

1 **TELEHEALTH AMENDMENTS**

2 2017 GENERAL SESSION

3 STATE OF UTAH

4 **Chief Sponsor: Ken Ivory**

5 Senate Sponsor: Allen M. Christensen

7 **LONG TITLE**

8 **General Description:**

9 This bill amends the Medical Assistance Act, the Public Employees' Benefit and
10 Insurance Program Act, and the Insurance Code to provide coverage, and coverage
11 transparency, for certain telehealth services.

12 **Highlighted Provisions:**

13 This bill:

- 14 ▶ defines terms;
- 15 ▶ amends the Medical Assistance Act regarding reimbursement for telemedicine
16 services;
- 17 ▶ amends the Insurance Code to require insurer transparency regarding telehealth
18 reimbursement;
- 19 ▶ amends the Public Employees' Benefit and Insurance Program Act (PEHP)
20 regarding reimbursement for telemedicine services;
- 21 ▶ requires the Department of Health and PEHP to report to a legislative interim
22 committee and a task force regarding telehealth services;
- 23 ▶ requires a legislative study; and
- 24 ▶ describes responsibilities of a provider offering telehealth services.

25 **Money Appropriated in this Bill:**

26 None

27 **Other Special Clauses:**

28 None

29 **Utah Code Sections Affected:**

30 AMENDS:

31 **26-18-13**, as enacted by Laws of Utah 2008, Chapter 41

32 **31A-22-613.5**, as last amended by Laws of Utah 2015, Chapters 257 and 283

33 ENACTS:

34 **26-18-13.5**, Utah Code Annotated 1953

35 **26-59-101**, Utah Code Annotated 1953

36 **26-59-102**, Utah Code Annotated 1953

37 **26-59-103**, Utah Code Annotated 1953

38 **26-59-104**, Utah Code Annotated 1953

39 **26-59-105**, Utah Code Annotated 1953

40 **49-20-414**, Utah Code Annotated 1953

41

42 *Be it enacted by the Legislature of the state of Utah:*

43 Section 1. Section **26-18-13** is amended to read:

44 **26-18-13. Telemedicine -- Reimbursement -- Rulemaking.**

45 (1) (a) [~~On or after July 1, 2008;~~] As used in this section, communication by
46 telemedicine is considered [~~face-to-face~~] face-to-face contact between a health care provider
47 and a patient under the state's medical assistance program if:

48 (i) the communication by telemedicine meets the requirements of administrative rules
49 adopted in accordance with Subsection (3); and

50 (ii) the health care services are eligible for reimbursement under the state's medical
51 assistance program.

52 (b) This Subsection (1) applies to any managed care organization that contracts with
53 the state's medical assistance program.

54 (2) The reimbursement rate for telemedicine services approved under this section:

55 (a) shall be subject to reimbursement policies set by the state plan; and

56 (b) may be based on:

57 (i) a monthly reimbursement rate;

58 (ii) a daily reimbursement rate; or

59 (iii) an encounter rate.

60 (3) The department shall adopt administrative rules in accordance with Title 63G,
61 Chapter 3, Utah Administrative Rulemaking Act, which establish:

62 (a) the particular telemedicine services that are considered [~~face-to-face~~] face-to-face
63 encounters for reimbursement purposes under the state's medical assistance program; and

64 (b) the reimbursement methodology for the telemedicine services designated under
65 Subsection (3)(a).

66 Section 2. Section **26-18-13.5** is enacted to read:

67 **26-18-13.5. Mental health telemedicine services -- Reimbursement -- Reporting.**

68 (1) As used in this section:

69 (a) "Mental health therapy" means the same as the term "practice of mental health
70 therapy" is defined in Section 58-60-102.

71 (b) "Mental illness" means a mental or emotional condition defined in an approved
72 diagnostic and statistical manual for mental disorders generally recognized in the professions of
73 mental health therapy listed in Section 58-60-102.

74 (c) "Telehealth services" means the same as that term is defined in Section 26-59-102.

75 (d) "Telemedicine services" means the same as that term is defined in Section
76 26-59-102.

77 (2) This section applies to:

78 (a) a managed care organization that contracts with the Medicaid program; and

79 (b) a provider who is reimbursed for health care services under the Medicaid program.

80 (3) The Medicaid program shall reimburse for personal mental health therapy office
81 visits provided through telemedicine services at a rate set by the Medicaid program.

82 (4) Before December 1, 2017, the department shall report to the Legislature's Public
83 Utilities, Energy, and Technology Interim Committee and Health Reform Task Force on:

84 (a) the result of the reimbursement requirement described in Subsection (3);

85 (b) existing and potential uses of telehealth and telemedicine services;

- 86 (c) issues of reimbursement to a provider offering telehealth and telemedicine services;
- 87 (d) potential rules or legislation related to:
- 88 (i) providers offering and insurers reimbursing for telehealth and telemedicine services;
- 89 and
- 90 (ii) increasing access to health care, increasing the efficiency of health care, and
- 91 decreasing the costs of health care; and
- 92 (e) the department's efforts to obtain a waiver from the federal requirement that
- 93 telemedicine communication be face-to-face communication.

94 Section 3. Section 26-59-101 is enacted to read:

95 **CHAPTER 59. TELEHEALTH ACT**

96 **26-59-101. Title.**

97 This chapter is known as the "Telehealth Act."

98 Section 4. Section 26-59-102 is enacted to read:

99 **26-59-102. Definitions.**

100 As used in this chapter:

101 (1) "Asynchronous store and forward transfer" means the transmission of a patient's
102 health care information from an originating site to a provider at a distant site.

103 (2) "Distant site" means the physical location of a provider delivering telemedicine
104 services.

105 (3) "Originating site" means the physical location of a patient receiving telemedicine
106 services.

107 (4) "Patient" means an individual seeking telemedicine services.

108 (5) "Provider" means an individual who is:

109 (a) licensed under Title 26, Chapter 21, Health Care Facility Licensing and Inspection
110 Act;

111 (b) licensed under Title 58, Occupations and Professions, to provide health care; or

112 (c) licensed under Title 62A, Chapter 2, Licensure of Programs and Facilities.

113 (6) "Synchronous interaction" means real-time communication through interactive

114 technology that enables a provider at a distant site and a patient at an originating site to interact
115 simultaneously through two-way audio and video transmission.

116 (7) "Telehealth services" means the transmission of health-related services or
117 information through the use of electronic communication or information technology.

118 (8) "Telemedicine services" means telehealth services:

119 (a) including:

120 (i) clinical care;

121 (ii) health education;

122 (iii) health administration;

123 (iv) home health; or

124 (v) facilitation of self-managed care and caregiver support; and

125 (b) provided by a provider to a patient through a method of communication that:

126 (i) (A) uses asynchronous store and forward transfer; or

127 (B) uses synchronous interaction; and

128 (ii) meets industry security and privacy standards, including compliance with:

129 (A) the federal Health Insurance Portability and Accountability Act of 1996, Pub. L.

130 No. 104-191, 110 Stat. 1936, as amended; and

131 (B) the federal Health Information Technology for Economic and Clinical Health Act,

132 Pub. L. No. 111-5, 123 Stat. 226, 467, as amended.

133 Section 5. Section **26-59-103** is enacted to read:

134 **26-59-103. Scope of telehealth practice.**

135 (1) A provider offering telehealth services shall:

136 (a) at all times:

137 (i) act within the scope of the provider's license under Title 58, Occupations and

138 Professions, in accordance with the provisions of this chapter and all other applicable laws and

139 rules; and

140 (ii) be held to the same standards of practice as those applicable in traditional health

141 care settings;

142 (b) in accordance with Title 58, Chapter 82, Electronic Prescribing Act, before
143 providing treatment or prescribing a prescription drug, establish a diagnosis and identify
144 underlying conditions and contraindications to a recommended treatment after:

145 (i) obtaining from the patient or another provider the patient's relevant clinical history;
146 and

147 (ii) documenting the patient's relevant clinical history and current symptoms;

148 (c) be available to a patient who receives telehealth services from the provider for
149 subsequent care related to the initial telemedicine services, in accordance with community
150 standards of practice;

151 (d) be familiar with available medical resources, including emergency resources near
152 the originating site, in order to make appropriate patient referrals when medically indicated;
153 and

154 (e) in accordance with any applicable state and federal laws, rules, and regulations,
155 generate, maintain, and make available to each patient receiving telehealth services the patient's
156 medical records.

157 (2) A provider may not offer telehealth services if:

158 (a) the provider is not in compliance with applicable laws, rules, and regulations
159 regarding the provider's licensed practice; or

160 (b) the provider's license under Title 58, Occupations and Professions, is not active and
161 in good standing.

162 Section 6. Section **26-59-104** is enacted to read:

163 **26-59-104. Enforcement.**

164 (1) The Division of Occupational and Professional Licensing created in Section
165 58-1-103 is authorized to enforce the provisions of Section 26-59-103 as it relates to providers
166 licensed under Title 58, Occupations and Professions.

167 (2) The department is authorized to enforce the provisions of Section 26-59-103 as it
168 relates to providers licensed under this title.

169 (3) The Department of Human Services created in Section 62A-1-102 is authorized to

170 enforce the provisions of Section 26-59-103 as it relates to providers licensed under Title 62A,
171 Chapter 2, Licensure of Programs and Facilities.

172 Section 7. Section 26-59-105 is enacted to read:

173 **26-59-105. Study by Public Utilities, Energy, and Technology Interim Committee**
174 **and Health Reform Task Force.**

175 The Legislature's Public Utilities, Energy, and Technology Interim Committee and
176 Health Reform Task Force shall receive the reports required in Sections 26-18-13.5 and
177 49-20-414 and study:

178 (1) the result of the reimbursement requirement described in Sections 26-18-13.5 and
179 49-20-414;

180 (2) practices and efforts of private health care facilities, health care providers,
181 self-funded employers, third-party payors, and health maintenance organizations to reimburse
182 for telehealth services;

183 (3) existing and potential uses of telehealth and telemedicine services;

184 (4) issues of reimbursement to a provider offering telehealth and telemedicine services;

185 and

186 (5) potential rules or legislation related to:

187 (a) providers offering and insurers reimbursing for telehealth and telemedicine
188 services; and

189 (b) increasing access to health care, increasing the efficiency of health care, and
190 decreasing the costs of health care.

191 Section 8. Section 31A-22-613.5 is amended to read:

192 **31A-22-613.5. Price and value comparisons of health insurance.**

193 (1) (a) This section applies to all health benefit plans.

194 (b) Subsection (2) applies to:

195 (i) all health benefit plans; and

196 (ii) coverage offered to state employees under Subsection 49-20-202(1)(a).

197 (2) (a) The commissioner shall promote informed consumer behavior and responsible

198 health benefit plans by requiring an insurer issuing a health benefit plan to:

199 (i) provide to all enrollees, prior to enrollment in the health benefit plan, written
200 disclosure of:

201 (A) restrictions or limitations on prescription drugs and biologics including:

202 (I) the use of a formulary;

203 (II) co-payments and deductibles for prescription drugs; and

204 (III) requirements for generic substitution;

205 (B) coverage limits under the plan;

206 (C) any limitation or exclusion of coverage including:

207 (I) a limitation or exclusion for a secondary medical condition related to a limitation or
208 exclusion from coverage; and

209 (II) easily understood examples of a limitation or exclusion of coverage for a secondary
210 medical condition; [~~and~~]

211 (D) whether the insurer permits an exchange of the adoption indemnity benefit in

212 Section [31A-22-610.1](#) for infertility treatments, in accordance with Subsection

213 [31A-22-610.1\(1\)\(c\)\(ii\)](#) and the terms associated with the exchange of benefits; and

214 (E) whether the insurer provides coverage for telehealth services in accordance with
215 Section [26-18-13.5](#) and terms associated with that coverage; and

216 (ii) provide the commissioner with:

217 (A) the information described in Subsections [31A-22-635\(5\)](#) through (7) in the
218 standardized electronic format required by Subsection [63N-11-107\(1\)](#); and

219 (B) information regarding insurer transparency in accordance with Subsection (4).

220 (b) An insurer shall provide the disclosure required by Subsection (2)(a)(i) in writing to
221 the commissioner:

222 (i) upon commencement of operations in the state; and

223 (ii) anytime the insurer amends any of the following described in Subsection (2)(a)(i):

224 (A) treatment policies;

225 (B) practice standards;

226 (C) restrictions;
227 (D) coverage limits of the insurer's health benefit plan or health insurance policy; or
228 (E) limitations or exclusions of coverage including a limitation or exclusion for a
229 secondary medical condition related to a limitation or exclusion of the insurer's health
230 insurance plan.

231 (c) An insurer shall provide the enrollee with notice of an increase in costs for
232 prescription drug coverage due to a change in benefit design under Subsection (2)(a)(i)(A):

233 (i) either:

234 (A) in writing; or

235 (B) on the insurer's website; and

236 (ii) at least 30 days prior to the date of the implementation of the increase in cost, or as
237 soon as reasonably possible.

238 (d) If under Subsection (2)(a)(i)(A) a formulary is used, the insurer shall make
239 available to prospective enrollees and maintain evidence of the fact of the disclosure of:

240 (i) the drugs included;

241 (ii) the patented drugs not included;

242 (iii) any conditions that exist as a precedent to coverage; and

243 (iv) any exclusion from coverage for secondary medical conditions that may result
244 from the use of an excluded drug.

245 (e) (i) The commissioner shall develop examples of limitations or exclusions of a
246 secondary medical condition that an insurer may use under Subsection (2)(a)(i)(C).

247 (ii) Examples of a limitation or exclusion of coverage provided under Subsection
248 (2)(a)(i)(C) or otherwise are for illustrative purposes only, and the failure of a particular fact
249 situation to fall within the description of an example does not, by itself, support a finding of
250 coverage.

251 (3) The commissioner:

252 (a) shall forward the information submitted by an insurer under Subsection (2)(a)(ii) to
253 the Health Insurance Exchange created under Section [63N-11-104](#); and

254 (b) may request information from an insurer to verify the information submitted by the
255 insurer under this section.

256 (4) The commissioner shall:

257 (a) convene a group of insurers, a member representing the Public Employees' Benefit
258 and Insurance Program, consumers, and an organization that provides multipayer and
259 multiprovider quality assurance and data collection, to develop information for consumers to
260 compare health insurers and health benefit plans on the Health Insurance Exchange, which
261 shall include consideration of:

262 (i) the number and cost of an insurer's denied health claims;

263 (ii) the cost of denied claims that is transferred to providers;

264 (iii) the average out-of-pocket expenses incurred by participants in each health benefit
265 plan that is offered by an insurer in the Health Insurance Exchange;

266 (iv) the relative efficiency and quality of claims administration and other administrative
267 processes for each insurer offering plans in the Health Insurance Exchange; and

268 (v) consumer assessment of each insurer or health benefit plan;

269 (b) adopt an administrative rule that establishes:

270 (i) definition of terms;

271 (ii) the methodology for determining and comparing the insurer transparency
272 information;

273 (iii) the data, and format of the data, that an insurer shall submit to the commissioner in
274 order to facilitate the consumer comparison on the Health Insurance Exchange in accordance
275 with Section 63N-11-107; and

276 (iv) the dates on which the insurer shall submit the data to the commissioner in order
277 for the commissioner to transmit the data to the Health Insurance Exchange in accordance with
278 Section 63N-11-107; and

279 (c) implement the rules adopted under Subsection (4)(b) in a manner that protects the
280 business confidentiality of the insurer.

281 Section 9. Section 49-20-414 is enacted to read:

282 **49-20-414. Mental health telemedicine services -- Reimbursement -- Reporting.**

283 (1) As used in this section:

284 (a) "Mental health therapy" means the same as the term "practice of mental health
285 therapy" is defined in Section 58-60-102.

286 (b) "Mental illness" means the same as that term is defined in Section 26-18-13.5.

287 (c) "Network provider" means a health care provider who has an agreement with the
288 program to provide health care services to a patient with an expectation of receiving payment,
289 other than coinsurance, copayments, or deductibles, directly from the managed care
290 organization.

291 (d) "Telehealth services" means the same as that term is defined in Section 26-59-102.

292 (e) "Telemedicine services" means the same as that term is defined in Section
293 26-59-102.

294 (2) This section applies to the risk pool established for the state under Subsection
295 49-20-201(1)(a).

296 (3) The program shall reimburse a network provider for personal mental health therapy
297 office visits provided through telemedicine services at a rate set by the program.

298 (4) Before December 1, 2017, the program shall report to the Legislature's Public
299 Utilities, Energy, and Technology Interim Committee and Health Reform Task Force on:

300 (a) the result of the reimbursement requirement described in Subsection (3);

301 (b) existing and potential uses of telehealth and telemedicine services;

302 (c) issues of reimbursement to a provider offering telehealth and telemedicine services;

303 and

304 (d) potential rules or legislation related to:

305 (i) providers offering and insurers reimbursing for telehealth and telemedicine services;

306 and

307 (ii) increasing access to health care, increasing the efficiency of health care, and
308 decreasing the costs of health care.