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**SENATE BILL NO. 675**

Offered January 22, 2010

A *BILL to amend and reenact §§ 32.1-137.7 and 38.2-4319 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 38.2-3418.16, relating to health insurance coverage for telemedicine services.*

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 Patron—Wampler
 

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Referred to Committee on Commerce and Labor

**Be it enacted by the General Assembly of Virginia:**

**1. That §§ 32.1-137.7 and 38.2-4319 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding a section numbered 38.2-3418.16 as follows:**

§ 32.1-137.7. Definitions.

As used in this article:

"Adverse decision" means a utilization review determination by the utilization review entity that a health service rendered or proposed to be rendered was or is not medically necessary, when such determination may result in noncoverage of the health service or health services. *When the policy, contract, plan, certificate, or evidence of coverage includes coverage for telemedicine services as provided by § 38.2-3418.16, "adverse decision" also includes a determination that the use of telemedicine services rendered or proposed to be rendered was or is not covered under the policy, contract, or plan.* When the policy, contract, plan, certificate, or evidence of coverage includes coverage for prescription drugs and the health service rendered or proposed to be rendered is a prescription for the alleviation of cancer pain, any adverse decision shall be made within twenty-four hours of the request for coverage.

"Commission" means the Virginia State Corporation Commission.

"Covered person" means a subscriber, policyholder, member, enrollee or dependent, as the case may be, under a policy or contract issued or issued for delivery in Virginia by a managed care health insurance plan licensee, insurer, health services plan, or preferred provider organization.

"Evidence of coverage" includes any certificate, individual or group agreement or contract, or identification card or related documents issued in conjunction with the certificate, agreement or contract, issued to a subscriber setting out the coverage and other rights to which a covered person is entitled.

"Final adverse decision" means a utilization review determination made by a physician advisor or peer of the treating health care provider in a reconsideration of an adverse decision, and upon which a provider or patient may base an appeal.

"Medical director" means a physician licensed to practice medicine in the Commonwealth of Virginia who is an employee of a utilization review organization responsible for compliance with the provisions of this article.

"Peer of the treating health care provider" means a physician or other health care professional who holds a nonrestricted license in the Commonwealth of Virginia or under a comparable licensing law of a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review.

"Physician advisor" means a physician licensed to practice medicine in the Commonwealth of Virginia or under a comparable licensing law of a state of the United States who provides medical advice or information to a private review agent or a utilization review entity in connection with its utilization review activities.

"Private review agent" means a person or entity performing utilization reviews, except that the term shall not include the following entities or employees of any such entity so long as they conduct utilization reviews solely for subscribers, policyholders, members or enrollees:

1. A health maintenance organization authorized to transact business in Virginia; or

2. A health insurer, hospital service corporation, health services plan or preferred provider organization authorized to offer health benefits in this Commonwealth.

"Treating health care provider" or "provider" means a licensed health care provider who renders or proposes to render health care services to a covered person.

"Utilization review" means a system for reviewing the necessity, appropriateness and efficiency of hospital, medical or other health care services rendered or proposed to be rendered to a patient or group of patients for the purpose of determining whether such services should be covered or provided by an insurer, health services plan, managed care health insurance plan licensee, or other entity or person. For purposes of this article, "utilization review" shall include, but not be limited to, preadmission, concurrent

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59 and retrospective medical necessity determination, and review related to the appropriateness of the site at  
60 which services were or are to be delivered, *and shall include reviews related to whether coverage of the*  
61 *delivery by a health care provider of health care services through the use of interactive audio, video, or*  
62 *other telecommunications technology is required pursuant to § 38.2-3418.16. "Utilization review" shall*  
63 not include (i) any review of issues concerning insurance contract coverage or contractual restrictions on  
64 facilities to be used for the provision of services, (ii) any review of patient information by an employee  
65 of or consultant to any licensed hospital for patients of such hospital, or (iii) any determination by an  
66 insurer as to the reasonableness and necessity of services for the treatment and care of an injury suffered  
67 by an insured for which reimbursement is claimed under a contract of insurance covering any classes of  
68 insurance defined in §§ 38.2-117 through 38.2-119, 38.2-124 through 38.2-126, 38.2-130 through  
69 38.2-132 and 38.2-134.

70 "Utilization review entity" or "entity" means a person or entity performing utilization review.

71 "Utilization review plan" or "plan" means a written procedure for performing review.

72 § 38.2-3418.16. *Coverage for telemedicine services.*

73 A. *Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or*  
74 *group accident and sickness insurance policies providing hospital, medical and surgical, or major*  
75 *medical coverage on an expense-incurred basis; each corporation providing individual or group*  
76 *accident and sickness subscription contracts; and each health maintenance organization providing a*  
77 *health care plan for health care services shall provide coverage for the cost of telemedicine services, as*  
78 *provided in this section.*

79 B. *As used in this section, "telemedicine services" means the use of interactive audio, video, or other*  
80 *telecommunications technology by a health care provider to deliver health care services within the scope*  
81 *of the provider's practice at a site other than the site where the patient is located, including the use of*  
82 *electronic media for consultation relating to the health care diagnosis or treatment of the patient.*  
83 *"Telemedicine services" do not include an audio-only telephone conversation, electronic mail message,*  
84 *or facsimile transmission between a health care provider and a patient.*

85 C. *An insurer, corporation, or health maintenance organization shall not exclude a service for*  
86 *coverage solely because the service is provided through telemedicine services and is not provided*  
87 *through face-to-face consultation or contact between a health care provider and a patient for services*  
88 *appropriately provided through telemedicine services.*

89 D. *A determination by an insurer, corporation, or health maintenance organization that the delivery*  
90 *by a health care provider of health care services through the use of interactive audio, video, or other*  
91 *telecommunications technology is not covered pursuant to this section shall be subject to utilization*  
92 *review pursuant to Article 1.2 (§ 32.1-137.7 et seq.) of Chapter 5 of Title 32.1 and independent external*  
93 *review of adverse utilization review decisions pursuant to Chapter 59 (§ 38.2-5900 et seq.) of this title.*

94 E. *No insurer, corporation, or health maintenance organization shall impose any annual or lifetime*  
95 *dollar maximum on coverage for telemedicine services other than an annual or lifetime dollar maximum*  
96 *that applies in the aggregate to all items and services covered under the policy, or impose upon any*  
97 *person receiving benefits pursuant to this section any copayment, coinsurance, or deductible amounts, or*  
98 *any policy year, calendar year, lifetime, or other durational benefit limitation or maximum for benefits*  
99 *or services, that is not equally imposed upon all terms and services covered under the policy, contract,*  
100 *or plan.*

101 F. *The requirements of this section shall apply to all insurance policies, contracts, and plans*  
102 *delivered, issued for delivery, reissued, or extended in the Commonwealth on and after January 1, 2011,*  
103 *or at any time thereafter when any term of the policy, contract, or plan is changed or any premium*  
104 *adjustment is made.*

105 G. *This section shall not apply to short-term travel, accident-only, limited or specified disease, or*  
106 *individual conversion policies or contracts, nor to policies or contracts designed for issuance to persons*  
107 *eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other*  
108 *similar coverage under state or federal governmental plans.*

109 § 38.2-4319. *Statutory construction and relationship to other laws.*

110 A. *No provisions of this title except this chapter and, insofar as they are not inconsistent with this*  
111 *chapter, §§ 38.2-100, 38.2-136, 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218*  
112 *through 38.2-225, 38.2-229, 38.2-232, 38.2-305, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through*  
113 *38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.),*  
114 *§§ 38.2-1016.1 through 38.2-1023, 38.2-1057, Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1306.1,*  
115 *§ 38.2-1315.1, Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.) and 5 (§ 38.2-1322 et seq.) of*  
116 *Chapter 13, Articles 1 (§ 38.2-1400 et seq.) and 2 (§ 38.2-1412 et seq.) of Chapter 14, §§ 38.2-1800*  
117 *through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3407.2 through 38.2-3407.6:1, 38.2-3407.9*  
118 *through 38.2-3407.16, 38.2-3411.2, 38.2-3411.3, 38.2-3411.4, 38.2-3412.1:01, 38.2-3414.1, 38.2-3418.1*  
119 *through 38.2-3418.15 38.2-3418.16, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500, subdivision*  
120 *13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through*

38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3541.1, 38.2-3542, 38.2-3543.2, Article 5 (§ 38.2-3551 et seq.) of Chapter 35, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et seq.) and § 38.2-5903 of this title shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) of this title except with respect to the activities of its health maintenance organization.

B. For plans administered by the Department of Medical Assistance Services that provide benefits pursuant to Title XIX or Title XXI of the Social Security Act, as amended, no provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-136, 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, § 38.2-1306.1, Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1315.1, Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.) and 5 (§ 38.2-1322 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.) and 2 (§ 38.2-1412 et seq.) of Chapter 14, §§ 38.2-3401, 38.2-3405, 38.2-3407.2 through 38.2-3407.5, 38.2-3407.6 and 38.2-3407.6:1, 38.2-3407.9, 38.2-3407.9:01, and 38.2-3407.9:02, subdivisions 1, 2, and 3 of subsection F of § 38.2-3407.10, 38.2-3407.11, 38.2-3407.11:3, 38.2-3407.13, 38.2-3407.13:1, and 38.2-3407.14, 38.2-3411.2, 38.2-3418.1, 38.2-3418.2, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3542, 38.2-3543.2, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et seq.) and § 38.2-5903 shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) of this title except with respect to the activities of its health maintenance organization.

C. Solicitation of enrollees by a licensed health maintenance organization or by its representatives shall not be construed to violate any provisions of law relating to solicitation or advertising by health professionals.

D. A licensed health maintenance organization shall not be deemed to be engaged in the unlawful practice of medicine. All health care providers associated with a health maintenance organization shall be subject to all provisions of law.

E. Notwithstanding the definition of an eligible employee as set forth in § 38.2-3431, a health maintenance organization providing health care plans pursuant to § 38.2-3431 shall not be required to offer coverage to or accept applications from an employee who does not reside within the health maintenance organization's service area.

F. For purposes of applying this section, "insurer" when used in a section cited in subsections A and B of this section shall be construed to mean and include "health maintenance organizations" unless the section cited clearly applies to health maintenance organizations without such construction.