ASSEMBLY BILL

No. 744

Introduced by Assembly Member Aguiar-Curry

February 19, 2019

An act to amend Section 2290.5 of the Business and Professions Code, to amend Section 1374.13 of, and to add Sections 1341.46 and 1374.14 to, the Health and Safety Code, to amend Section 10123.85 of, and to add Section 10123.855 to, the Insurance Code, and to amend Section 14132.725 of the Welfare and Institutions Code, relating to healthcare coverage.

LEGISLATIVE COUNSEL’S DIGEST

AB 744, as introduced, Aguiar-Curry. Healthcare coverage: telehealth. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive healthcare services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, face-to-face contact between a health care provider and a patient is not required under the Medi-Cal program for teleophthalmology, teledermatology, and teledentistry by store and forward. Existing law requires a Medi-Cal patient receiving teleophthalmology, teledermatology, or teledentistry by store and forward to be notified of the right to receive interactive communication with a distant specialist physician, optometrist, or dentist, and authorizes a patient to request that interactive communication.

This bill would delete those interactive communication provisions.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans
by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law prohibits a health care service plan or health insurer from requiring that in-person contact occur between a healthcare provider and a patient, and from limiting the type of setting where services are provided, before payment is made for covered services provided appropriately through telehealth services.

This bill would require a contract issued, amended, or renewed on or after January 1, 2020, between a health care service plan and a healthcare provider for the provision of healthcare services to an enrollee or subscriber, or a contract issued, amended, or renewed on or after January 1, 2020, between a health insurer and a healthcare provider for an alternative rate of payment to specify that the health care service plan or health insurer reimburse a healthcare provider for the diagnosis, consultation, or treatment of an enrollee, subscriber, insured, or policyholder delivered through telehealth services on the same basis and to the same extent that the health care service plan or health insurer is responsible for reimbursement for the same service through in-person diagnosis, consultation, or treatment. The bill would authorize a health care service plan or health insurer to offer a contract or policy containing a deductible, copayment, or coinsurance requirement for a healthcare service delivered through telehealth services, subject to specified limitations. The bill would prohibit a health care service plan contract or policy or health insurance issued, amended, or renewed on or after January 1, 2020, from imposing an annual or lifetime dollar maximum for telehealth services, and would prohibit those contracts and policies from imposing a deductible, copayment, or coinsurance, or a plan year, calendar year, lifetime, or other durational benefit limitation or maximum for benefits or services that is not equally imposed on all terms and services covered under the contract.

This bill would authorize the Director of the Department of Managed Health Care or the Insurance Commissioner to assess an administrative penalty by order, after appropriate notice and opportunity for hearing, if the director or commissioner determines that a health care service plan or health insurer has failed to comply with those provisions. The bill would create the Managed Care Penalty Account, within the Managed Care Administrative Fines and Penalties Fund, subject to appropriation by the Legislature, into which administrative penalties for a health care service plan’s violations of those provisions would be
deposited. The bill would specify that administrative penalties assessed against a health insurer be deposited into the Insurance Fund. Because a willful violation of the bill’s requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.


The people of the State of California do enact as follows:

SECTION 1. Section 2290.5 of the Business and Professions Code is amended to read:

2290.5. (a) For purposes of this division, the following definitions shall apply:

(1) “Asynchronous store and forward” means the transmission of a patient’s medical information from an originating site to the health care provider at a distant site without the presence of the patient.

(2) “Distant site” means a site where a health care provider who provides health care services is located while providing these services via a telecommunications system.

(3) “Healthcare provider” means either of the following:

(A) A person who is licensed under this division.

(B) An associate marriage and family therapist or marriage and family therapist trainee functioning pursuant to Section 4980.43.3.

(4) “Originating site” means a site where a patient is located at the time health care services are provided via a telecommunications system or where the asynchronous store and forward service originates.

(4) “Store and forward” means the transmission of a patient’s medical information from an originating site to the health care provider at a distant site.
(5) “Synchronous interaction” means a real-time interaction between a patient and a health care provider located at a distant site.

(6) “Telehealth” means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient’s health care while the patient is at the originating site and the health care provider is at a distant site.

Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

(b) Prior to the delivery of health care via telehealth, the health care provider initiating the use of telehealth shall inform the patient about the use of telehealth and obtain verbal or written consent from the patient for the use of telehealth as an acceptable mode of delivering health care services and public health. The consent shall be documented.

(c) Nothing in this section shall preclude a patient from receiving in-person health care delivery services during a specified course of health care and treatment after agreeing to receive services via telehealth.

(d) The failure of a health care provider to comply with this section shall constitute unprofessional conduct. Section 2314 shall not apply to this section.

(e) This section shall not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law.

(f) All laws regarding the confidentiality of health care information and a patient’s rights to his or her medical information shall apply to telehealth interactions.

(g) This section shall not apply to a patient under the jurisdiction of the Department of Corrections and Rehabilitation or any other correctional facility.

(h) (1) Notwithstanding any other provision of law and for purposes of this section, the governing body of the hospital whose patients are receiving the telehealth services may grant privileges to, and verify and approve credentials for, providers of telehealth
services based on its medical staff recommendations that rely on
information provided by the distant-site hospital or telehealth
entity, as described in Sections 482.12, 482.22, and 485.616 of
Title 42 of the Code of Federal Regulations.
(2) By enacting this subdivision, it is the intent of the Legislature
to authorize a hospital to grant privileges to, and verify and approve
credentials for, providers of telehealth services as described in
paragraph (1).
(3) For the purposes of this subdivision, “telehealth” shall
include “telemedicine” as the term is referenced in Sections 482.12,
482.22, and 485.616 of Title 42 of the Code of Federal Regulations.
SEC. 2. Section 1341.46 is added to the Health and Safety
Code, to read:
1341.46. (a) There is hereby created the Managed Care Penalty
Account within the Managed Care Administrative Fines and
Penalties Fund.
(b) Moneys in the Managed Care Penalty Account shall be
subject to appropriation by the Legislature.
(c) Notwithstanding Section 1341.45, fines and administrative
penalties collected pursuant to this chapter shall be deposited into
the Managed Care Penalty Account.
SEC. 3. Section 1374.13 of the Health and Safety Code is
amended to read:
1374.13. (a) For the purposes of this section, the definitions
in subdivision (a) of Section 2290.5 of the Business and Professions
Code shall apply.
(b) It is the intent of the Legislature to recognize the practice
of telehealth as a legitimate means by which an individual may
receive healthcare services from a healthcare provider without in-person contact with the healthcare
provider.
(c) No healthcare service plan shall not require that in-person
contact occur between a healthcare provider and a
patient before payment is made for the covered services
appropriately provided through telehealth, subject to the terms and
conditions of the contract entered into between the enrollee or
subscriber and the healthcare service plan, and between the healthcare
service plan and its participating providers or provider groups,
pursuant to Section 1374.14.
(d) A health care service plan shall not limit the type of setting where services are provided for the patient or by the healthcare provider before payment is made for the covered services appropriately provided through telehealth, subject to the terms and conditions of the contract entered into between the enrollee or subscriber and the health care service plan, and between the health care service plan and its participating providers or provider groups, and pursuant to Section 1374.14.

(e) The requirements of this section shall also apply to health care service plan and Medi-Cal managed care plan contracts with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code.

(f) Notwithstanding any other provision of law, this section shall not be interpreted to authorize a health care service plan to require the use of telehealth when the healthcare provider has determined that it is not appropriate.

SEC. 4. Section 1374.14 is added to the Health and Safety Code, to read:

1374.14. (a) A contract issued, amended, or renewed on or after January 1, 2020, between a health care service plan and a healthcare provider for the provision of healthcare services to an enrollee or subscriber shall specify that the health care service plan shall reimburse the treating or consulting healthcare provider for the diagnosis, consultation, or treatment of an enrollee or subscriber delivered through telehealth services on the same basis and to the same extent that the health care service plan is responsible for reimbursement for the same service through in-person diagnosis, consultation, or treatment.

(b) (1) A health care service plan contract issued, amended, or renewed on or after January 1, 2020, shall specify that the health care service plan shall provide coverage for the cost of healthcare services delivered through telehealth services on the same basis and to the same extent that the health care service plan is responsible for coverage for the same service through in-person diagnosis, consultation, or treatment. Coverage shall not be limited only to services delivered by select third-party corporate telehealth providers.
(2) A health care service plan contract issued, amended, or renewed on or after January 1, 2020, shall not exclude coverage for a healthcare service solely because the service is delivered through telehealth services and not through in-person consultation or contact between a physician and a patient, if the service is appropriately delivered through telehealth services.

(c) A health care service plan may offer a contract containing a deductible, copayment, or coinsurance requirement for a healthcare service delivered through telehealth services, provided that the deductible, copayment, or coinsurance does not exceed the deductible, copayment, or coinsurance applicable if the same services were delivered through in-person diagnosis, consultation, treatment.

(d) (1) A health care service plan contract issued, amended, or renewed on or after January 1, 2020, shall not impose an annual or lifetime dollar maximum for telehealth services, other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the contract.

(2) A health care service plan contract issued, amended, or renewed on or after January 1, 2020, shall not impose a deductible, copayment, or coinsurance, or a plan year, calendar year, lifetime, or other durational benefit limitation or maximum for benefits or services that is not equally imposed on all terms and services covered under the contract.

(e) (1) The director shall, after appropriate notice and opportunity for hearing in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), assess an administrative penalty by order if the director determines that a health care service plan has failed to comply with this section.

(2) Notwithstanding Section 1341.45, an administrative penalty collected pursuant to paragraph (1) shall be deposited into the Managed Care Penalty Account.

(f) The definitions in subdivision (a) of Section 2290.5 of the Business and Professions Code apply to this section.
It is the intent of the Legislature to recognize the practice of telehealth as a legitimate means by which an individual may receive health care services from a healthcare provider without in-person contact with the healthcare provider.

No health insurer shall not require that in-person contact occur between a healthcare provider and a patient before payment is made for the services appropriately provided through telehealth, subject to the terms and conditions of the contract entered into between the policyholder or contractholder and the insurer, and between the insurer and its participating providers or provider groups, and pursuant to Section 10123.855.

No health insurer shall not limit the type of setting where services are provided for the patient or by the healthcare provider before payment is made for the covered services appropriately provided by telehealth, subject to the terms and conditions of the contract between the policyholder or contract holder and the insurer, and between the insurer and its participating providers or provider groups, and pursuant to Section 10123.855.

Notwithstanding any other provision, law, this section shall not be interpreted to does not authorize a health insurer to require the use of telehealth when if the healthcare provider has determined that it is not appropriate.

SEC. 6. Section 10123.855 is added to the Insurance Code, to read:

10123.855. (a) A contract issued, amended, or renewed on or after January 1, 2020, between a health insurer and a healthcare provider for an alternative rate of payment pursuant to Section 10133 shall specify that the health insurer shall reimburse the treating or consulting healthcare provider for the diagnosis, consultation, or treatment of an insured or policyholder delivered through telehealth services on the same basis and to the same extent that the health insurer is responsible for reimbursement for the same service through in-person diagnosis, consultation, or treatment.

(b) (1) A policy of health insurance issued, amended, or renewed on or after January 1, 2020, that provides benefits through contracts with providers at alternative rates of payment shall
(2) A policy of health insurance issued, amended, or renewed on or after January 1, 2020, that provides benefits through contracts with providers at alternative rates of payment shall not exclude coverage for a healthcare service solely because the service is delivered through telehealth services and not through in-person consultation or contact between a physician and a patient, if the service is appropriately delivered through telehealth services.

(c) A health insurer may offer a policy containing a deductible, copayment, or coinsurance requirement for a healthcare service delivered through telehealth services, provided that the deductible, copayment, or coinsurance does not exceed the deductible, copayment, or coinsurance applicable if the same services were delivered through in-person diagnosis, consultation, or treatment.

(d) (1) A policy of health insurance issued, amended, or renewed on or after January 1, 2020, shall not impose an annual or lifetime dollar maximum for telehealth services, other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy.

(2) A policy of health insurance issued, amended, or renewed on or after January 1, 2020, shall not impose a deductible, copayment, or coinsurance, or a policy year, calendar year, lifetime, or other durational benefit limitation or maximum for benefits or services that is not equally imposed on all terms and services covered under the policy.

(e) (1) The commissioner shall, after appropriate notice and opportunity for hearing in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), assess an administrative penalty by order if the commissioner determines that a health insurer has failed to comply with this section.

(2) An administrative penalty collected pursuant to paragraph (1) shall be deposited into the Insurance Fund.
(f) The definitions in subdivision (a) of Section 2290.5 of the Business and Professions Code apply to this section.

SEC. 7. Section 14132.725 of the Welfare and Institutions Code is amended to read:

14132.725. (a) To the extent that federal financial participation is available, face-to-face contact between a health care provider and a patient is not required under the Medi-Cal program for teleophthalmology, teledermatology, and teledentistry by store and forward. Services appropriately provided through the store and forward process are subject to billing and reimbursement policies developed by the department.

(b) For purposes of this section, “teleophthalmology, teledermatology, and teledentistry by store and forward” means an asynchronous transmission of medical or dental information to be reviewed at a later time by a physician at a distant site who is trained in ophthalmology or dermatology or, for teleophthalmology, by an optometrist who is licensed pursuant to Chapter 7 (commencing with Section 3000) of Division 2 of the Business and Professions Code, or a dentist, where the physician, optometrist, or dentist at the distant site reviews the medical or dental information without the patient being present in real time. A patient receiving teleophthalmology, teledermatology, or teledentistry by store and forward shall be notified of the right to receive interactive communication with the distant specialist physician, optometrist, or dentist and shall receive an interactive communication with the distant specialist physician, optometrist, or dentist, upon request. If requested, communication with the distant specialist physician, optometrist, or dentist may occur either at the time of the consultation, or within 30 days of the patient’s notification of the results of the consultation. If the reviewing optometrist identifies a disease or condition requiring consultation or referral pursuant to Section 3041 of the Business and Professions Code, that consultation or referral shall be with an ophthalmologist or other appropriate physician and surgeon, as required.

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, and make specific this section by means of all-county letters, provider bulletins, and similar instructions.
SEC. 8. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.