LEGISLATIVE GENERAL COUNSEL
₵ Approved for Filing: A.L. West ₵
₵ 01-19-17 10:23 AM ₵

H.B. 154

TELEHEALTH AMENDMENTS

2017 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Ken Ivory

Senate Sponsor: Allen M. Christensen

LONG TITLE

General Description:

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

Highlighted Provisions:

This bill:

- defines terms;
- amends the Medical Assistance Act regarding reimbursement for telemedicine services;
- amends the Insurance Code to require insurer transparency regarding telehealth reimbursement;
- amends the Public Employees' Benefit and Insurance Program Act (PEHP) regarding reimbursement for telemedicine services;
- requires the Department of Health and PEHP to report to a legislative interim committee and a task force regarding telehealth services;
- requires a legislative study;
- describes responsibilities of a provider offering telehealth services; and
- amends the Electronic Prescribing Act to restrict certain prescriptions in conjunction with telehealth services.

Money Appropriated in this Bill:

H.B. 154

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

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

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

58-82-201, as last amended by Laws of Utah 2012, Chapter 160

ENACTS:

26-18-13.5, Utah Code Annotated 1953

26-59-101, Utah Code Annotated 1953

26-59-102, Utah Code Annotated 1953

26-59-103, Utah Code Annotated 1953

26-59-104, Utah Code Annotated 1953

26-59-105, Utah Code Annotated 1953

49-20-414, Utah Code Annotated 1953

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

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

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

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

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

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

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

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

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

(b) may be based on:

(i) a monthly reimbursement rate;

(ii) a daily reimbursement rate; or

(iii) an encounter rate.

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

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

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

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

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

(1) As used in this section:

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

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

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

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

(2) This section applies to:

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

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

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

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

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

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

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

(d) potential rules or legislation related to:

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

(ii) increasing access to health care, increasing the efficiency of health care, and decreasing the costs of health care; and

(e) the department's efforts to obtain a waiver from the federal requirement that telemedicine communication be face-to-face communication.

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

CHAPTER 59. TELEHEALTH ACT

26-59-101. Title.

This chapter is known as the "Telehealth Act."

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

26-59-102. Definitions.

As used in this chapter:

(1) "Asynchronous store and forward transfer" means the transmission of a patient's health care information from an originating site to a provider at a distant site over a secure connection that complies with state and federal security and privacy laws.

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

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

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

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

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

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

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

(6) "Synchronous interaction" means real-time communication through interactive technology that enables a provider at a distant site and a patient at an originating site to interact simultaneously through two-way audio and video transmission.

(7) "Telehealth services" means the transmission of health-related services or

information through the use of electronic communication or information technology.

(8) "Telemedicine services" means telehealth services:

(a) including:

(i) clinical care;

(ii) health education;

(iii) health administration;

(iv) home health; or

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

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

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

(B) uses synchronous interaction; and

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

(A) the federal Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936, as amended; and

(B) the federal Health Information Technology for Economic and Clinical Health Act, Pub. L. No. 111-5, 123 Stat. 226, 467, as amended.

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

26-59-103. Scope of telehealth practice.

(1) A provider offering telehealth services shall:

(a) at all times:

(i) act within the scope of the provider's license under Title 58, Occupations and Professions, in accordance with the provisions of this chapter and all other applicable laws and rules; and

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

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

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

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

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

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

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

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

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

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

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

26-59-104. Enforcement.

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

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

(3) The Department of Human Services created in Section 62A-1-102 is authorized to enforce the provisions of Section 26-59-103 as it relates to providers licensed under Title 62A, Chapter 2, Licensure of Programs and Facilities.

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

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

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

(1) the result of the reimbursement requirement described in Sections 26-18-13.5 and

49-20-414;

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

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

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

(5) potential rules or legislation related to:

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

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

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

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

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

(b) Subsection (2) applies to:

(i) all health benefit plans; and

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

(2) (a) The commissioner shall promote informed consumer behavior and responsible health benefit plans by requiring an insurer issuing a health benefit plan to:

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

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

(I) the use of a formulary;

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

(III) requirements for generic substitution;

(B) coverage limits under the plan;

(C) any limitation or exclusion of coverage including:

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

(II) easily understood examples of a limitation or exclusion of coverage for a secondary

medical condition; [~~and~~]

(D) whether the insurer permits an exchange of the adoption indemnity benefit in Section 31A-22-610.1 for infertility treatments, in accordance with Subsection 31A-22-610.1(1)(c)(ii) and the terms associated with the exchange of benefits; and

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

(ii) provide the commissioner with:

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

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

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

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

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

(A) treatment policies;

(B) practice standards;

(C) restrictions;

(D) coverage limits of the insurer's health benefit plan or health insurance policy; or

(E) limitations or exclusions of coverage including a limitation or exclusion for a secondary medical condition related to a limitation or exclusion of the insurer's health insurance plan.

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

(i) either:

(A) in writing; or

(B) on the insurer's website; and

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

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

(i) the drugs included;

(ii) the patented drugs not included;

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

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

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

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

(3) The commissioner:

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

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

(4) The commissioner shall:

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

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

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

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

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

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

(b) adopt an administrative rule that establishes:

(i) definition of terms;

(ii) the methodology for determining and comparing the insurer transparency

information;

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

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

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

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

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

(1) As used in this section:

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

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

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

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

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

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

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

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

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

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

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

and

(d) potential rules or legislation related to:

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

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

Section 10. Section **58-82-201** is amended to read:

58-82-201. Electronic prescriptions -- Restrictions -- Rulemaking authority.

(1) Subject to the provisions of this section, a practitioner shall:

(a) provide each existing patient of the practitioner with the option of participating in electronic prescribing for prescriptions issued for the patient, if the practitioner prescribes a drug or device for the patient on or after July 1, 2012; and

(b) offer the patient a choice regarding to which pharmacy the practitioner will issue the electronic prescription.

(2) A practitioner may not issue a prescription through electronic prescribing for a drug, device, or federal controlled substance that the practitioner is prohibited by federal law or federal rule from issuing through electronic prescribing.

(3) A pharmacy shall:

(a) accept an electronic prescription that is transmitted in accordance with the requirements of this section and division rules; and

(b) dispense a drug or device as directed in an electronic prescription described in Subsection (3)(a).

(4) The division shall make rules to ensure that:

(a) except as provided in Subsection (6), practitioners and pharmacies comply with this section;

(b) electronic prescribing is conducted in a secure manner, consistent with industry standards; and

(c) each patient is fully informed of the patient's rights, restrictions, and obligations pertaining to electronic prescribing.

(5) An entity that facilitates the electronic prescribing process under this section shall:

(a) transmit to the pharmacy the prescription for the drug prescribed by the prescribing

practitioner however, this Subsection (5)(a) does not prohibit the use of an electronic intermediary if the electronic intermediary does not over-ride a patient's or prescriber's choice of pharmacy;

(b) transmit only scientifically accurate, objective, and unbiased information to prescribing practitioners; and

(c) allow a prescribing practitioner to electronically override a formulary or preferred drug status when medically necessary.

(6) The division may, by rule, grant an exemption from the requirements of this section to a pharmacy or a practitioner to the extent that the pharmacy or practitioner can establish, to the satisfaction of the division, that compliance with the requirements of this section would impose an extreme financial hardship on the pharmacy or practitioner.

(7) A practitioner treating a patient through telehealth services, as described in Title 26, Chapter 59, Telehealth Act, may not issue a prescription through electronic prescribing for a drug or treatment to cause an abortion, except in cases of rape, incest, or if the life of the mother would be endangered without an abortion.

Legislative Review Note
Office of Legislative Research and General Counsel