HB 1149

Department of Legislative Services

Maryland General Assembly
2012 Session

FISCAL AND POLICY NOTE
Revised

House Bill 1149 (Delegate Lee, *et al.*)
Health and Government Operations Finance

Health Insurance - Coverage for Services Delivered Through Telemedicine

This bill generally requires insurers, nonprofit health service plans, and health maintenance organizations (HMOs) (collectively known as carriers) to cover and reimburse for health care services appropriately delivered through "telemedicine."

The bill applies to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after October 1, 2012.

Fiscal Summary

State Effect: Minimal special fund revenue increase for the Maryland Insurance Administration (MIA) from the $125 rate and form filing fee in FY 2013. Review of filings can be handled with existing budgeted MIA resources. The Department of Health and Mental Hygiene and the Department of Public Safety and Correctional Services can conduct the required studies and reviews and submit the required reports within existing budgeted resources. The bill does not apply to the Maryland Medicaid program or the State Employee and Retiree Health and Welfare Benefits Program (State plan). However, to the extent that the State plan voluntarily complies with the bill (as it typically does with health insurance mandates), State plan expenditures increase beginning in FY 2014 to cover and reimburse for health care services delivered through telemedicine.

Local Effect: Potential increase in expenditures for some local governments to reimburse for services delivered through telemedicine.

Small Business Effect: Potential meaningful. Some small business health care providers could receive increased reimbursement for telemedicine services under the bill. However, the bill does not impact the small group health insurance market.

Analysis

Bill Summary: "Telemedicine" is the use of interactive audio, video, or other telecommunications or electronic technology by a licensed health care provider to deliver a health care service within the scope of practice of the provider at a site other than the site at which the patient is located. Telemedicine does not include audio-only telephone calls, email messages, or communications via fax.

Private Insurance: Carriers must provide coverage for health care services appropriately delivered through telemedicine. Carriers must reimburse for a covered health care service that can be appropriately provided through telemedicine. Carriers may not exclude coverage of a health care service solely because it is provided through telemedicine rather than in person.

A carrier is not required to reimburse a health care provider for a health care service, whether provided in person or through telemedicine, if the service is not a covered benefit or if the provider is not a covered provider.

A carrier may require cost sharing or impose an annual dollar maximum, as permitted by federal law. However, a carrier may not impose a lifetime dollar maximum.

Carriers may perform utilization review, including preauthorization, to determine the appropriateness of any health care service whether the service is delivered in person or through telemedicine, provided that the appropriateness of the health care service is determined in the same manner. A health insurance policy or contract cannot distinguish between patients in rural or urban locations in providing coverage for health care services delivered through telemedicine. A decision by a carrier not to provide coverage for telemedicine constitutes an adverse decision if the decision finds that telemedicine is not medically necessary, appropriate, or efficient.

Uncodified Study Language: The Department of Public Safety and Correctional Services must study the use of telemedicine services to identify opportunities to reduce costs and report to the General Assembly, including a plan for implementing the use of telemedicine to deliver health care services to inmates, by December 1, 2012.

The Department of Health and Mental Hygiene must conduct a review of literature and evidence regarding telemedicine, conduct a review of other payors' and other state Medicaid agencies' telemedicine policies and procedures, review evidence regarding the appropriate use of telemedicine in delivering mental health services, determine which types of patients would be suitable for telemedicine, conduct a fiscal analysis of the potential effect of Medicaid coverage of telemedicine, and submit a report on its findings and recommendations to specified committees of the General Assembly by December 1, 2012.

Current Law: In general, Title 15, Subtitle 7 of the Insurance Article requires health insurance policies, contracts, and certificates to reimburse for any covered service if a practitioner is providing services within the lawful scope of practice. Policies, contracts, and certificates must provide the option of covering services rendered by certain licensed providers.

Background: Telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve a patient's health status. There are generally two types of telemedicine encounters – those that require two providers and those that do not. Certain telemedicine encounters require a provider at the location with the patient to "present" the patient and manage the telemedicine technology, while another provider conducts the evaluation or consultation remotely. Other forms of telemedicine, such as remote monitoring, require only one provider to receive and interpret clinical data or provide consultation to another provider.

National Activity: Twelve states (California, Colorado, Georgia, Hawaii, Kentucky, Louisiana, Maine, New Hampshire, Oklahoma, Oregon, Texas, and Virginia) mandate health insurance coverage of telemedicine or telehealth services.

Virginia adopted its telemedicine mandate in 2010. The law requires all health insurers, health care subscription plans, and HMOs to offer coverage for telemedicine services. Payors may not discriminate with regards to reimbursement levels, premium payments, or other aspects of coverage on the basis that a service is being provided via telemedicine. According to the Virginia Department of Human Resource Management, during the first 14 months of implementation of the mandate, Virginia's state employee health insurance plan received a total of 78 claims for 11 enrollees for telemedicine services.

Medicare and Medicaid Coverage: The federal Medicare program provides reimbursement for some telemedicine services. Beneficiaries must present from an originating site located in either a rural health professional shortage area or a county outside of a metropolitan statistical area. Covered services are limited and must be provided at qualifying originating sites by designated Medicare practitioners. According to the American Telemedicine Association, Medicare spending for telehealth was about $0.26 per year per covered beneficiary in 2009.

Telemedicine is not a distinct service under Medicaid. However, states may seek a State Plan Amendment to cover telemedicine. An estimated 35 state Medicaid programs (including Virginia and West Virginia) provide some reimbursement for services provided via telemedicine.

Maryland Medicaid currently does not reimburse for telemedicine with the exception of a telemental health services pilot program for fee-for-services enrollees. The purpose of

the pilot is to provide psychiatric care via telemental health technology to improve access to outpatient psychiatric care, improve access to outpatient and inpatient psychiatric subspecialty consultation, and improve capacity and choice for outpatient ongoing psychiatric treatment.

Maryland Telemedicine Task Force: In June 2010, the Maryland Health Quality and Cost Council approved the creation of the Maryland Telemedicine Task Force. A final report to the council was issued in December 2011. The report found that effective use of telemedicine can increase access to health care, reduce health disparities, and create efficiencies in health care delivery. Telemedicine is generally considered as a viable means of delivering health care remotely through the use of communication technologies and can bridge the gaps of distance and health care disparity. Although telemedicine is well established, a number of technology and policy challenges need to be resolved before its full potential can be realized.

The task force's three advisory groups (clinical, technology solutions and standards, and financial and business model) identified the following recommendations to promote telemedicine in Maryland:

- **State-regulated payors should reimburse for telemedicine services** to the same extent as health care services provided face-to-face, regardless of the location. Telemedicine services should be assessed to determine their appropriateness in the same manner as face-to-face services as part of benefit design and through utilization review.

- **Establish a centralized telemedicine network built on existing industry standards.** An interoperable network built on existing standards and integrated into the State-designated health information exchange would enable broad provider participation, allow networks to connect to other networks, and have access to clinical information through the exchange. Organizations that adopt telemedicine should meet certain minimum requirements related to technology and connectivity to a centralized network.

- **Implement changes in licensure, credentialing, and privileging of providers to facilitate the adoption of telemedicine.** Regulations should be aligned with newly revised federal Centers for Medicare and Medicaid Services rules that permit privileging and credentialing by proxy. As telemedicine advances, additional consideration regarding expanding existing regulations to support out-of-state providers that meet certain conditions to provide telemedicine services to patients in Maryland is required. Future changes in licensure are needed to enable reciprocity of licensure for physicians practicing in neighboring states.

The report noted that little evidence exists to suggest that adoption of telemedicine increases health care costs and that aligning prices of telemedicine equitably with face-to-face care will help ensure that the service is used appropriately and does not lead to a surge in utilization. However, more information is needed on the costs of telemedicine before payment levels should be guaranteed relative to face-to-face visits. The appropriateness of new forms of reimbursement, such as bundling payments around a single episode of care or permitting telemedicine when delivered by an accountable care organization recognized by the payor, may prove attractive for providers and payors.

The report also recommended that Medicaid's current telemental health pilot program continue and that Maryland Medicaid more fully consider the financial impact of supporting telemedicine and propose a reasonable adoption strategy relating to telemedicine services.

Additional Comments: One other bill, SB 817 of 2011, addresses coverage and reimbursement for health care services provided via telemedicine.

Additional Information

Prior Introductions: Similar legislation, SB 298 and SB 744 of 2011, was heard by the Senate Finance Committee, but no further action was taken on either of the bills.

Cross File: SB 781 (Senator Pugh, *et al.*) - Finance.

Information Source(s): *Telemedicine Recommendations: A Report Prepared for the Maryland Health Quality and Cost Council*, December 2011; American Telemedicine Association; Virginia Department of Human Resource Management; Department of Budget and Management; Department of Health and Mental Hygiene; Department of Public Safety and Correctional Services; Maryland Insurance Administration; Department of Legislative Services

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