

By Senator Ausley

3-01061-21

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1                                   A bill to be entitled  
2       An act relating to telehealth; amending s. 409.967,  
3       F.S.; prohibiting Medicaid managed care plans from  
4       using providers who exclusively provide services  
5       through telehealth to achieve network adequacy;  
6       amending s. 627.42396, F.S.; prohibiting certain  
7       health insurance policies from denying coverage for  
8       covered services provided through telehealth under  
9       certain circumstances; prohibiting health insurers  
10      from excluding covered services provided through  
11      telehealth from coverage; providing reimbursement  
12      requirements and cost-sharing limitations for health  
13      insurers relating to telehealth services; prohibiting  
14      health insurers from requiring an insured to receive  
15      services through telehealth services; authorizing  
16      health insurers to conduct utilization reviews under  
17      certain circumstances; authorizing health insurers to  
18      limit telehealth services to certain providers;  
19      deleting requirements for contracts between certain  
20      health insurers and telehealth providers; amending s.  
21      627.6699, F.S.; requiring certain small employer  
22      benefit plans to comply with certain requirements for  
23      reimbursement of telehealth services; amending s.  
24      641.31, F.S.; prohibiting a health maintenance  
25      organization from requiring a subscriber to receive  
26      certain services through telehealth; deleting  
27      requirements for contracts between certain health  
28      insurers and telehealth providers; creating s.  
29      641.31093, F.S.; prohibiting certain health

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30 maintenance organizations from denying coverage for  
31 covered services provided through telehealth under  
32 certain circumstances; prohibiting health maintenance  
33 organizations from excluding covered services provided  
34 through telehealth from coverage; providing  
35 reimbursement requirements and cost-sharing  
36 limitations for health maintenance organizations  
37 relating to telehealth services; prohibiting a health  
38 maintenance organization from requiring a subscriber  
39 to receive services through telehealth; authorizing  
40 health maintenance organizations to conduct  
41 utilization reviews under certain circumstances;  
42 authorizing health maintenance organizations to limit  
43 telehealth services to certain providers; providing an  
44 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 such health care practitioner or professional and in  
53 accordance with section 456.47, Florida Statutes, NOW,  
54 THEREFORE,

55  
56 Be It Enacted by the Legislature of the State of Florida:

57  
58 Section 1. Paragraph (c) of subsection (2) of section

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59 409.967, Florida Statutes, is amended to read:

60 409.967 Managed care plan accountability.—

61 (2) The agency shall establish such contract requirements  
62 as are necessary for the operation of the statewide managed care  
63 program. In addition to any other provisions the agency may deem  
64 necessary, the contract must require:

65 (c) Access.—

66 1. The agency shall establish specific standards for the  
67 number, type, and regional distribution of providers in managed  
68 care plan networks to ensure access to care for both adults and  
69 children. Each plan must maintain a regionwide network of  
70 providers in sufficient numbers to meet the access standards for  
71 specific medical services for all recipients enrolled in the  
72 plan. A plan may not use providers who exclusively provide  
73 services through telehealth, as defined in s. 456.47, to meet  
74 this requirement. The exclusive use of mail-order pharmacies may  
75 not be sufficient to meet network access standards. Consistent  
76 with the standards established by the agency, provider networks  
77 may include providers located outside the region. A plan may  
78 contract with a new hospital facility before the date the  
79 hospital becomes operational if the hospital has commenced  
80 construction, will be licensed and operational by January 1,  
81 2013, and a final order has issued in any civil or  
82 administrative challenge. Each plan shall establish and maintain  
83 an accurate and complete electronic database of contracted  
84 providers, including information about licensure or  
85 registration, locations and hours of operation, specialty  
86 credentials and other certifications, specific performance  
87 indicators, and such other information as the agency deems

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88 necessary. The database must be available online to both the  
89 agency and the public and have the capability to compare the  
90 availability of providers to network adequacy standards and to  
91 accept and display feedback from each provider's patients. Each  
92 plan shall submit quarterly reports to the agency identifying  
93 the number of enrollees assigned to each primary care provider.  
94 The agency shall conduct, or contract for, systematic and  
95 continuous testing of the provider network databases maintained  
96 by each plan to confirm accuracy, confirm that behavioral health  
97 providers are accepting enrollees, and confirm that enrollees  
98 have access to behavioral health services.

99       2. Each managed care plan must publish any prescribed drug  
100 formulary or preferred drug list on the plan's website in a  
101 manner that is accessible to and searchable by enrollees and  
102 providers. The plan must update the list within 24 hours after  
103 making a change. Each plan must ensure that the prior  
104 authorization process for prescribed drugs is readily accessible  
105 to health care providers, including posting appropriate contact  
106 information on its website and providing timely responses to  
107 providers. For Medicaid recipients diagnosed with hemophilia who  
108 have been prescribed anti-hemophilic-factor replacement  
109 products, the agency shall provide for those products and  
110 hemophilia overlay services through the agency's hemophilia  
111 disease management program.

112       3. Managed care plans, and their fiscal agents or  
113 intermediaries, must accept prior authorization requests for any  
114 service electronically.

115       4. Managed care plans serving children in the care and  
116 custody of the Department of Children and Families must maintain

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117 complete medical, dental, and behavioral health encounter  
118 information and participate in making such information available  
119 to the department or the applicable contracted community-based  
120 care lead agency for use in providing comprehensive and  
121 coordinated case management. The agency and the department shall  
122 establish an interagency agreement to provide guidance for the  
123 format, confidentiality, recipient, scope, and method of  
124 information to be made available and the deadlines for  
125 submission of the data. The scope of information available to  
126 the department shall be the data that managed care plans are  
127 required to submit to the agency. The agency shall determine the  
128 plan's compliance with standards for access to medical, dental,  
129 and behavioral health services; the use of medications; and  
130 followup on all medically necessary services recommended as a  
131 result of early and periodic screening, diagnosis, and  
132 treatment.

133 Section 2. Section 627.42396, Florida Statutes, is amended  
134 to read:

135 627.42396 Requirements for reimbursement by health insurers  
136 for telehealth services.—

137 (1) An individual, group, blanket, or franchise health  
138 insurance policy delivered or issued for delivery to any insured  
139 person in this state on or after January 1, 2022, may not deny  
140 coverage for a covered service on the basis of the service being  
141 provided through telehealth if the same service would be covered  
142 if provided through an in-person encounter.

143 (2) A health insurer may not exclude an otherwise covered  
144 service from coverage solely because the service is provided  
145 through telehealth rather than through an in-person encounter.

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146       (3) A health insurer shall reimburse a telehealth provider  
147 for the diagnosis, consultation, or treatment of any insured  
148 person provided through telehealth on the same basis and at  
149 least at the same rate that the health insurer would reimburse  
150 the provider if the covered service were delivered through an  
151 in-person encounter. However, a health insurer may not require a  
152 health care provider or telehealth provider to accept a  
153 reimbursement amount greater than the amount the provider is  
154 willing to charge.

155       (4) A health insurer shall reimburse a telehealth provider  
156 for reasonable originating site fees or costs for the provision  
157 of telehealth services.

158       (5) A covered service provided through telehealth may not  
159 be subject to a greater deductible, copayment, or coinsurance  
160 amount than would apply if the same service were provided  
161 through an in-person encounter.

162       (6) A health insurer may not impose upon any insured person  
163 receiving benefits under this section any copayment,  
164 coinsurance, or deductible amount or any policy-year, calendar-  
165 year, lifetime, or other durational benefit limitation or  
166 maximum for benefits or services provided through telehealth  
167 which is not equally imposed upon all terms and services covered  
168 under the policy.

169       (7) A health insurer may not require an insured person to  
170 obtain a covered service through telehealth instead of an in-  
171 person encounter.

172       (8) This section does not preclude a health insurer from  
173 conducting a utilization review to determine the appropriateness  
174 of telehealth as a means of delivering a covered service if such

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175 determination is made in the same manner as would be made for  
176 the same service provided through an in-person encounter.

177 (9) A health insurer may limit the covered services that  
178 are provided through telehealth to providers who are in a  
179 network approved by the insurer ~~A contract between a health~~  
180 ~~insurer issuing major medical comprehensive coverage through an~~  
181 ~~individual or group policy and a telehealth provider, as defined~~  
182 ~~in s. 456.47, must be voluntary between the insurer and the~~  
183 ~~provider and must establish mutually acceptable payment rates or~~  
184 ~~payment methodologies for services provided through telehealth.~~  
185 ~~Any contract provision that distinguishes between payment rates~~  
186 ~~or payment methodologies for services provided through~~  
187 ~~telehealth and the same services provided without the use of~~  
188 ~~telehealth must be initialed by the telehealth provider.~~

189 Section 3. Paragraph (h) is added to subsection (5) of  
190 section 627.6699, Florida Statutes, to read:

191 627.6699 Employee Health Care Access Act.—

192 (5) AVAILABILITY OF COVERAGE.—

193 (h) A health benefit plan covering small employers which is  
194 delivered, issued, or renewed in this state on or after January  
195 1, 2022, must comply with s. 627.42396.

196 Section 4. Subsection (45) of section 641.31, Florida  
197 Statutes, is amended to read:

198 641.31 Health maintenance contracts.—

199 (45) A ~~contract between a~~ health maintenance organization  
200 issuing major medical individual or group coverage may not  
201 require a subscriber to consult with, seek approval from, or  
202 obtain any type of referral or authorization by way of  
203 telehealth from ~~and~~ a telehealth provider, as defined in s.

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204 ~~456.47, must be voluntary between the health maintenance~~  
205 ~~organization and the provider and must establish mutually~~  
206 ~~acceptable payment rates or payment methodologies for services~~  
207 ~~provided through telehealth. Any contract provision that~~  
208 ~~distinguishes between payment rates or payment methodologies for~~  
209 ~~services provided through telehealth and the same services~~  
210 ~~provided without the use of telehealth must be initialed by the~~  
211 ~~telehealth provider.~~

212 Section 5. Section 641.31093, Florida Statutes, is created  
213 to read:

214 641.31093 Requirements for reimbursement by health  
215 maintenance organizations for telehealth services.-

216 (1) A health maintenance organization that offers, issues,  
217 or renews a major medical or similar comprehensive contract in  
218 this state on or after January 1, 2022, may not deny coverage  
219 for a covered service on the basis of the covered service being  
220 provided through telehealth if the same service would be covered  
221 if provided through an in-person encounter.

222 (2) A health maintenance organization may not exclude an  
223 otherwise covered service from coverage solely because the  
224 service is provided through telehealth rather than through an  
225 in-person encounter.

226 (3) A health maintenance organization shall reimburse a  
227 telehealth provider for the diagnosis, consultation, or  
228 treatment of any subscriber provided through telehealth on the  
229 same basis and at least the same rate that the health  
230 maintenance organization would reimburse the provider if the  
231 service were provided through an in-person encounter. However, a  
232 health maintenance organization may not require a health care



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233 provider or telehealth provider to accept a reimbursement amount  
234 greater than the amount the provider is willing to charge.

235 (4) A health maintenance organization shall reimburse a  
236 telehealth provider for reasonable originating site fees or  
237 costs for the provision of telehealth services.

238 (5) A covered service provided through telehealth may not  
239 be subject to a greater deductible, copayment, or coinsurance  
240 amount than would apply if the same service were provided  
241 through an in-person encounter.

242 (6) A health maintenance organization may not impose upon  
243 any subscriber receiving benefits under this section any  
244 copayment, coinsurance, or deductible amount or any contract-  
245 year, calendar-year, lifetime, or other durational benefit  
246 limitation or maximum for benefits or services provided through  
247 telehealth which is not equally imposed upon all services  
248 covered under the contract.

249 (7) A health maintenance organization may not require an  
250 insured person to obtain a covered service through telehealth  
251 instead of an in-person encounter.

252 (8) This section does not preclude a health maintenance  
253 organization from conducting a utilization review to determine  
254 the appropriateness of telehealth as a means of delivering a  
255 covered service if such determination is made in the same manner  
256 as would be made for the same service provided through an in-  
257 person encounter.

258 (9) A health maintenance organization may limit covered  
259 services that are provided through telehealth to providers who  
260 are in a network approved by the health maintenance  
261 organization.

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Section 6. This act shall take effect July 1, 2021.