



State Legislation for Telehealth-Provided Covered Services

An important cause for telehealth is coverage in health benefit plans for otherwise covered services. One opportunity is state insurance law governing private and state benefit plans offered in the state.

State laws

12 states, covering over 106 million Americans, have adopted mandates for telehealth-provided covered services, with the year of enactment indicated: California (1996), Colorado (2001), Georgia (2006), Hawaii (1999), Kentucky (2000), Louisiana (1995), Maine (2009), New Hampshire (2009), Oklahoma (1997), Oregon (2009), Texas (1997), and Virginia (2010).

In 2011, 6 states had pending legislative proposals: Florida (S.B. 1842, H.B. 60), Maryland (S.B. 298, S.B. 744, H.B. 14), New Mexico (H.B. 591), Ohio (S.B. 280), Pennsylvania (H.B. 273), and Vermont (H.B. 37).

Lessons from those enacted

In general, the experience has been positive, largely has been as expected, and without adverse or unintended consequences. Importantly, 6 states have had such law in effect for over 10 years -- with no efforts to repeal, roll-back, or restrict. In fact, the leading state on this regard, California, after a thorough review of its 14 years of experience is considering legislation to reduce further barriers to telehealth.

Mandating private coverage is often a spur to improve a state's Medicaid coverage, similarly.

Model legislative language

Each states' laws and proposals have been slightly different. In general, the state laws say--
A health benefit plan may not deny coverage on the basis that the coverage is provided through telemedicine if the health care service would be covered were it provided in-person. Coverage for health care services provided through telemedicine must be determined in a manner consistent with coverage for health care services provided in-person.

This principle would also extend to a state's Medicaid coverage by a proposal from the National Organization of Black Elected Legislative Women (NOBEL/Women) (see page 4):

Let the Medicaid plan not deny coverage on the basis that the coverage is provided through telemedicine if the health care service would be covered were it provided in-person. Coverage for health care services provided through telemedicine must be determined in a manner consistent with coverage for health care services provided through in-person consultation.

Importance of net cost impact

Cost for the state and policyholders are a key consideration for legislators. Unfortunately, the data on cost and utilization is not conclusive on a national basis, much less state by state, for a variety of reasons.

- Such legislation would not increase benefits, only to explicitly recognize telehealth as a way to deliver the covered services. This is unlike other common insurance mandates, such as vision services.

- Many insurers already cover telehealth-provided covered services under the plain language of their benefit coverage. For example, if a policy covers “physician services” then there is no basis to deny a telehealth-provided covered physician service.
- If politically important, legislators could include a provision, as did Oregon, “This section does not require a health benefit plan to reimburse a provider for a health service that is not a covered benefit under the plan or to reimburse a health professional who is not a covered provider under the plan.”

One issue is the difference of claims experience as opposed to net cost impact. Some recent state fiscal notes have been “zero” (for example, Maine (http://www.mainelegislature.org/legis/bills/bills_124th/fiscalnotes/FN107302.htm) and Virginia). Some states (for example, Maryland (http://mlis.state.md.us/2011rs/fnotes/bil_0004/hb0014.pdf) have projected a small increase based on telehealth claims, not the net cost after substituting for in-person services.

- There is some concern that as barriers to access are removed that policyholders will use their benefit.

As a point of reference, Medicare spending for telehealth was only about \$0.26 per year per covered beneficiary in 2009 (and this is not net cost).

Talking points for telehealth-provided covered services

Consumer choice -- Patients should be able to choose how they receive a covered service, including their urgency, convenience and satisfaction.

Non-discrimination -- Telehealth methods of providing covered services should be on parity with in-person methods. This legislation does not require new coverage.

Reduce disparities in access to care -- For many people access to in-person services is very difficult for a wide variety of reasons, notably their mobility limitations, major distance or time barriers, and transportation limitations (don’t drive, have a car or have transit available). For existing programs however funded, track metrics of interest to the legislature (miles saved, transfers avoided)

Improve physician availability -- Many areas of the state already have numerical shortage of needed providers. Another problem is a lack of providers willing to treat the patients of a particular payor (usually for reimbursement reasons). These problems are only expected to worsen. Telehealth methods can reduce provider’s practice costs, improve their productivity, and facilitate triaging for specialty care.

Improve quality of care -- Identify key health status indicators that can be improved with improved access (infant mortality, stroke related disability). Wider patient choices will foster provider competition.

Using innovation -- Each state, as the regulator of insurance policies offered to its citizens, has a strong and vital interest in taking advantage of health care delivery innovations, especially to improve quality, reduce costs, improve timely access to needed care, and improve citizen satisfaction.

Possible points against telehealth-provided covered services and rebuttals

Essential benefits – An opposition argument may be that the state should not enact further health benefit requirements until “essential health benefits” under the federal Patient Protection and Affordable Care Act are determined. This is a weak diversionary attempt to forestall action. Such legislation does not require any health benefit plan to add new covered services, only to recognize telehealth-provided covered services.

Malpractice -- An opposition argument may be that telemedicine increases a provider's medical liability. This is largely a baseless scare. There have been few liability claims. Instead, the more recordable nature of telemedicine improves documentation and there is some increasing liability in standard of care case law for not using telehealth.

Mandating -- Commercial insurers oppose, as a philosophical principle, almost any state requirement.

Lessons from recent state campaigns

Plan for a multi-year campaign. It takes time to build legislative support and momentum. Do not be discouraged if your bill does not pass the first year.

- Conducting a comprehensive campaign plan needs to include setting short, intermediate and long term goals with an evaluation process as well. It will be critical to analyze the external political environment, complete SWOT analysis, determine targets and resources to meet the goals.
- Consider grassroots and target strategies to influence policy successes that align with timelines.
- Consider power mapping processes to determine how to influence and gain sponsor support.
- Compose a coalition or a group of allies that represent key organizations and individuals who can progress the issue forward.
- Consider recruiting "power brokers," people who have influence over targets/sponsors. This could be someone like the Secretary of Health or powerful business executive who has investment in the issue.
- Recommendations and planning should also include a current review of existing statutes and or regulations that either assist or create barriers for moving telehealth forward. Consider strategies to address issues identified in the review that may have solutions through a policy process. Examples could include reimbursement for services.
- Utilize and leverage science, evidence-based recommendations from national organizations to build case for need, policy language and overall recommendations when considering working on barriers for telemedicine models.
- Cost vs. Benefit analysis is highly recommended and specific data by Districts can help build your argument for the need. Look at current health data sources regarding health conditions and disparities. What does the condition cost the state currently untreated vs. addressing care through diverse delivery models like telemedicine.

Strong sponsor -- It is important to have a key legislator introduce the telehealth bill. The following are some key considerations:

- Member in the majority party: especially in a highly partisan legislature
- Member of the committee of jurisdiction
- Personal passion for telehealth
- Strong constituent support for telehealth
- Engage potential sponsors in community based activities, announcements and ribbon cutting
- Consider reaching out to NOBEL women members whose national organization has already endorsed model telehealth legislation

Potential state allies:

- Consumer groups, or specialty healthcare groups, such as state chapters of the American Heart Association and American Psychiatric Association.
- State health provider groups, such as the state medical society, or the state hospital association, state telehealth networks
- State Department of Health – makes critical access hospital designation, medically underserved area, workforce shortages, health status indicators, emergency preparedness

- Commercial insurers that support telehealth services in other states
- Telehealth resource centers
- Phone and cable companies

**Proposal from the National Organization of Black Elected Legislative Women
Offered January 2011**

PREAMBLE

Today, more and more people take advantage of telemedicine and e-health opportunities, including consultations with doctors and joining monitoring programs for patients with chronic disease. By connecting Americans with geographically distant specialists, telemedicine can improve the quality of care Americans can expect to receive, and also cut costs by providing services that might otherwise require long distance travel or admission to a health care facility.

SECTION 1: Let health insurers, health care subscription plans, and health maintenance organizations provide coverage for the cost of telemedicine services when the services are appropriately provided through such means.

SECTION 2: Let the definition of telemedicine services be the use of interactive audio, video, or other telecommunications technology by a health care provider to deliver health care services at a site other than the site where the patient is located, including the use of electronic media for consultation relating to the health care diagnosis or treatment of the patient.

SECTION 3: Let one telehealth method which will be advanced by such language be home telehealth (video conferencing) and remote patient monitoring (because there is no "in-person" counterpart).

SECTION 4: Let decisions denying coverage of services provided via telemedicine be subject to utilization review procedures.

SECTION 5: Let the Medicaid plan not deny coverage on the basis that the coverage is provided through telemedicine if the health care service would be covered were it provided through in-person consultation between the recipient and a health care provider. Coverage for health care services provided through telemedicine must be determined in a manner consistent with coverage for health care services provided through in-person consultation.

SECTION 6: Let this bill also require, by January 1, 2012, a statewide medical assistance benefit of a health home for individuals with chronic conditions (defined under 42 U.S.C 1396a).

SECTION 7: Let the requirements of the bill apply to all insurance policies, contracts, and plans delivered, issued for delivery, reissued, or at any time thereafter when any term of the policy, contract, or plan is changed or any premium adjustment is made. The bill does not apply to short-term travel, accident-only, limited or specified disease, or individual conversion policies or contracts, or to policies or contracts designed for issuance to persons eligible for coverage under Medicare, or any other similar coverage under state or federal governmental plans.