HB0313S01 compared with HB0313

~~{deleted text}~~ shows text that was in HB0313 but was deleted in HB0313S01.

inserted text shows text that was not in HB0313 but was inserted into HB0313S01.

DISCLAIMER: This document is provided to assist you in your comparison of the two bills. Sometimes this automated comparison will NOT be completely accurate. Therefore, you need to read the actual bills. This automatically generated document could contain inaccuracies caused by: limitations of the compare program; bad input data; or other causes.

Representative Melissa G. Ballard proposes the following substitute bill:

TELEHEALTH PARITY AMENDMENTS

2020 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Melissa G. Ballard

Senate Sponsor: Allen M. Christensen

LONG TITLE

General Description:

This bill amends provisions related to insurance coverage for telehealth services and telemedicine services.

Highlighted Provisions:

This bill:

- amends the definition of telemedicine services;
- clarifies the scope of telehealth practice; and
- requires certain health benefit plans to provide coverage parity and commercially reasonable reimbursement for telehealth services and telemedicine services.

Money Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

26-60-102, as enacted by Laws of Utah 2017, Chapter 241

26-60-103, as enacted by Laws of Utah 2017, Chapter 241

ENACTS:

31A-22-649.5, Utah Code Annotated 1953

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

Section 1. Section **26-60-102** is amended to read:

26-60-102. 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.

(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) (a) "Patient-generated medical history" means medical data about a patient that the patient creates, records, or gathers.

(b) "Patient-generated medical history" does not include a patient's medical record that a healthcare professional creates and the patient personally delivers to a different healthcare professional.

[~~(5)~~] (6) "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)~~] (7) "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)~~] (8) "Telehealth services" means the transmission of health-related services or information through the use of electronic communication or information technology.

[~~(8)~~] (9) "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~~] or

(vi) remote patient monitoring occurring incidentally to general supervision; 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 2. Section **26-60-103** is amended to read:

26-60-103. 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) if the provider does not already have a provider-patient relationship with the patient, establish a provider-patient relationship during the patient encounter in a manner consistent with the standards of practice, determined by the Division of Professional Licensing

in rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, including providing the provider's licensure and credentials to the patient;

[~~(b)~~] (c) 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)~~] (d) 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)~~] (e) 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)~~] (f) 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[~~.~~]; and

(g) if the patient has a primary care provider who is not the telemedicine provider~~{,}~~:

(i) consult with the patient regarding whether to provide~~{ to}~~ the patient's primary care provider a medical record or other report containing an explanation of the treatment provided to the patient and the telemedicine provider's evaluation, analysis, or diagnosis of the patient's condition; and

(ii) within ~~{three business days}~~two weeks after the day on which the telemedicine provider provides services to the patient, and to the extent allowed under HIPAA as that term is defined in Section 26-18-17, provide the medical record or report to the patient's primary care provider, unless the patient ~~{asks the provider to not send the evaluation, analysis, or diagnosis.~~

~~(2)}~~indicates that the patient does not want the telemedicine provider to send the medical record or report to the patient's primary care provider.

(2) Subsection (1)(g) does not apply to prescriptions for eyeglasses or contacts.

(3) Except as specifically provided in Title 58, Chapter 83, Online Prescribing, Dispensing, and Facilitation Licensing Act, and unless a provider has established a

provider-patient relationship with a patient, a provider offering telemedicine services may not diagnose a patient, provide treatment, or prescribe a prescription drug based solely on one of the following:

(a) an online questionnaire;

(b) an email message; or

(c) a patient-generated medical history~~{; or}~~.

~~{ (d) an audio-only electronic consultation.~~

~~}~~ [~~(2)~~] (~~{3}~~4) 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 3. Section **31A-22-649.5** is enacted to read:

31A-22-649.5. Insurance parity for telemedicine services.

(1) As used in this section:

~~{ (a) "Preauthorization requirement" means the same as that term is defined in Section 31A-22-650.~~

~~(b) "Service" means diagnosis, consultation, treatment, or care that is included in a health benefit plan and is provided to an insured.~~

~~}~~ (~~{c}~~a) "Telehealth services" means the same as that term is defined in Section 26-60-102.

(~~{d}~~b) "Telemedicine services" means the same as that term is defined in Section 26-60-102.

(2) Notwithstanding the provisions of Section 31A-22-618.5, a health benefit plan offered in the individual market, the small group market, or the large group market and entered into or renewed on or after January 1, 2021, shall:

(a) provide coverage~~{ and reimbursement}~~ for telemedicine services ~~{in accordance with the requirements of this section.~~

~~(3) If a health benefit plan provides in-network or out-of-network coverage for a healthcare provider that offers services in person and that healthcare provider offers the same services via telemedicine services, the health benefit plan shall provide the same coverage for~~

~~both the in-person services and the telemedicine services at the rate described in Subsection (5), on the same basis, and to the same extent that the health benefit plan covers the same services in person.~~

~~(4) A health benefit plan shall reimburse a healthcare provider for telemedicine services at the rate described in Subsection (5), on the same basis, and to the same extent that the health benefit plan would reimburse for those services if they had been delivered in an in-person encounter with the healthcare provider.~~

~~(5) A health benefit plan shall reimburse a healthcare provider for telemedicine services}~~that are covered by Medicare; and

(b) reimburse, at a commercially reasonable rate~~{ that:~~

~~(a) covers a proportionate share of the fixed and variable costs of the provider;~~

~~(b) does not require the provider to shift costs to other reimbursement sources;~~

~~(c) is negotiated in good faith with the provider; and~~

~~(d) that the provider agrees to pay.~~

~~(6) If a health benefit plan and a provider cannot agree on the rate}~~, a network provider that provides the telemedicine services described in Subsection (~~{5), either party may request the department to determine a rate that complies with the requirements described in Subsections (5)(a) and (b).~~

~~(7) If the department receives a request described in Subsection (6), the department shall determine a rate that complies with the requirements described in Subsections (5)(a) and (b).~~

~~(8) A health benefit plan may require a deductible, co-payment, or coinsurance for a telemedicine service if:~~

~~(a) the deductible, co-payment, or coinsurance for the telemedicine service does not exceed the deductible, co-payment, or coinsurance the plan requires for the same in-person service; and~~

~~(b) the plan counts the deductible, co-payment, or coinsurance for the telemedicine service as contributing to the same deductible, co-payment, or coinsurance the plan requires for the same in-person service.~~

~~(9}~~2)(a).

(3) Notwithstanding Section 31A-45-303, a health benefit plan providing treatment

under Subsection (~~{~~(3) or (4)~~}~~2) may not impose originating site restrictions, geographic restrictions, or distance-based restrictions~~{~~, or other restrictions or conditions on coverage or reimbursement for telemedicine services.

~~(10) A health benefit plan may not:~~

~~(a) subject telemedicine services to deductible, co-payment, or coinsurance requirements that are additional to or separate from a deductible, co-payment, or coinsurance the health benefit plan requires for the same in-person services;~~

~~(b) impose an annual maximum or lifetime-dollar maximum on coverage for telemedicine services other than an annual maximum or lifetime-dollar maximum that applies in the aggregate to all items and services covered under the health benefit plan;~~

~~(c) impose terms for telemedicine services that are not equally imposed upon all terms and services covered under the health benefit plan, including terms regulating:~~

~~(i) deductibles;~~

~~(ii) co-payments;~~

~~(iii) coinsurance;~~

~~(iv) policy year, calendar year, lifetime, or other time-restrictive benefits; or~~

~~(v) maximums for benefits or services;~~

~~(d) limit coverage for telemedicine services only to services provided by select corporate telemedicine healthcare providers;~~

~~(e) impose preauthorization requirements on telemedicine services beyond those imposed on the same in-person services; or~~

~~(f) refuse to cover a service solely because the service is provided through telemedicine services and is not provided through in-person services~~}~~.~~

~~{ (11) Other terms and conditions in the health benefit plan that apply to other benefits covered by the health benefit plan apply to coverage required by this section.~~

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