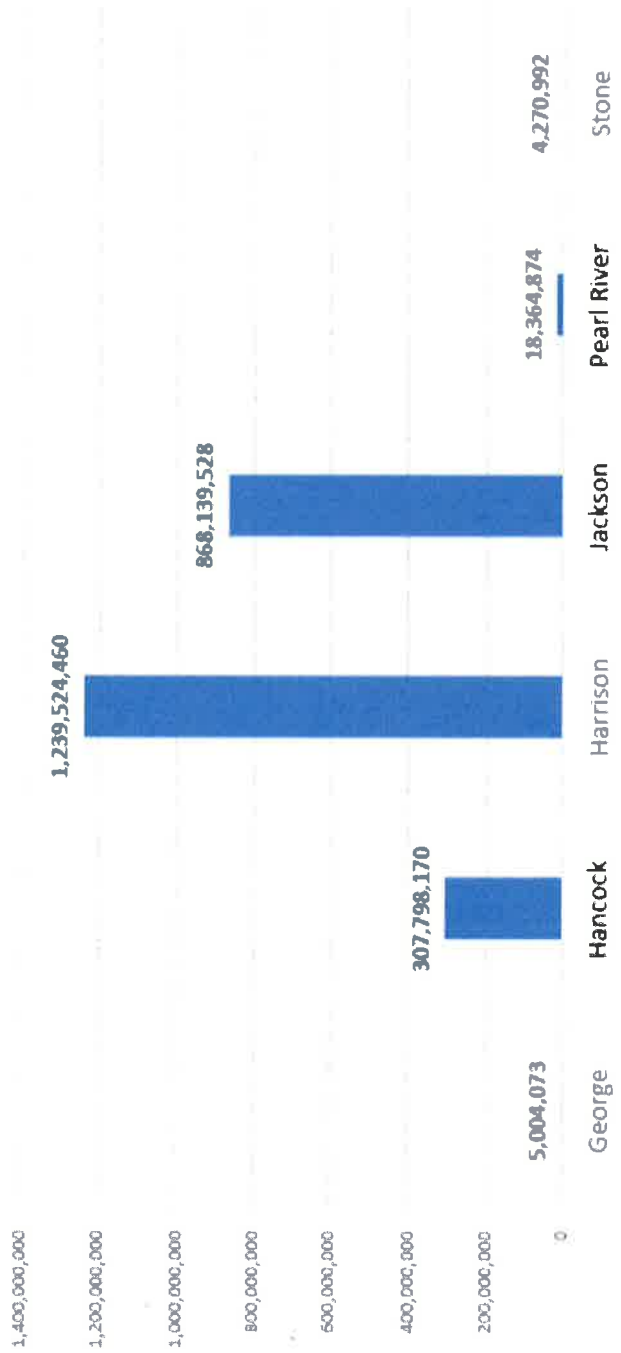
Limits by Occupancy

(as of 10/31/20)



Limits by County

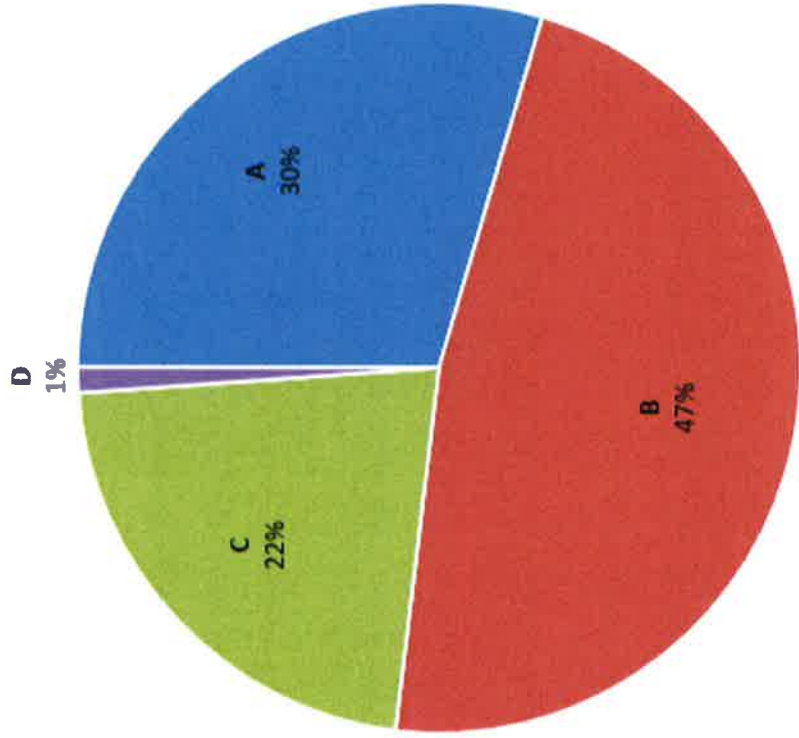
(as of 10/31/20)



Limits by Rating Zone

(as of 10/31/20)

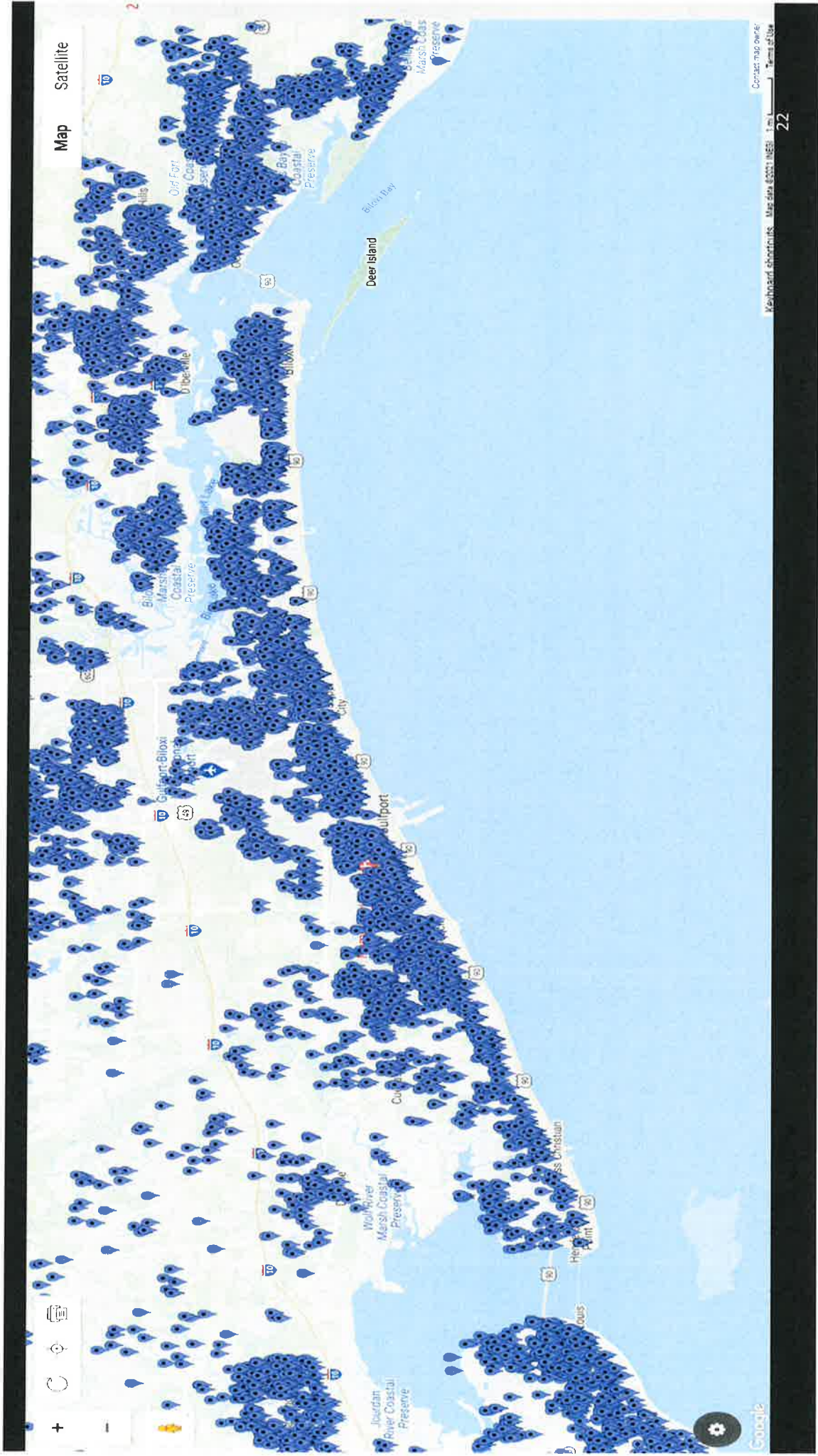
**77% in Zones A & B
South of Interstate**





Keyboard shortcuts - Map data ©2011 INEGI

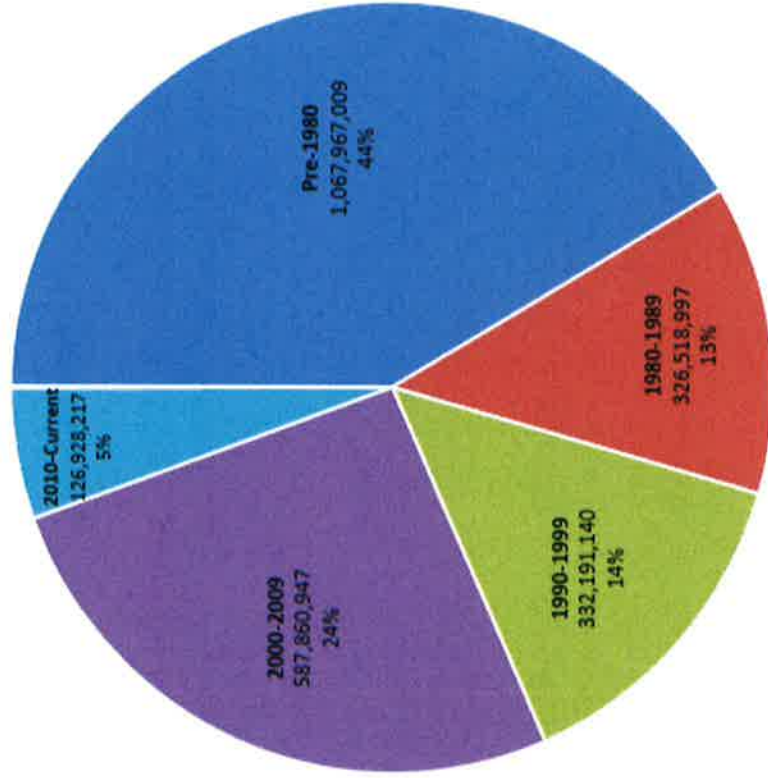
NA



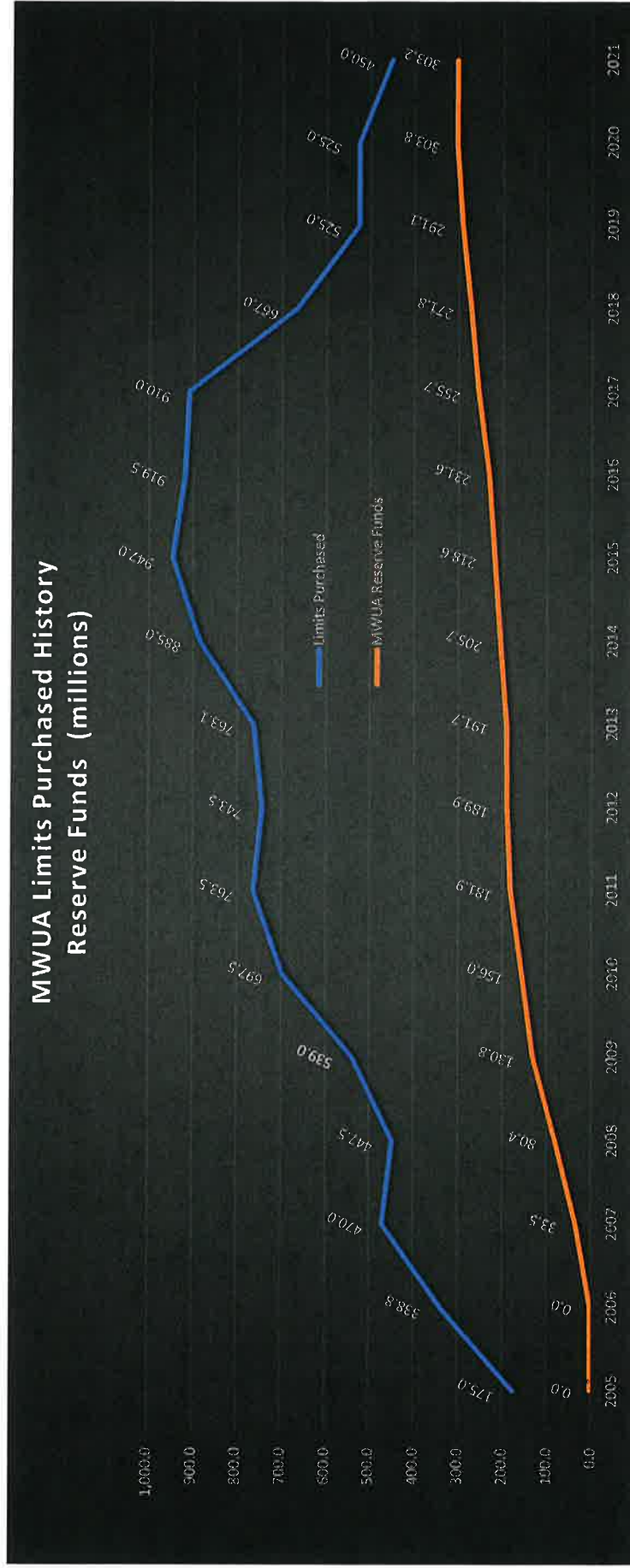
Contact map owner
View history
Terms of Use

Limits by Year Built

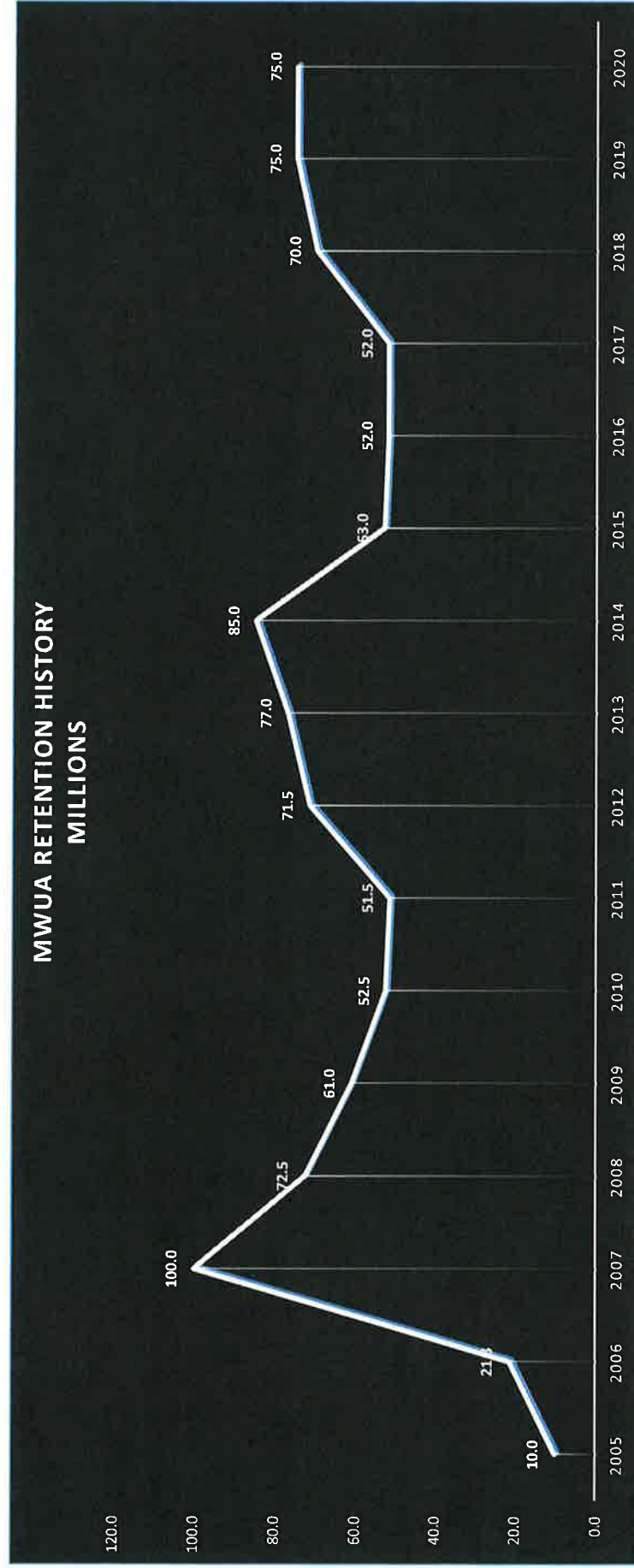
(as of 10/31/20)



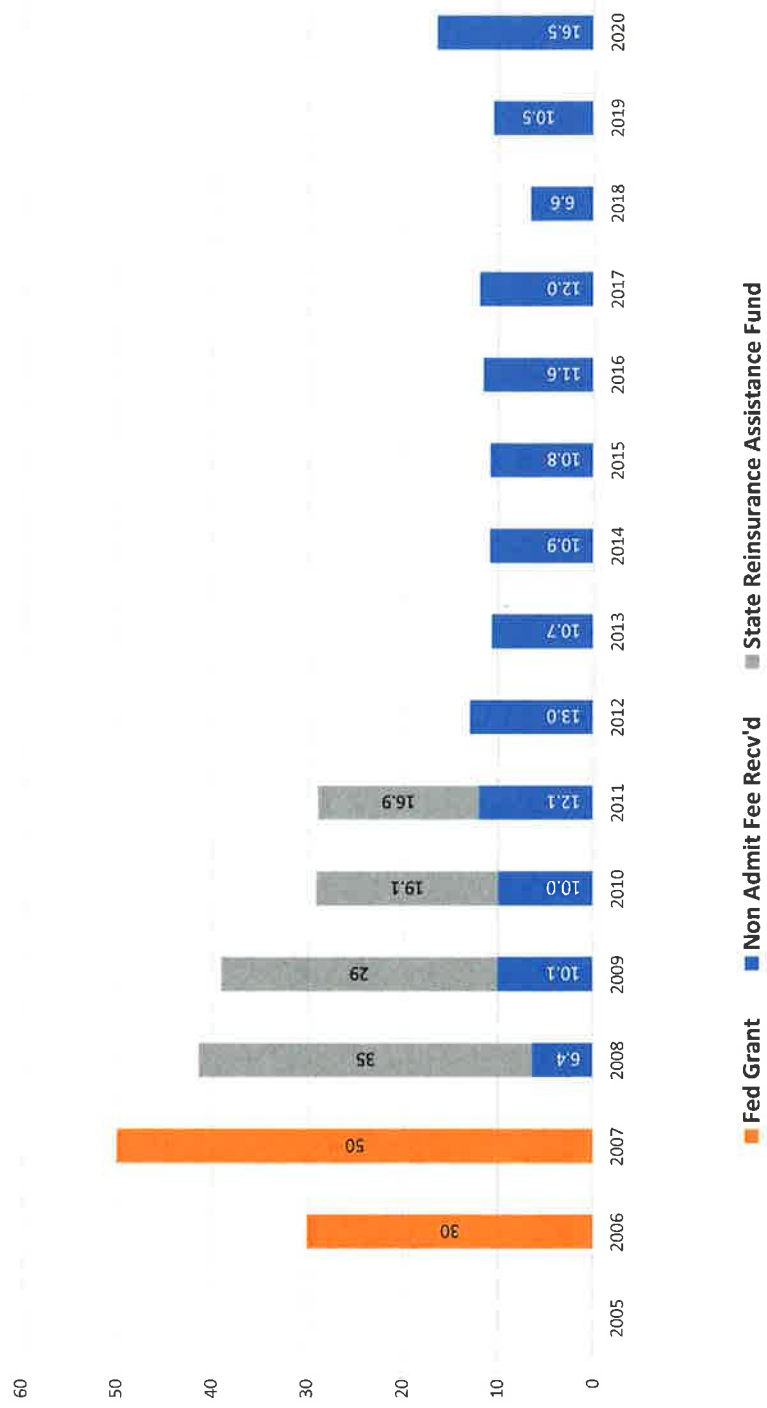
MWUA – SOLVENCY / PROTECTION Reinsurance Purchase History



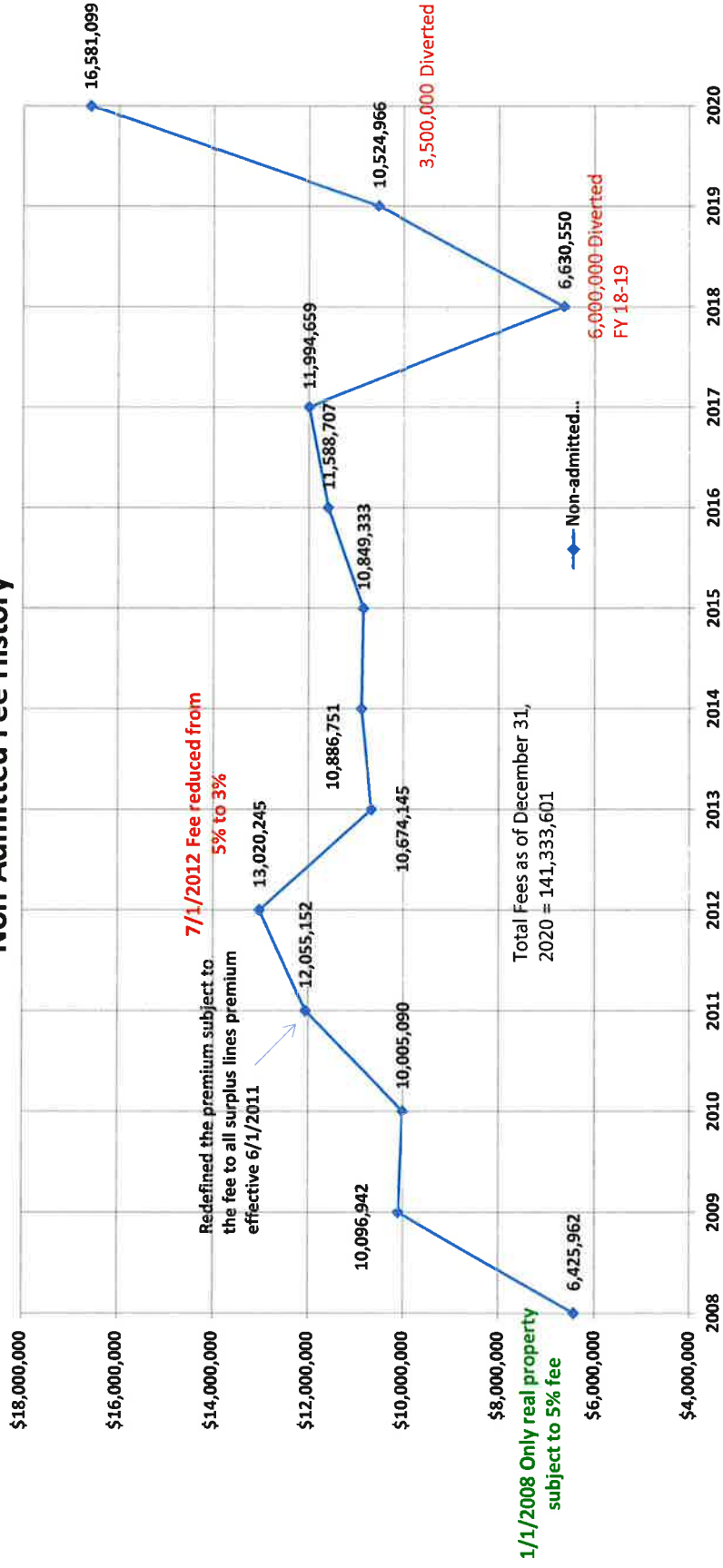
MWUA - SOLVENCY Retention History



Grants & Non Admit Fee Income



Non-Admitted Fee History



MWUA RATE HISTORY
\$100,000 Frame Dwelling

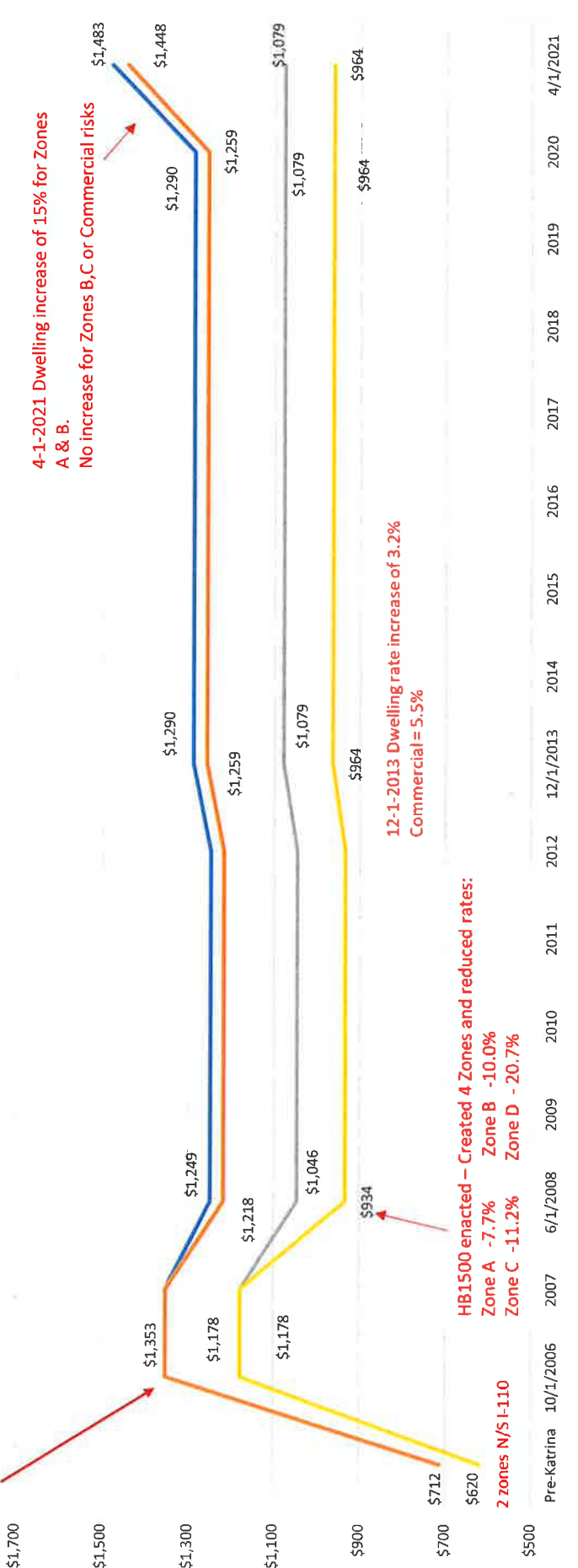
Filed +398%
 DOI Approved +90% with
 \$50M Fed Subsidy

4-1-2021 Dwelling increase of 15% for Zones
 A & B.
 No increase for Zones B,C or Commercial risks

12-1-2013 Dwelling rate increase of 3.2%
 Commercial = 5.5%

HB1500 enacted - Created 4 Zones and reduced rates:
 Zone A -7.7%
 Zone B -10.0%
 Zone C -11.2%
 Zone D -20.7%

2 zones N/S I-110



Beach(A) RR / I10 (B) NI-10/Lower Counties(C) Upper 3 Counties (D)

Statutes: 83-34-1 through 83-34-39

- Before March 22, 2007 (pre-HB 1500), MWUA had member companies.
- All companies admitted to and actually writing property insurance in Mississippi. Surplus Lines carriers were not members.
- These member companies were shared in MWUA's profits and losses.
- Member companies could reduce their share of the profits and losses by voluntarily writing wind insurance in the 6 Coast counties.

What did HB 1500 do?

- Changed member companies to assessable insurers.
 - No longer any profit sharing required, so MWUA can develop and grow its funds in non-event years.
- Requires a fee to be collected on all property policies issued by non-admitted insurers.
 - Fee is currently 3% of total policy premium for property coverage.
 - MSLA collects fee for MWUA.

What did HB 1500 do? (cont'd)

- Expanded Board of Directors to consist of 5 admitted insurance companies, 2 coastal insurance agents, 1 non-coastal insurance agent, 2 coastal business representatives and the State Treasurer.
- Appointments are now made by the Governor, Lt. Governor, and Insurance Commissioner.

Board of Directors serve voluntarily without any compensation and only reimbursed for expenses incurred.

What did HB 1500 do? (cont'd)

- Assessments to the assessable insurers are triggered when MWUA determines it will have a deficit in excess of the funds that are immediately available.
- HB444 changed Carrier Assessments to Non-Recoupable

Plan – Key Provisions

- Encouraging the voluntary market is important to the Board.
- Assessable Insurers may reduce their assessment based voluntary writings.
 - They may reduce their potential assessment by as much as 75%.
 - Non Admitted Carriers are not subject to MWUA assessments.

HB444 Revisions to HB1500 in 2019 Session

Key Points and Changes

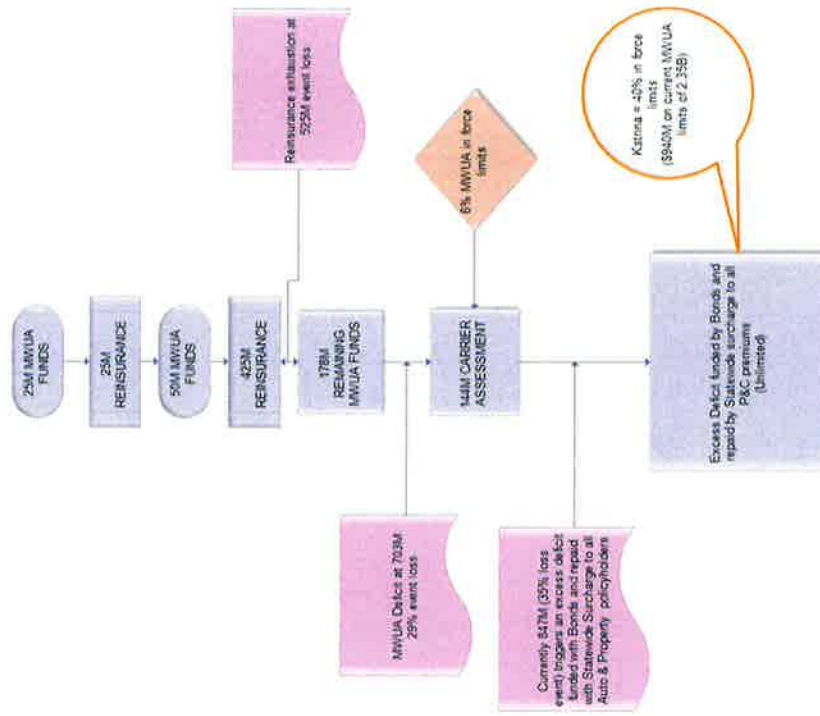
- Definition of “Essential property insurance” is clarified to remove any uncertainty of the MWUA authority to provide either actual cash value or **replacement cost value coverage**.
- **MWUA now provides coverage to strengthen roof to IBHS standards on RCV claims**
- Established a “**Minimum Reserve**” to be defined in the Plan of Operations.
- **MWUA reinsurance retentions** require approval from Commissioner
- Regular Assessments are now called **Non-recoupable Assessments**. The new Cap for Non-recoupable Assessments is the lesser of 6% of the Association’s Total Limits in Force (\$2.4 billion for 2020 = 6% x \$2.4 billion = \$144 million cap) or \$250 million. Prior years limits will determine Non-recoupable assessments for following year. The calendar year cap for multiple Non-recoupable Assessments is \$250 million.

HB4444

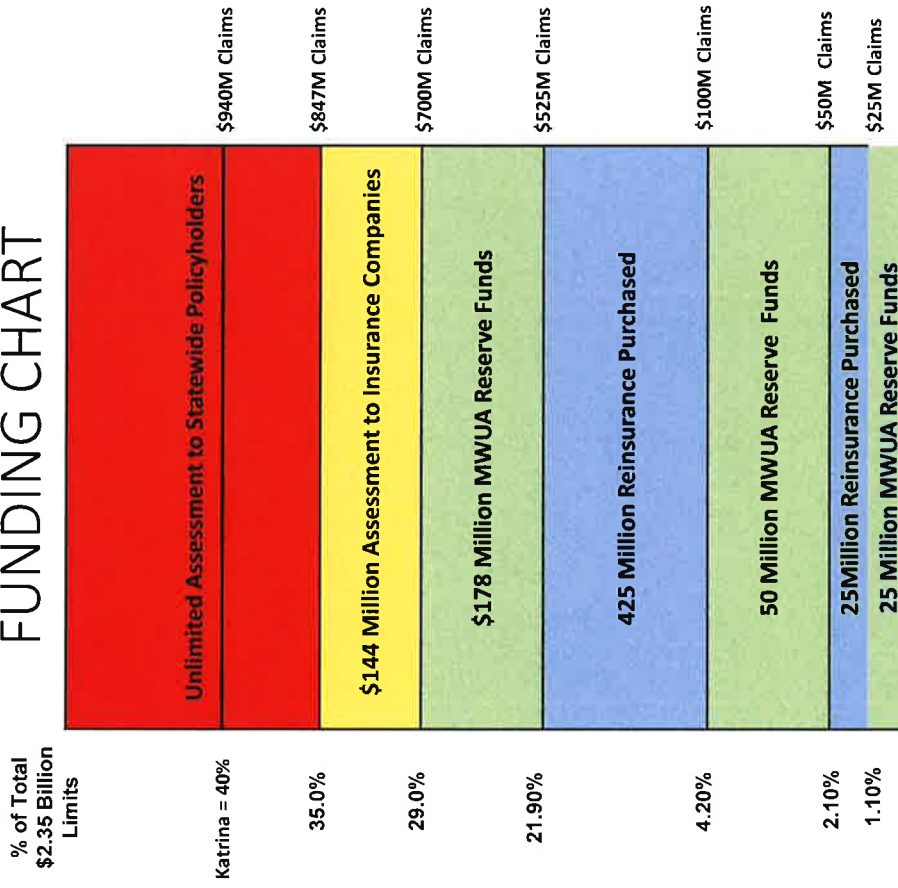
Key Points and Changes (cont'd)

- Reduces the threat of a **Statewide policyholder surcharge** until all reserves (excluding Minimum Reserve), reinsurance and non-recoupable assessments have been exhausted.
- **Non-Admitted fee** remains at 3% and is extended for 3 years ending July 1, 2022. During first year \$3.5M will be diverted to the Rural Fire Truck Fund but MWUA will receive the full 3% for remaining 2 years unless further legislation amends.
- Maintains the current **authority to issue bonds** in the event of an “Excess Deficit” to be repaid by **Statewide policyholder surcharges** on all property and casualty policies.
- Plan of Operations revised to reflect HB4444 changes

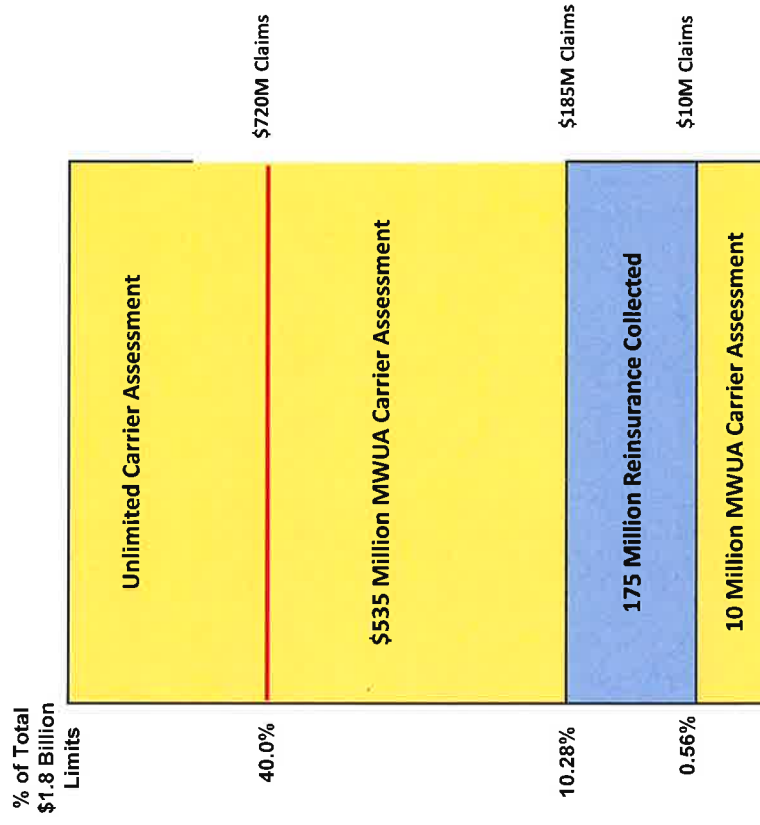
MWUA CATASTROPHE FUNDING FLOW



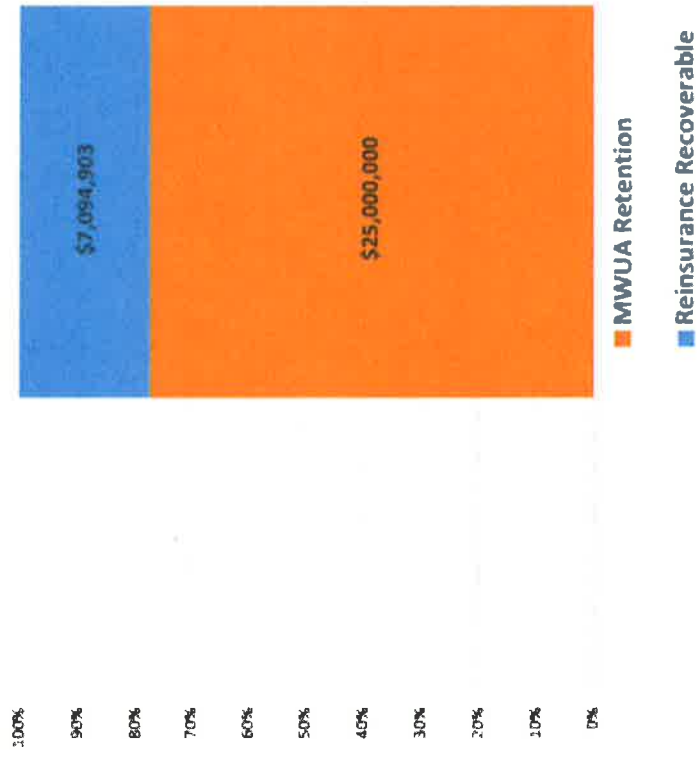
2021 MWUA CATASTROPHE FUNDING CHART



HURRICANE KATRINA FUNDING CHART



**Total Zeta Incurred
Including Eberl per Claim Fee**



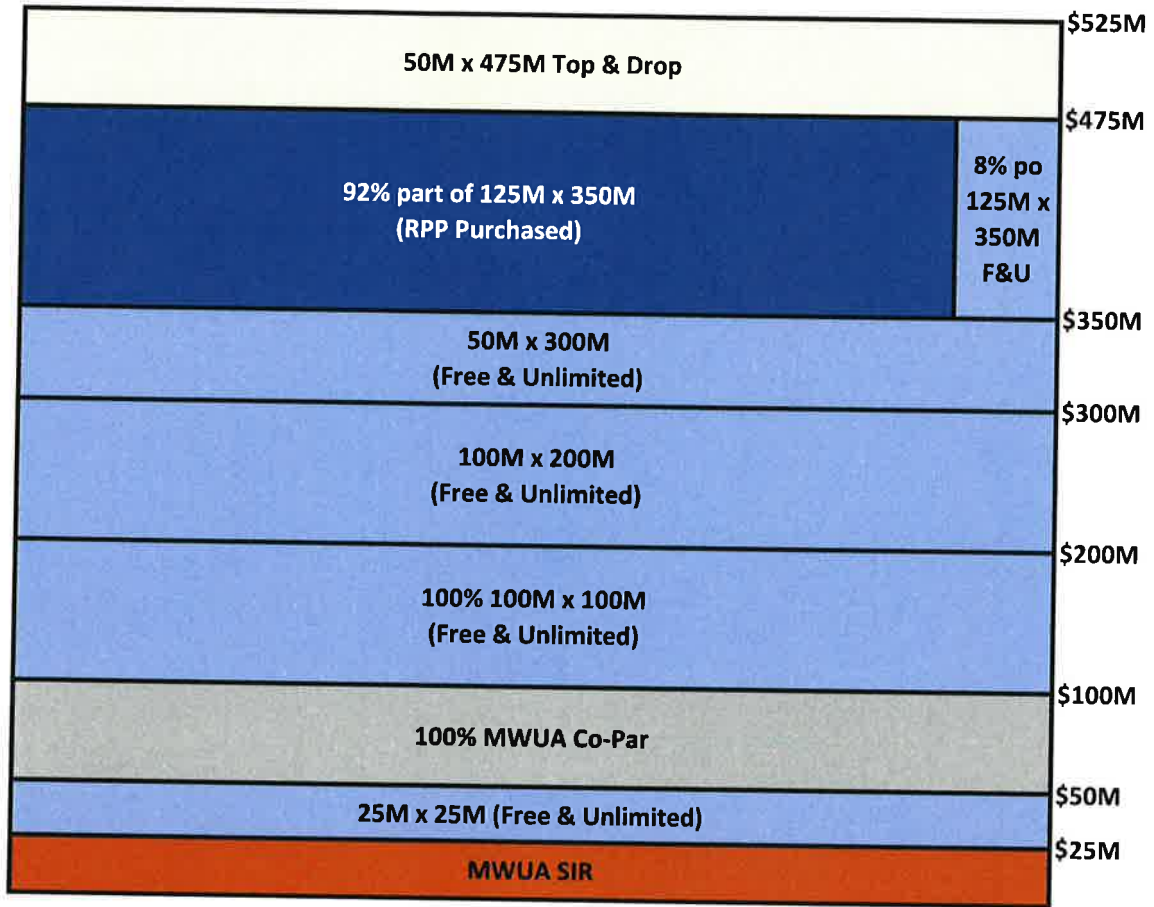
ZETA TOTAL INCURRED = \$32,094,903
4,637 claims reported

Questions ?

Scott Lemon, Chairman – MWUA Board of Directors

Joe Shumaker, Manager – MS Rating Bureau - MWUA

2021 BOUND PLACEMENT



- = retained by MWUA
- = Direct & Facultative Capacity
- = Treaty Capacity
- = Top and Drop
- = SIR / Not eligible for T&D

COST OF HEARING AIDS

(President's Council of Advisors on Science and Technology, October 2015)

avg **\$2363** per aid

This does not include the cost of custom fit earmolds, which may need replacing as frequently as every few months for growing infants. Hearing aids on average are replaced every five years.

AVAILABLE COVERAGE

\$0 private insurance

Medicaid covers \$1600 per hearing aid per year, \$18.15 per earmold, and an \$80 professional fitting fee. Mississippi Vocational Rehab pays approximately \$2500 every 4 years for adults holding full time jobs in state of MS.

LEGISLATION WILL IMPACT

(In Sept. 2020 - Sept. 2021 this accounted for approximately 10% of new pediatric hearing aid fittings per month.)

middle-class, working families who do not qualify for Medicaid.

WHY IS IT IMPORTANT?

Effects of Childhood Hearing Loss on Development:

- Delay in speech and language development
- Language deficit results in learning problems leading to poor academic achievement (particularly in literacy)
- Grade repetitions
- Social and behavioral deficits and delays
- Impact on vocational choices

<https://www.asha.org/public/hearing/effects-of-hearing-loss-on-development/>

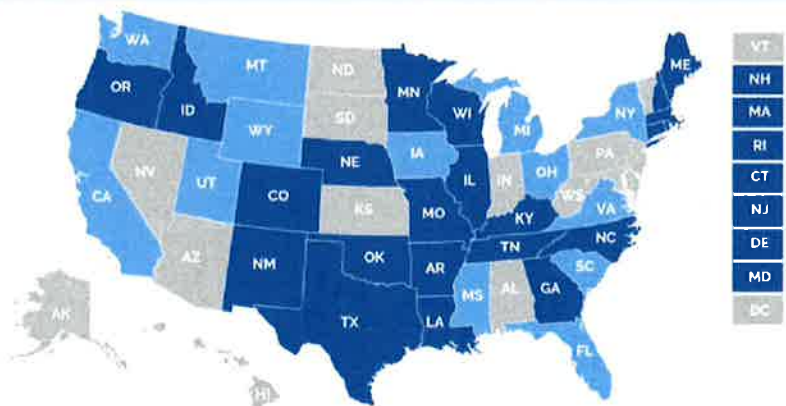
UNTREATED HEARING LOSS

- During the 1999 – 2000 school year, total cost in the U.S. for special ed programs for children who were deaf / hard of hearing was \$652 million, \$11,006 per child.
- Lifetime educational cost (2007 value) of hearing loss (more than 40 dB permanent loss without other disabilities) has been estimated at \$115,600 per child.
- It is expected that the lifetime costs for all people with hearing loss who were born in 2000 will total \$2.1 billion (in 2003 dollars).
 - Direct medical costs, such as doctor visits, prescription drugs, and inpatient hospital stays, will make up 6% of these costs.
 - Direct nonmedical expenses, such as home modifications and special ed, will make up 30% of these costs.
 - Indirect costs, like value of lost wages when a person cannot work or whose work is limited, will make up 63% of the costs.

<https://www.cdc.gov/ncbddd/hearingloss/data.htm>

IN OTHER STATES

- GA: \$3K per yr every 48 months for under 18
- LA: \$1400 per aid every 36 months for under 18
- KY: 1400 per aid every 36 months for under 18
- TN: \$1K per hearing aid every 3 yrs for under 18
- TX: 1 hearing aid per ear every 3 yrs for under 18
- AR: \$1400 per ear every 3 yrs for children & adults



Legislation passed

Legislation in progress

<http://www.letamericahear.org/other-states-efforts/>

Private Insurance Coverage of Hearing Aids for Children 0-21 Years of Age: Cost Analysis

National and state EHDI average incidence of infants diagnosed with permanent hearing loss:

.17% of all live births

(<https://www.cdc.gov/ncbddd/hearingloss/ehdi-data2017.html>)

Applying this incidence most recent available MS vital statistics, the estimated of infants born with hearing loss in MS is approximately

62.

Taking into consideration potential loss to follow-up and development of hearing loss later in childhood, let's use a generous estimate of **100** children diagnosed with hearing loss each year in MS.

Percentage of non-Medicaid pediatric fittings per month (average from University of MS Medical Center and University of Southern MS Audiology Clinics):

10%

Total number of children private insurance would cover per year:

10% of 100 = **10**

Assuming those children have *bilateral* hearing loss and need 2 hearing aids (which they may not), at the current Medicaid reimbursement rate of \$1600 per aid,

the maximum potential cost to private insurers would be

\$32,000 per year

Per Child Cost Estimate:

We are asking for coverage of new hearing aids every 5 years. This is the average lifespan of a hearing device with proper use and maintenance.

At the Medicaid rate of \$1600/aid, for a child with bilateral hearing loss, the maximum cost to insurance would be **\$16,000** per child from birth to age 21 years.

(max 5 sets of HAs over an 21 year period)

Testimony for the Joint Insurance Cte Regarding Telemedicine 9/21/21

Chairman Michel, Chairman Zuber, Vice Chairman McLendon and Vice Chairman Ford, Members of the Senate Insurance Committee, and all Senate and House members here today, thank you for allowing me the opportunity to speak during today's hearing on Telemedicine. *My name is Frank "Finn" Perkins, and I am a board-certified forensic psychiatrist at the Mississippi State Hospital at Whitfield.* In addition to working with students in training at MSH, I am also the Chief of Psychiatry-Elect for Merit Central Health and I have an outpatient psychiatry practice with Precise Clinical Neuroscience Specialists in Flowood. During an average week, our clinic averages 250 visits among 4 Psychiatrists, 8 Nurse Practitioners and 4 Therapists.

My testimony this morning comes as the Public Affairs Chairman of the Mississippi Psychiatric Association (MPA), a state affiliate organization of the American Psychiatric Association, which represents almost 37,000 in the United States. Our mission is to educate the public and Mississippi's lawmakers on the science of psychiatry, support the development of psychiatrists in training, and advocate to protect the interests of patients and their families in the state.

The State of Mississippi's Mental Health

Our state has deeply felt the impact of the COVID-19 crisis, and I thank you for your leadership throughout it. As our state continues to fight variants and large numbers of COVID positive patients, I urge you consider focus on the mental health needs of new and existing patients, who suffer with brain disorders and substance use disorders. Even before the crisis, over a fifth of Mississippi adults reported having a serious mental illness that went untreated, while just under 1/3 of adolescents reported having a major depressive episode that went untreated.¹ In addition to the increased anxiety among individuals afraid of becoming sick, the pandemic's social distancing policies have also led to people becoming isolated or unemployed. Both these situations are linked to poor mental health outcomes.

The pandemic has also placed an unmeasurable burden on our frontline workers. Our frontline workers have cared for many patients with limited

¹ U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality (2019). [2017-2018 NSDUH State Estimates of Substance Use and Mental Disorders](#).

resources, and many have experienced personal losses among their patients and colleagues. There will be a lingering impact on our medical workforce, on both their physical and mental health, and protecting their wellness should be a priority.

An added layer of the pandemic's complexity is its impact on minority patients. The Mississippi Department of Health's data shows that our African American, Hispanic, and Native Indian residents have been disproportionately impacted by COVID-19. As a physician, I want to highlight how deeply this will affect this population's mental health. Even before the pandemic, these patients were less likely to receive care due to lack of insurance, stigma, and distrust in the health care system.

Swift Expansion of Telehealth During COVID-19 Emergency

During this unprecedented time, state and federal action on telehealth has enabled thousands of Mississippi residents to access behavioral health services. These temporary changes include:

- Governor Reeves signed an order in March 2020 removing the barriers to telemedicine access and allowing for provider to patient telehealth during a state of emergency or a public health emergency.
- The Mississippi Department of Insurance directed commercial payers to reimburse for telehealth services at the same rate as in-person services and allow for audio-only telehealth services.
- The Department of Human Services expanded telehealth for Medicaid patients by announcing pay parity for telehealth services and allowing providers to use alternative technology, such as FaceTime and landlines.
- At the Federal level, the Centers for Medicare and Medicaid Services and the Drug Enforcement Agency have respectively lifted barriers to expand telehealth for Medicare patients and to allow providers to electronically prescribe controlled substances without an initial in-person examination.

Collectively, these changes have dramatically changed the way many of our doctors deliver psychiatric care. Our members have quickly adapted to telemedicine. They note that no-show rates have significantly decreased, with patients no longer having to leave their homes or consider travel to access care – some even report a no-show rate of 0%. For patients who lack broadband access or video-only technology, the ability to reach patients over telephone has been critical to ensuring continuity of care.

These changes have also allowed many clinics and practices to stay open when they may have otherwise been forced to close.

It is unlikely that in-person visits will return to pre-pandemic levels, as patients remain concerned about the spread of the virus and have become accustomed to and appreciate telehealth and the flexibility it provides. Even before the COVID-19 Public Health Emergency, 36 states had coverage parity policies and 16 states had payment parity for commercial health plans. Mississippi did not require either. For Medicaid, 21 states had coverage parity policies and 28 states had payment parity. Without telehealth coverage and payment parity for Medicaid and commercial insurance, Mississippi health plans can reimburse providers at unsustainably low rates or choose not to cover services at all, stifling flexible access to services and investments in virtual technologies that have been rapidly adopted and accepted this year. Healthcare Quality analyses from other states and reputable third-party study projections indicate that telehealth coverage expansion can improve access to care by avoiding emergency department visits, hospital admissions and unnecessary transportation.

Recommendations to Address the MH/SUD Needs of Mississippi

As our state moves into adopting formal legislation that failed to emerge from the conference process in 2021, MPA asks that you support continued access to telemedicine services by codifying many of these temporary changes. Legislation will allow all Mississippians, especially those in rural communities, to be able to eliminate costly travel and missing work to go long distances for a face-to-face visit. Historically, access to rural health care has been met with challenges and the advancement of telehealth carries its benefits to rural health care professionals and how they are able to treat patients. This revolutionary approach to health care services can reduce or minimize challenges and burdens patients encounter, such as transportation issues related to traveling for specialty care. Telemedicine can also improve monitoring, timeliness, and communications within the healthcare system.

We also urge you to support separate legislation that requires pay parity for telehealth services to ensure that these services are reimbursed at the same rate as services provided in-person.

Additionally, using audio-only technology is not our first choice when providing care, but we recognize it is a vital tool to reach vulnerable

patients who lack access to broadband or video technology. **We ask that you support equal reimbursement for audio-only telehealth services and allow clinicians, like our members, to use their judgement to determine when it is clinically appropriate.**

Lastly, MPA respectfully asks that any future bill include language that would prohibit insurers from requiring providers to use specific telehealth vendors, that would prohibit placing barriers to delivering telehealth, such as stricter utilization reviews or requiring specific technology platforms. This would prevent the bill's intended telehealth expansion from becoming inhibited by burdensome requirements to providers.

Thank you for the opportunity to share MPA's concerns and requests with you. Please use our Association as a resource for any questions you may have. Our Executive Director and MPA lobbyist, Mrs. Angela Ladner will work on behalf of the members of the Mississippi Psychiatric Association to assist you during the 2022 legislative session and we are happy to connect you with practicing psychiatrists in your districts to use as additional resources.

Psychiatrists cannot be at the Capitol near as much as we would like because we must treat patients and keep them stabilized so they can overcome hurdles and experience the same quality of life as those who do not have mental health or substance use disorders.

Telemedicine has changed access for many of our citizens who were too afraid of being categorized for seeking treatment for mental illness by their family or colleagues. This pandemic has taken a toll on all of us. We must be willing to admit that and take the necessary steps to improve outcomes, which means telemedicine is a tool that physicians can use to keep patients safe and stabilized over the course of this struggle. Please pass legislation that allows physicians to choose the best option for each specific patient and for some that is utilizing telemedicine when appropriate.

I thank the committee for your time, attention, and leadership on this very important topic.

Dr. Frank "Finn" Pekins, MPA Public Affairs Chairman on behalf of the membership of the Mississippi Psychiatric Association

UMMC's Center for Telehealth programs deliver care using interactive media and electronic information exchange (e.g., video, monitoring, transmitted images)



Telemedicine: Distance Care via Live (Audio-Video) Interaction



Store & Forward & Diagnostic Tests Interpretation



Mobile Health & Remote Patient Monitoring



Scheduled & Unscheduled Visits

- Emergency Medicine
- Specialty Care (e.g., Behavioral Health, Child Development)
- Corporate Health

Providers can share patients' medical information such as lab reports and images with physicians and patients, across time zones and locations

- Dermatology
- Ophthalmology
- Radiology

Transmission of physiologic and other data electronically to remote care team.

- Endocrinology (e.g., diabetes)
- Congestive Heart Failure & Hypertension
- Pulmonary (e.g., Asthma, COPD)

Credentials and Designations:

UMMC's Center for Telehealth (CFT) holds accreditation from URAC, a nonprofit organization and independent leader in promoting health care quality.

UMMC is designated as a National Telehealth Center of Excellence by the Health Resources and Services Administration (HRSA), one of only two in the nation.

The CFT also holds an "A" rating from the American Telemedicine Association.

Statewide Footprint:

53 of Mississippi's 82 counties are more than a 40-minute drive from specialty care. The CFT extends care by providing specialty services across multiple care settings.



- Community Hospitals & Clinics
- Corporations
- Federally Qualified Health Centers (FQHCs)
- Patient's Homes
- Prisons
- Schools & Colleges



Shaded counties are those served by UMMC telehealth programs. UMMC's Urgent Care telehealth program serves the entire state.

STRENGTHS:

- Access
- Cost Savings
- Adjunct to Medical Home

NEEDS:

- Standardized definitions
- Regulation flexibility
- Pay parity (network/rates)



MISSISSIPPI STATE MEDICAL ASSOCIATION

PO Box 2548, Ridgeland, MS 39158 | 408 West Parkway Place 39157 | (601) 853-6733 | MSMAonline.com

September 21, 2021

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Chairman Walter Michel
Senate Insurance Committee
Mississippi State Capitol
Jackson, Mississippi 39201

Dear Chairman Michel and Senate Insurance Committee Members:

On behalf of our Mississippi State Medical Association Board of Trustees and membership, thank you for your leadership and continued support for Mississippi physicians and your work to improve the health outcomes for all Mississippians.

Due to the pandemic, on March 14, 2020, Governor Reeves issued a State of Emergency which invoked his emergency powers and delegated those powers to state agencies, including the Mississippi Insurance Department. As part of those powers, the Commissioner of Insurance was given the authority to promulgate emergency regulations and guidelines to promote and secure the safety and protection of Mississippians. As a result, MID Bulletin 2020-1 was issued which, among other things, suspended certain limitations applicable to telemedicine services found in Miss. Code Ann. § 83-9-351, including the limitation of providing telemedicine services only on a provider-to-provider consultation. As a result of Bulletin 2020-1, telemedicine services could be used on patient to provider consultations, which has and continues to be greatly helpful to elderly and rural Mississippians throughout the COVID-19 pandemic. **Once the Governor's State of Emergency ends however, so will the provisions of MID Bulletin 2020-1, including the ability of telemedicine services to be used on a patient to provider basis.**

Patient and providers have seen the following throughout the pandemic with the ability to conduct telemedicine under the Commissioner of Insurance's Bulletin:

- Greater access to healthcare by the elderly or rural residents as they can consult with their medical provider by the use of their phone or computer.
- People in need of mental health services have received immediate, thorough, and consistent treatment, especially children and teenagers who have needed this type of service.
- Patients are able to have a consult with their provider on a more consistent basis as issues such as work and school conflicts or transportation issues are negated by the use of telemedicine.
- Patients who would have to go to a clinic or emergency room for certain non-life-threatening treatment have been able to receive their care at home through telemedicine.
- Patients who may have to travel great distances to see a specialist have been able to have video consultations with their specialist, saving the patient time and money.

It is clearly evident that the utilization of telemedicine with a patient to provider focus under the Commissioner of Insurance's bulletin has greatly enhanced the ability of physicians to better manage and improve the health of their patient population during the COVID-19 pandemic. We would ask that the Mississippi Legislature codify the Commissioner of Insurance's bulletin during the upcoming 2022 legislative session so that Mississippi patients can permanently receive and benefit from the additional tool of telemedicine in the maintenance of their health.

Sincerely,

Geri Weiland, MD
President

Katherine Pannel, DO

Katherine Pannel, DO
Chair, MSMA Board of Trustees

Cc: Chairman Hank Zuber, House Insurance Committee



State & School Employees' Life & Health Insurance Plan



Presented to

Senate Insurance Committee Hearing
September 21, 2021

Motivating
MISSISSIPPI



keys to living healthy

State and School Employees Health Insurance Management Board

- Authorized by law to promulgate rules and regulations governing the Plan
- Defines the scope and coverages provided by the Plan
- Selects vendors to provide administrative and operational support
- Develops and adopts strategic plans and budgets (including setting premium rates)
- Department of Finance and Administration, Office of Insurance provides administrative support

Health Insurance Management Board Members

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Executive Director, Mississippi Department of
Finance and Administration

Dr. Alfred Rankins, Jr., Commissioner

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Senate Appropriations Committee

State and School Employees' Life & Health Insurance Plan Eligibility

Active and retired employees (and dependents) of:

- Agencies
- School Districts
- Community Colleges
- Public Libraries
- Universities
- Mississippi House of Representatives and Senate, members and staff
- State Judges and District Attorneys
- Statewide Elected Officials

Health Insurance Enrollment as of June 30, 2021

192,906 Total Covered Lives

- 109,261 Active and COBRA employees plus 52,611 dependents
- 17,160 Medicare retirees plus 3,206 dependents
- 8,611 Non-Medicare retirees plus 2,057 dependents

Source: BCBSMS Enrollment Reports
BCBSMS Summary of Premium Billing Reports



Health Insurance Self-Insured Plan

- No direct appropriation from the State
- State assumes all the risk
- Employers submit enrollment to TPA
- TPA bills employers for premium
- Premiums are remitted to the Plan
- Vendors are reimbursed for claims and paid an administrative fee for their services

Vendors

- Blue Cross & Blue Shield of Mississippi – *third party medical claims administrator & medical provider network contracting vendor*
- CVS Caremark– *pharmacy benefit manager*
- Kepro – *case management and utilization review management*
- ActiveHealth Management, Inc. – *disease management and wellness promotion vendor*
- American Well (AmWell) – *telemedicine vendor*
- Minnesota Life Insurance Company – *life insurer*

Vendors

- Wm. Lynn Townsend, FSA, MAAA – *consulting actuary*
- Segal Consulting – *consultant*
- Claim Technologies, Inc. – *claims and performance review auditor – Medical*
- PillarRx Consulting, LLC – *claims and performance review auditor – Pharmacy*
- Health Data & Management Solutions – *decision support services vendor*

Participant Types

- **Legacy** - An active or retired employee who began full-time employment with the State prior to 1/1/06. This includes any current or subsequently hired employee who was ever employed by the State prior to 1/1/06.
- **Horizon** - An active or retired employee who began full-time employment with the State on or after 1/1/06, and has not previously been employed full-time by the State prior to 1/1/06.

Coverage Options

- Base Coverage:
 - \$1,800 deductible for individual
 - \$3,000 deductible for family
- Select Coverage:
 - \$1,300 deductible for individual
 - \$2,600 deductible for family

(Base coverage qualifies as a high deductible health plan under IRS rules for Health Savings Accounts.)

Premium Contributions

- State pays full cost for active employees enrolled in Base Coverage
- Employees may choose Select Coverage and pay applicable premium (Legacy \$20, Horizon \$41)
- Employee pays full premium for dependents
- Retirees pay full premium for themselves and dependents (115% of active rate for Legacy Employees and actuarial value for Horizon Employees)

Active Employee Monthly Premium Rates Calendar Year 2021

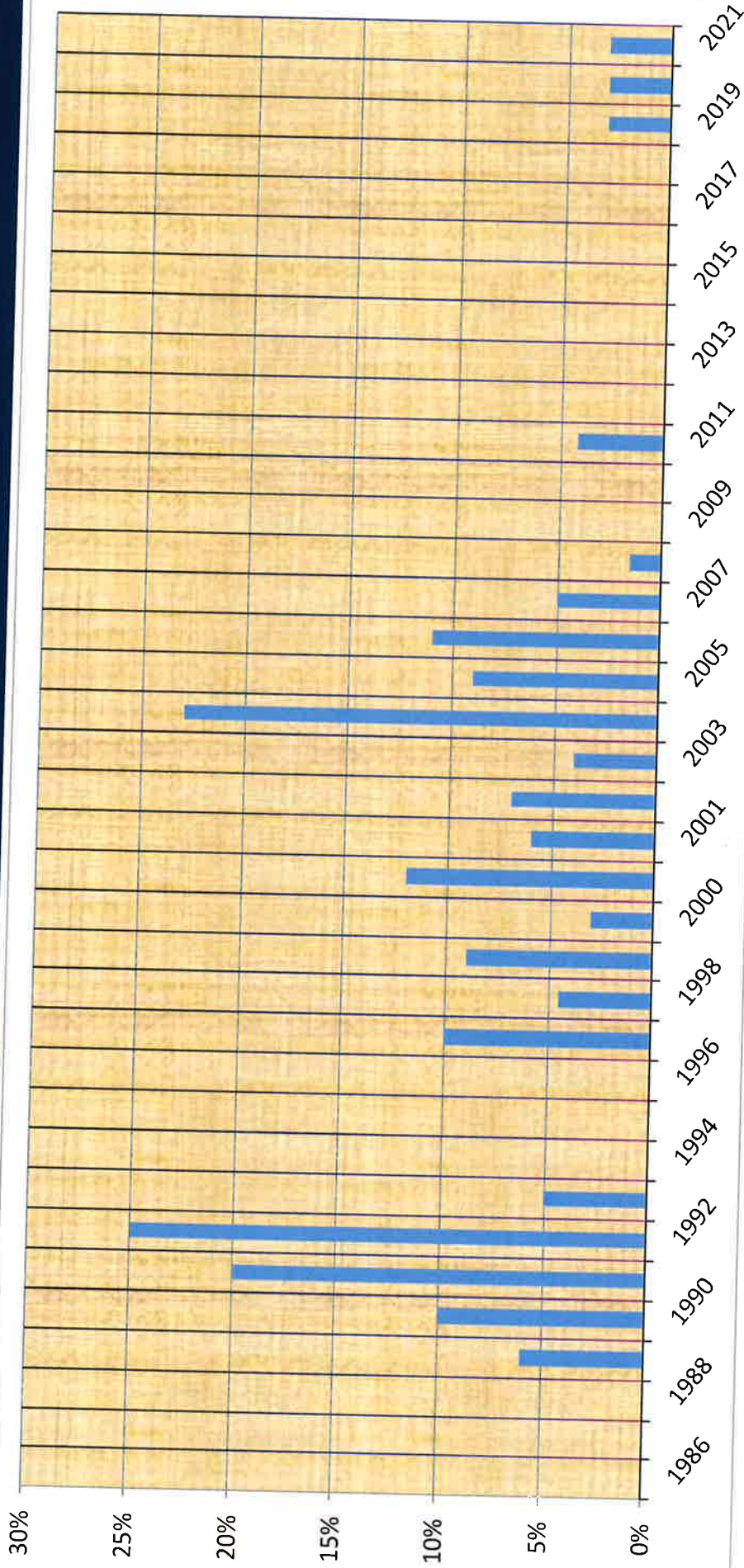
	BASE		SELECT	
	TOTAL	EMPLOYEE	TOTAL	EMPLOYEE
ACTIVE EMPLOYEE - LEGACY				
Employee	\$389	\$0	\$409	\$20
Employee + Spouse	\$814	\$425	\$893	\$504
Employee + Spouse & Child(ren)	\$1,037	\$648	\$1,116	\$727
Employee + Child	\$499	\$110	\$579	\$190
Employee + Children	\$671	\$282	\$750	\$361
ACTIVE EMPLOYEE - HORIZON				
Employee	\$389	\$0	\$430	\$41
Employee + Spouse	\$814	\$425	\$914	\$525
Employee + Spouse & Child(ren)	\$1,037	\$648	\$1,137	\$748
Employee + Child	\$499	\$110	\$600	\$211
Employee + Children	\$671	\$282	\$771	\$382

Retiree Monthly Premium Rates Calendar Year 2021

	LEGACY RETIREES		HORIZON RETIREES	
	BASE	SELECT	BASE	SELECT
RETIRED EMPLOYEE - NON-MEDICARE ELIGIBLE				
Retiree	\$447	\$470	\$714	\$739
Retiree + Spouse (Non-Medicare)	\$936	\$1,026	\$1,431	\$1,524
Retiree + Spouse & Child(ren) (Non-Medicare)	\$1,192	\$1,283	\$1,600	\$1,693
Retiree + Child	\$574	\$640	\$841	\$909
Retiree + Children	\$771	\$811	\$1,038	\$1,080
Retiree + Spouse (Medicare)	N/A	\$666	N/A	\$935
Retiree + Spouse & Child(ren) (One or more Medicare)	N/A	\$836	N/A	\$1,105
RETIRED EMPLOYEE - MEDICARE ELIGIBLE				
Retiree	BASE	SELECT	BASE	SELECT
Retiree + Spouse (Non-Medicare)	N/A	\$196	N/A	\$196
Retiree + Spouse & Child(ren) (Non-Medicare)	N/A	\$752	N/A	\$981
Retiree + Child	N/A	\$1,009	N/A	\$1,150
Retiree + Children	N/A	\$366	N/A	\$366
Retiree + Spouse (Medicare)	N/A	\$537	N/A	\$537
Retiree + Spouse & Child(ren) (One or more Medicare)	N/A	\$392	N/A	\$392
	N/A	\$562	N/A	\$562

Historical Premium Rate Increases

Summary of Active Employee Rate Increases from 1986 through 2021



Equivalent to a compound annual rate increase of 3.8% for last 20 years, .8% for last 10 years, and 1.7% for last 5 years

Source: CY 2020 Actuarial Report



Historical Financial Overview

HISTORICAL FINANCIAL OVERVIEW OF THE STATE & SCHOOL LIFE AND HEALTH INSURANCE PLAN *PRELIMINARY, Based on Current Claims Liability Estimates

	CY10	CY11	CY12	CY13	CY14	CY15	CY16	CY17	CY18	CY19	CY20*
REVENUE & EXPENSES (millions)											
Health Premiums	\$714	\$742	\$732	\$723	\$718	\$718	\$720	\$723	\$722	\$747	\$768
Medical Claims	-598	-547	-557	-574	-513	-515	-550	-556	-566	-589	-583
Drug Claims (Net of Rebates)	-106	-105	-117	-135	-145	-161	-154	-161	-168	-176	-185
Administrative Expenses	-54	-39	-33	-34	-32	-32	-35	-37	-35	-33	-33
ACA Fees INCURRED	0	0	0	0	-11	-8	-5	0	0	0	0
Life Insurance Gain	5	5	6	5	1	1	0	3	2	3	-2
Interest Income	5	2	3	3	2	3	3	3	5	4	2
ERRP	5	14	0	0	0	0	0	0	0	0	0
Drug Company Settlements	0	0	1	14	0	0	0	0	0	0	0
Total Gain (Loss)	-\$29	\$72	\$35	\$2	\$21	\$5	-\$20	-\$25	-\$40	-\$44	-\$33
SURPLUS (DEFICIT), End of Year	\$139	\$211	\$247	\$249	\$269	\$274	\$254	\$229	\$189	\$146	\$113
% INCREASE IN CLAIMS											
Medical	4%	-9%	2%	3%	-11%	0%	7%	1%	2%	4%	-1%
Drugs (Net)	-1%	-1%	11%	15%	8%	11%	-4%	4%	4%	5%	5%
Total Medical & Drugs	3%	-7%	3%	5%	-7%	3%	4%	2%	2%	4%	0%
KEY PLAN CHANGES											
Rate Increases - Active EEs		4.2%								3%	3%
Deductible Change-Select Plan		\$1,000									
Blue Card (out-of-state claims)					CY14						
PCP Copay Plan											
Drug Vendor											
							CY16				
							Prime				

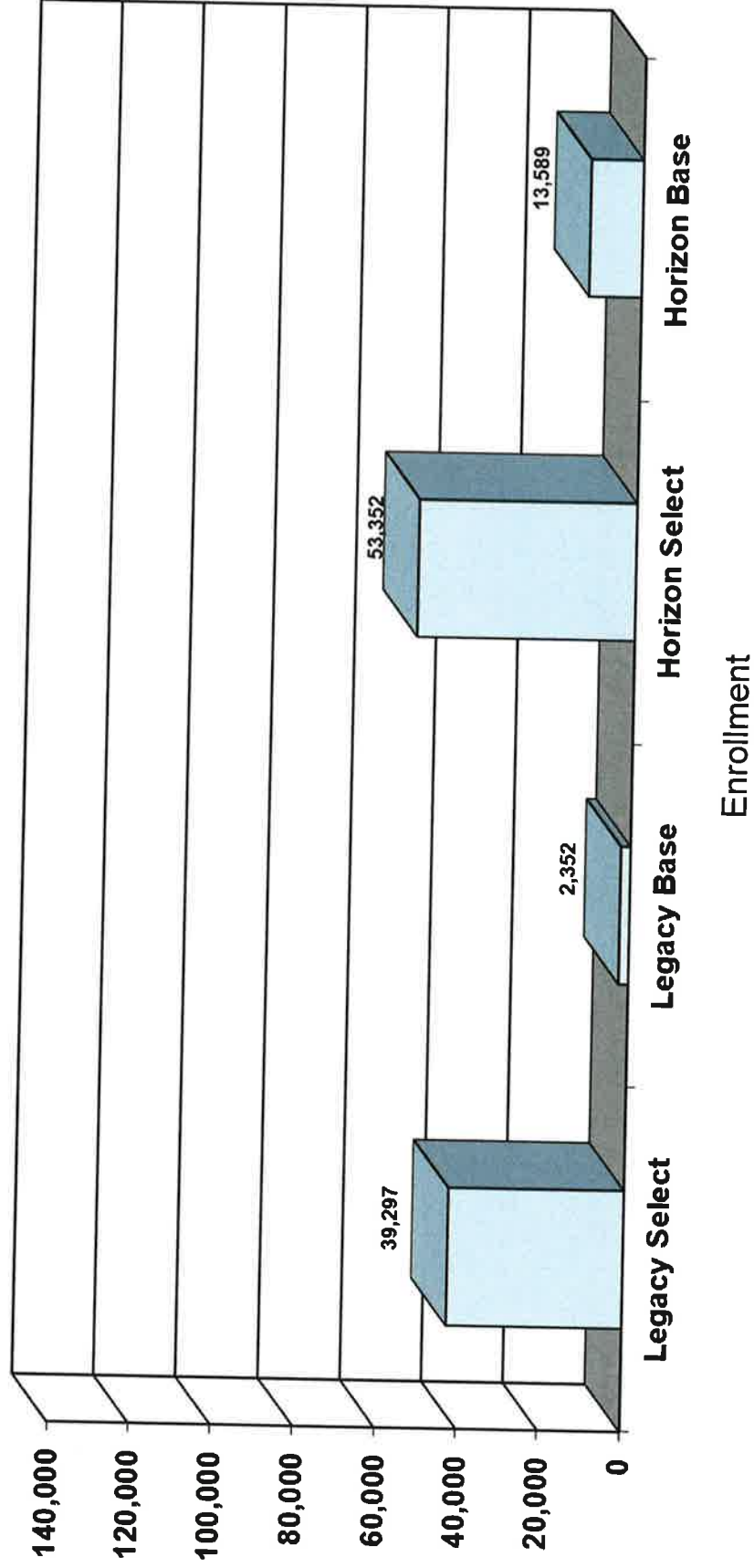


Southeastern States

2020 Active Employee Health Insurance Monthly Premium Rates

State	Active Employee Health Insurance Monthly Premium Rates										
	Single Coverage					Family Coverage					
	Total Cost	Employee Share	State Share	State Share %	Total Cost	Employee Share	State Share	State Share %	Total Cost	Employee Share	State Share %
Alabama	\$519.00	\$42.00	\$477.00	92%	\$1,342.000	\$251.00	\$1,091.00	81%			
Arkansas	\$526.98	\$188.32	\$338.66	64%	\$1,544.24	\$598.82	\$945.42	61%			
Florida	\$763.80	\$50.00	\$713.80	93%	\$1,719.32	\$180.00	\$1,539.32	89%			
Georgia	\$686.61	\$110.89	\$575.72	84%	\$1,922.51	\$394.54	\$1,527.97	79%			
Kentucky	\$731.82	\$84.86	\$646.96	88%	\$1,787.46	\$682.12	\$1,105.34	62%			
Louisiana	\$737.50	\$184.34	\$553.16	75%	\$1,652.18	\$641.66	\$1,010.52	61%			
North Carolina	\$582.36	\$50.00	\$532.36	91%	\$1,252.36	\$720.00	\$532.36	43%			
South Carolina	\$500.38	\$97.68	\$402.70	80%	\$1,305.28	\$306.56	\$998.72	77%			
Tennessee	\$679.00	\$136.00	\$543.00	80%	\$1,763.00	\$352.00	\$1,411.00	80%			
Texas	\$624.82	\$0.00	\$624.82	100%	\$1,820.22	\$597.70	\$1,222.52	67%			
Virginia	\$779.00	\$92.00	\$687.00	88%	\$2,089.00	\$287.00	\$1,802.00	86%			
West Virginia	\$596.00	\$122.00	\$474.00	80%	\$1,271.00	\$307.00	\$964.00	75%			
Mississippi	\$418.00	\$40.00	\$378.00	90%	\$1,104.00	\$726.00	\$378.00	34%			
State Average	\$626.56	\$92.16	\$534.40	85%	\$1,582.51	\$464.95	\$1,117.55	71%			
Variance	\$208.56	\$52.16	\$156.40		\$478.51	(\$261.05)	\$739.55				

Active Employee Enrollment by Coverage Type as of June 30, 2021



Base Coverage Option

	<u>Network</u>	<u>Out-of-Network</u>
<u>Individual Coverage</u>		
Calendar Year Deductible	\$1,800	
Preventive Medications Deductible (Other medications are subject to Calendar Year Deductible)	\$75	
Coinsurance Maximum	\$3,000	\$4,000
Out-of-Pocket Limit	\$6,500	N/A
<u>Family Coverage</u>		
Calendar Year Deductible	\$3,000	
Preventive Medications Individual Deductible (Other medications are subject to Calendar Year Deductible)	\$75	
Coinsurance Maximum	\$5,500	\$7,500
Out-of-Pocket Limit (In no event shall any one individual with family coverage exceed \$6,500 out-of-pocket expenses for covered network expenses.)	\$13,000	N/A

Base Coverage Option PPO

Network Services

Plan Pay 80%
after deductible
is met

Non-network Services

Plan Pays 60%
after deductible
is met

Base Coverage Option Preventive Wellness Services

Adult Wellness/Preventive Services

Plan pays 100%

Maternity – Specified prenatal care and network routine physician delivery covered at 100% subject to completion of the Maternity Management Program.

20% Coinsurance

Provider Online Primary Care Visit

\$10 Copayment
(after deductible)

Well-Newborn Nursery Care

Plan pays 100%

Well-Child Office Visits and Routine Tests

Plan pays 100%

Well-Child Routine Immunizations

Plan pays 100%

Base Coverage Option Pharmacy Benefits

Prescription medications are subject to the applicable deductible and the following copayments:

Preferred Generic Drug	\$12 Copayment
Non-preferred Generic Drug	\$30 Copayment
Preferred Brand Drug	\$45 Copayment
Non-preferred Brand Drug	\$100 Copayment
Specialty Drug	\$100 Copayment

Select Coverage Option PPO

Individual Coverage

Calendar Year Deductible
Coinsurance Maximum
Out-of-Pocket Limit

<u>Network</u>	<u>Out-of- Network</u>
\$1,300	\$2,300
\$3,000	\$4,000
\$6,500	N/A

Family Coverage

Calendar Year Deductible
Out-of-Pocket Limit

\$2,600	\$4,600
\$13,000	N/A

Select Coverage Option Network Provider Services

Primary Care Office Visits	\$25 Copayment
Other Office Services	20% Coinsurance
Online Primary Care Visit (Applicable to network primary care providers, registered dietitians and Plan approved vendors only)	\$10 Copayment
Online Behavioral Health Therapy (Applicable to network providers and Plan approved vendors only)	20% Coinsurance
Specialty Physician/Health Care Professional Services	20% Coinsurance

Select Coverage Option Network Services

Inpatient Hospital

20% Coinsurance

Outpatient Hospital Services

20% Coinsurance

Emergency Room – Services are subject to a \$50 copayment for the first visit and a \$200 copayment for each subsequent visit in addition to the deductible and coinsurance. Copayment is waived if admitted.

20% Coinsurance

X-Rays, Laboratory

20% Coinsurance

Select Coverage Option Preventive Wellness Services

Adult Wellness/Preventive Services

Plan Pays 100%

Maternity – Specified prenatal care and network routine physician delivery is covered at 100% subject to completion of the Maternity Management Program.

Plan Pays 100%

Maternity – Hospital; Other Services

Plan Pays 100%

Well-Newborn Nursery Care

Plan Pays 100%

Well-Child Office Visits and Routine Tests

Plan Pays 100%

Well-Child Routine Immunizations

Plan Pays 100%

Select Coverage Option Pharmacy Benefits

Prescription medications are subject to the \$75 pharmacy deductible and the following copayments:

Preferred Generic Drug	\$12 Copayment
Non-preferred Generic Drug	\$30 Copayment
Preferred Brand Drug	\$45 Copayment
Non-preferred Brand Drug	\$100 Copayment
Specialty Drug	\$100 Copayment

Motivating Mississippi Keys to Living Healthy

Objectives:

- Identify and encourage positive health practices to improve the overall health and wellness of Plan participants
- Reduce health care costs to the Plan and participants by providing appropriate behavioral modification and preventive services

Components:

- Annual wellness benefit for participants who use AHS State Network providers
- List of covered services available at knowyourbenefits.dfa.ms.gov
- Weight Management, Tobacco Cessation, Maternity Management
- Worksite Wellness provided by Wellness Coordinators throughout employer units' Site Champion network
- Desktop and Mobile Apps

Plan Payments - Top Four Chronic Conditions

Chronic Condition	2018 Plan Payments	2019 Plan Payments	2020 Plan Payments	2020 Increase over 2019	2020 Impacted Participants
Cancer	\$62,998,430	\$69,012,821	\$88,227,177	27.8%	10,621
Cardiovascular Disease	\$46,182,324	\$48,034,773	\$64,249,363	33.8%	76,594
Arthritis	\$31,021,503	\$34,536,234	\$46,042,896	33.3%	25,457
Diabetes	\$53,685,550	\$60,012,821	\$78,246,970	30.4%	24,446

Source: Health Data & Management Solutions, Inc.,
State of MS Database



Telemedicine Services Contracted Vendor

- Board released RFP in 2016 for 24/7 access direct access to care for participants for acute care
- AmWell went live March 1, 2017 having over 4,000 online visits
- Estimated saving of over \$700,000

Telemedicine Services Network Providers

- UMMC has provided 3,300 visits
- Hattiesburg Clinic has provided 580 visits

Telemedicine Services

- Repeat usage is very high
- Primary treatments are
 - Respiratory related
 - ADHD
 - UTI
 - Flu

Telemedicine Services Services Added

- Nutritional Counseling – RD
- Behavioral Health – Talk Therapy

Telemedicine – COVID-19 Provider Visits

- Behavioral Health Therapy – 34,000
- Psychiatric Encounters – 17,000
- Primary Care Encounters – 74,490
- Specialist Encounters – 35,000

Contact

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Department of Finance and Administration
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