1 A bill to be entitled
2 An act relating to insurance coverage for telehealth
3 services; amending s. 409.967, F.S.; prohibiting
4 Medicaid managed care plans from using providers who
5 provide services exclusively through telehealth to
6 achieve network adequacy; amending s. 627.42396, F.S.;
7 prohibiting certain health insurance policies from
8 denying coverage for covered services provided through
9 telehealth under certain circumstances; prohibiting
10 health insurers from excluding covered services
11 provided through telehealth from coverage; providing
12 reimbursement requirements and cost-sharing
13 limitations for health insurers relating to telehealth
14 services; prohibiting health insurers from requiring
15 insured persons to receive services through
16 telehealth; authorizing health insurers to conduct
17 utilization reviews under certain circumstances;
18 authorizing health insurers to limit telehealth
19 services to certain providers; deleting requirements
20 for contracts between certain health insurers and
21 telehealth providers; amending s. 627.6699, F.S.;
22 requiring certain small employer benefit plans to
23 comply with certain requirements for reimbursement of
24 telehealth services; amending s. 641.31, F.S.;
25 prohibiting a health maintenance organization from

26 requiring a subscriber to receive certain services
27 through telehealth; deleting requirements for
28 contracts between certain maintenance organizations
29 and telehealth providers; creating s. 641.31093, F.S.;
30 prohibiting certain health maintenance organizations
31 from denying coverage for covered services provided
32 through telehealth under certain circumstances;
33 prohibiting health maintenance organizations from
34 excluding covered services provided through telehealth
35 from coverage; providing reimbursement requirements
36 and cost-sharing limitations for health maintenance
37 organizations relating to telehealth services;
38 prohibiting health maintenance organizations from
39 requiring subscribers to receive services through
40 telehealth; authorizing health maintenance
41 organizations to conduct utilization reviews under
42 certain circumstances; authorizing health maintenance
43 organizations to limit telehealth services to certain
44 providers; providing an effective date.
45
46 WHEREAS, it is the intent of the Legislature to mitigate
47 geographic discrimination in the delivery of health care by
48 recognizing the provision of and payment for covered medical
49 care by means of telehealth services, provided that such
50 services are provided by a physician or by another health care

51 practitioner or professional acting within the scope of practice
52 of a health care practitioner or professional and in accordance
53 with s. 456.47, Florida Statutes, NOW, THEREFORE,
54
55 Be It Enacted by the Legislature of the State of Florida:
56
57 Section 1. Paragraph (c) of subsection (2) of section
58 409.967, Florida Statutes, is amended to read:
59 409.967 Managed care plan accountability.—
60 (2) The agency shall establish such contract requirements
61 as are necessary for the operation of the statewide managed care
62 program. In addition to any other provisions the agency may deem
63 necessary, the contract must require:
64 (c) Access.—
65 1. The agency shall establish specific standards for the
66 number, type, and regional distribution of providers in managed
67 care plan networks to ensure access to care for both adults and
68 children. Each plan must maintain a regionwide network of
69 providers in sufficient numbers to meet the access standards for
70 specific medical services for all recipients enrolled in the
71 plan. <u>A plan may not use providers who provide services</u>
72 <u>exclusively through telehealth as defined in s. 456.47(1) to</u>
73 <u>meet this requirement.</u> The exclusive use of mail-order
74 pharmacies may not be sufficient to meet network access
75 standards. Consistent with the standards established by the

76 agency, provider networks may include providers located outside
77 the region. A plan may contract with a new hospital facility
78 before the date the hospital becomes operational if the hospital
79 has commenced construction, will be licensed and operational by
80 January 1, 2013, and a final order has issued in any civil or
81 administrative challenge. Each plan shall establish and maintain
82 an accurate and complete electronic database of contracted
83 providers, including information about licensure or
84 registration, locations and hours of operation, specialty
85 credentials and other certifications, specific performance
86 indicators, and such other information as the agency deems
87 necessary. The database must be available online to both the
88 agency and the public and have the capability to compare the
89 availability of providers to network adequacy standards and to
90 accept and display feedback from each provider's patients. Each
91 plan shall submit quarterly reports to the agency identifying
92 the number of enrollees assigned to each primary care provider.
93 The agency shall conduct, or contract for, systematic and
94 continuous testing of the provider network databases maintained
95 by each plan to confirm accuracy, confirm that behavioral health
96 providers are accepting enrollees, and confirm that enrollees
97 have access to behavioral health services.
98 2. Each managed care plan must publish any prescribed drug
99 formulary or preferred drug list on the plan's website in a
100 manner that is accessible to and searchable by enrollees and

101 providers. The plan must update the list within 24 hours after
102 making a change. Each plan must ensure that the prior
103 authorization process for prescribed drugs is readily accessible
104 to health care providers, including posting appropriate contact
105 information on its website and providing timely responses to
106 providers. For Medicaid recipients diagnosed with hemophilia who
107 have been prescribed anti-hemophilic-factor replacement
108 products, the agency shall provide for those products and
109 hemophilia overlay services through the agency's hemophilia
110 disease management program.
111 3. Managed care plans, and their fiscal agents or
112 intermediaries, must accept prior authorization requests for any
113 service electronically.
114 4. Managed care plans serving children in the care and
115 custody of the Department of Children and Families must maintain
116 complete medical, dental, and behavioral health encounter
117 information and participate in making such information available
118 to the department or the applicable contracted community-based
119 care lead agency for use in providing comprehensive and
120 coordinated case management. The agency and the department shall
121 establish an interagency agreement to provide guidance for the
122 format, confidentiality, recipient, scope, and method of
123 information to be made available and the deadlines for
124 submission of the data. The scope of information available to
125 the department shall be the data that managed care plans are

126 required to submit to the agency. The agency shall determine the
127 plan's compliance with standards for access to medical, dental,
128 and behavioral health services; the use of medications; and
129 follow up ~~followup~~ on all medically necessary services
130 recommended as a result of early and periodic screening,
131 diagnosis, and treatment.
132 Section 2. Section 627.42396, Florida Statutes, is amended
133 to read:
134 627.42396 Requirements for reimbursement by health
135 insurers for telehealth services.—
136 (1) An individual, group, blanket, or franchise health
137 insurance policy delivered or issued for delivery to any insured
138 person in this state on or after January 1, 2023, may not deny
139 coverage for a covered service on the basis of the service being
140 provided through telehealth if the same service would be covered
141 if provided through an in-person encounter.
142 (2) A health insurer may not exclude an otherwise covered
143 service from coverage solely because the service is provided
144 through telehealth rather than through an in-person encounter.
145 (3) A health insurer shall reimburse a telehealth provider
146 for the diagnosis, consultation, or treatment of any insured
147 person provided through telehealth on the same basis and at
148 least at the same rate that the health insurer would reimburse
149 the provider if the covered service were delivered through an
150 in-person encounter. However, a health insurer may not require a

151 health care provider or telehealth provider to accept a
152 reimbursement amount greater than the amount the provider is
153 willing to charge.
154 (4) A health insurer shall reimburse a telehealth provider
155 for reasonable originating site fees or costs for the provision
156 of telehealth services.
157 (5) A covered service provided through telehealth may not
158 be subject to a greater deductible, copayment, or coinsurance
159 amount than would apply if the same service were provided
160 through an in-person encounter.
161 (6) A health insurer may not impose upon any insured
162 person receiving benefits under this section any copayment,
163 coinsurance, or deductible amount or any policy-year, calendar-
164 year, lifetime, or other durational benefit limitation or
165 maximum for benefits or services provided through telehealth
166 which is not equally imposed upon all terms and services covered
167 under the policy.
168 (7) A health insurer may not require an insured person to
169 obtain a covered service through telehealth instead of an in-
170 person encounter.
171 (8) This section does not preclude a health insurer from
172 conducting a utilization review to determine the appropriateness
173 of telehealth as a means of delivering a covered service if such
174 determination is made in the same manner as would be made for
175 the same service provided through an in-person encounter.

176 (9) A health insurer may limit the covered services
177 provided through telehealth to providers who are in a network
178 approved by the insurer ~~A contract between a health insurer~~
179 ~~issuing major medical comprehensive coverage through an~~
180 ~~individual or group policy and a telehealth provider, as defined~~
181 ~~in s. 456.47, must be voluntary between the insurer and the~~
182 ~~provider and must establish mutually acceptable payment rates or~~
183 ~~payment methodologies for services provided through telehealth.~~
184 ~~Any contract provision that distinguishes between payment rates~~
185 ~~or payment methodologies for services provided through~~
186 ~~telehealth and the same services provided without the use of~~
187 ~~telehealth must be initialed by the telehealth provider~~.
188 Section 3. Paragraph (h) is added to subsection (5) of
189 section 627.6699, Florida Statutes, to read:
190 627.6699 Employee Health Care Access Act.—
191 (5) AVAILABILITY OF COVERAGE.—
192 (h) A health benefit plan covering small employers which
193 is delivered, issued, or renewed in this state on or after
194 January 1, 2023, must comply with s. 627.42396.
195 Section 4. Subsection (45) of section 641.31, Florida
196 Statutes, is amended to read:
197 641.31 Health maintenance contracts.—
198 (45) A ~~contract between a~~ health maintenance organization
199 issuing major medical individual or group coverage may not
200 require a subscriber to consult with, seek approval from, or

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201 obtain any type of referral or authorization by way of
202 telehealth from and a telehealth provider, as defined in s.
203 456.47, must be voluntary between the health maintenance
204 organization and the provider and must establish mutually
205 acceptable payment rates or payment methodologies for services
206 provided through telehealth. Any contract provision that
207 distinguishes between payment rates or payment methodologies for
208 services provided through telehealth and the same services
209 provided without the use of telehealth must be initialed by the
210 telehealth provider.
211 Section 5. Section 641.31093, Florida Statutes, is created
212 to read:
213 641.31093 Requirements for reimbursement by health
214 maintenance organizations for telehealth services.—
215 (1) A health maintenance organization that offers, issues,
216 or renews a major medical or similar comprehensive contract in
217 this state on or after January 1, 2023, may not deny coverage
218 for a covered service on the basis of the covered service being
219 provided through telehealth if the same service would be covered
220 if provided through an in-person encounter.
221 (2) A health maintenance organization may not exclude an
222 otherwise covered service from coverage solely because the
223 service is provided through telehealth rather than through an
224 in-person encounter.
225 (3) A health maintenance organization shall reimburse a

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226 telehealth provider for the diagnosis, consultation, or
227 treatment of any subscriber provided through telehealth on the
228 same basis and at least the same rate that the health
229 maintenance organization would reimburse the provider if the
230 service were provided through an in-person encounter. However, a
231 health maintenance organization may not require a health care
232 provider or telehealth provider to accept a reimbursement amount
233 greater than the amount the provider is willing to charge.
234 (4) A health maintenance organization shall reimburse a
235 telehealth provider for reasonable originating site fees or
236 costs for the provision of telehealth services.
237 (5) A covered service provided through telehealth may not
238 be subject to a greater deductible, copayment, or coinsurance
239 amount than would apply if the same service were provided
240 through an in-person encounter.
241 (6) A health maintenance organization may not impose upon
242 any subscriber receiving benefits under this section any
243 copayment, coinsurance, or deductible amount or any contract-
244 year, calendar-year, lifetime, or other durational benefit
245 limitation or maximum for benefits or services provided through
246 telehealth which is not equally imposed upon all services
247 covered under the contract.
248 (7) A health maintenance organization may not require a
249 subscriber to obtain a covered service through telehealth
250 instead of an in-person encounter.

251 (8) This section does not preclude a health maintenance
252 organization from conducting a utilization review to determine
253 the appropriateness of telehealth as a means of delivering a
254 covered service if such determination is made in the same manner
255 as would be made for the same service provided through an in-
256 person encounter.
257 (9) A health maintenance organization may limit covered
258 services provided through telehealth to providers who are in a
259 network approved by the health maintenance organization.
260 Section 6. This act shall take effect July 1, 2022.