2023 SENATE HUMAN SERVICES

SB 2160

2023 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Lincoln Room, State Capitol

SB 2160
2/14/2023

Relating to health insurance coverage of telehealth.

9:59 AM **Madam Chair Lee** called the hearing to order. **Senators Lee, Cleary, Clemens, K. Roers, Weston, Hogan** are present.

Discussion Topics:

- Monitor coverage
- Rural health
- Telehealth visit
- In person visit

10:00 AM **Senator Judy Lee** introduced the bill and proposed an amendment 23.0547.02001 #20772, 20773 in favor verbal

10:01 AM **Andrew Askew, Vice President Public Policy**, **Essentia Health,** provided detailed explanation of amendment testimony in favor verbal #20772, 20773

10:09 AM **Donna Thronson, ND Medical Association**, distributed Dr. Gabriela Balf, testimony in favor #20766

10:10 AM **Andrew Askew**, provided additional information #20722

10:12 AM **Gabriela Balf, Psychiatrist, North Dakota Psychiatric Society,** testimony in favor #20766

10:21 AM **Jack McDonald,** on behalf of American Health Insurance Plans, in opposition verbal

10:23 AM **Meghan Houn**, Vice President of Public Policy and Government Affairs, ND **Blue Cross Blue Shield**, in opposition verbal

10:28 AM **Dylan Wheeler, Head of Government Affairs, Sanford Health** in opposition verbal

10:31 AM **Chrystal Bartuska, Life Health and Medicare Division Director, ND Insurance Department,** provided additional information neutral verbal

Additional written testimony:
Kyle Zebley, Executive Director, ATA Action in favor **#20576**
Kylie Nissen, Executive Director North Dakota Rural Health Association #20647

Karlee Tebbutt, Regional Director, State Affairs, AHIP – Guiding Great Health in opposition **#20770**
Scott Miller, Executive Director, North Dakota Public Employees Retirement System neutral **#20487, 20488**
Jennifer Clark, Legislative Council, neutral **#20574**

10:36 AM **Madam Chair Lee** closed the hearing

10:37 AM **Madam Chair Lee** reconvenes hearing

Senator Lee calls for discussion.

10:38 AM **Gabriela Balf, Psychiatrist** provided more information verbal

10:49 AM **Madam Chair Lee** closed the meeting.

Patricia Lahr, Committee Clerk

2023 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Lincoln Room, State Capitol

SB 2160
2/14/2023

Relating to health insurance coverage of telehealth.

11:49 AM **Madam Chair Lee** called the meeting to order. **Senators Lee, Cleary, Clemens, K. Roers, Weston, Hogan** are present.

Discussion Topics:

- Patient benefit
- Facility fee
- Telehealth mandate

Senator Judy Lee calls for discussion.

11:48 AM Lindsey Pouliot, Legislative Intern, Legislative Council, handed out proposed amendment. #20807

11:55 AM **Chrystal Bartuska, Director Life Health and Medicare Division, ND Insurance Department,** provides additional information verbally.

11:57 AM **Madam Chair Lee** closed the meeting.

Patricia Lahr, Committee Clerk

2023 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Lincoln Room, State Capitol

SB 2160
2/15/2023

Relating to health insurance coverage of telehealth.

9:02 AM **Madam Chair Lee** called the meeting to order. **Senators Lee, Cleary, Clemens, K. Roers, Weston, Hogan** are present.

Discussion Topics:

- Telehealth mandate
- PERS study

Senator Judy Lee called for discussion.

9:04 AM **Dylan Wheeler, Head of Government Affairs Sanford Health**, provided information verbal

9:12 AM **Andrew Askew, Vice President, Public Policy,** provided additional information

9:13 AM **Madam Chair Lee** closed the meeting.

Patricia Lahr, Committee Clerk

2023 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Lincoln Room, State Capitol

SB 2160
2/15/2023

Relating to health insurance coverage of telehealth.

3:09 PM **Madam Chair Lee** called the hearing to order. **Senators Lee, Cleary, Clemens, K. Roers, Weston, Hogan** are present.

Discussion Topics:

- Behavioral health
- PERS study

Senator Lee calls for discussion.

3:10 PM **Andy Askew, Vice President Public Policy, Essentia Health,** discussed proposed amendment. #20917

3:16 PM **Chelsey Matter, Executive Director of Government Programs, Blue Cross Blue of North Dakota**, provided information verbally.

3:24 PM **Jennifer Clark, Code Reviser, Legislative Council,** provides additional information verbally.

Senator Hogan moved to adopt amendment. LC 23.0547.02002.

Senator Weston seconded.

Roll call vote.

Senators	Vote
Senator Judy Lee	Y
Senator Sean Cleary	Y
Senator David A. Clemens	Y
Senator Kathy Hogan	Y
Senator Kristin Roers	Y
Senator Kent Weston	Y

The motion passed 6-0-0.

Senator Hogan moved **DO PASS** as **AMENDED**.

Senator Weston seconded the motion.

Roll call vote.

Senators	Vote
Senator Judy Lee	Y
Senator Sean Cleary	N
Senator David A. Clemens	N
Senator Kathy Hogan	Y
Senator Kristin Roers	N
Senator Kent Weston	N

Motion failed 2-4-0.

Senator K. Roers moved **DO NOT PASS** as **AMENDED.**

Senator Cleary seconded.

Roll call vote.

Senators	Vote
Senator Judy Lee	N
Senator Sean Cleary	Y
Senator David A. Clemens	Y
Senator Kathy Hogan	N
Senator Kristin Roers	Y
Senator Kent Weston	Y

Motion passed 4-2-0.

Senator K. Roers will carry SB 2160.

3:29 PM **Madam Chair Lee** closed the meeting.

Patricia Lahr, Committee Clerk

23.0547.02002
Title.03000

Prepared by the Legislative Council staff for
Senate Human Services Committee
February 15, 2023

AK 2-15-23 (1-4)

PROPOSED AMENDMENTS TO SENATE BILL NO. 2160

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact a new section to chapter 54-52.1 of the North Dakota Century Code, relating to public employee telehealth benefits; to provide for a report; to provide for application; to provide an expiration date; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 54-52.1 of the North Dakota Century Code is created and enacted as follows:

Coverage of telehealth services.

1. As used in this section:

   a. "Behavioral health" has the same meaning as provided under section 50-06-01.

   b. "Distant site" means a site at which a health care provider or health care facility is located while providing medical services by means of telehealth.

   c. "Health care facility" means any office or institution at which health services are provided. The term includes hospitals; clinics; ambulatory surgery centers; outpatient care facilities; nursing homes; nursing, basic, long-term, or assisted living facilities; laboratories; and offices of any health care provider.

   d. "Health care provider" includes an individual licensed under chapter 43-05, 43-06, 43-12.1 as a registered nurse or as an advanced practice registered nurse, 43-13, 43-15, 43-17, 43-26.1, 43-28, 43-32, 43-37, 43-40, 43-41, 43-42, 43-44, 43-45, 43-47, 43-58, or 43-60.

   e. "Originating site" means a site at which a patient is located at the time health services are provided to the patient by means of telehealth.

   f. "Store-and-forward technology" means asynchronous electronic transfer or transmission of a patient's medical information or data from an originating site to a distant site for the purpose of diagnostic and therapeutic assistance in the care of a patient.

   g. "Telehealth":

      (1) Means the delivery of health services or consultations through the use of real-time two-way interactive audio and visual communications to provide or support health care delivery and facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care.

(2) Includes the application of secure video conferencing, store-and-forward technology, and synchronous interactions between a patient located at an originating site and a health care provider located at a distant site.

(3) Includes audio-only communication between a health care provider and a patient as authorized under this section.

(4) Does not include communication between health care providers which consists solely of a telephone conversation, electronic mail, or facsimile transmission.

(5) Does not include communication between a health care provider and a patient which consists solely of an electronic mail or facsimile transmission.

(6) Includes telemonitoring services if the:

(a) Telemonitoring services are medically appropriate based on the patient's medical condition or status;

(b) Patient is cognitively and physically capable of operating the monitoring device or equipment, or the patient has a caregiver who is willing and able to assist with the monitoring device or equipment; and

(c) Patient resides in a setting suitable for telemonitoring services and not in a setting that has health care staff on site.

h. "Telemonitoring services" means the remote monitoring of clinical data related to the patient's vital signs or biometric data by a monitoring device or equipment that transmits the data electronically to a health care provider for analysis. Telemonitoring is intended to collect a patient's health-related data for the purpose of assisting a health care provider in assessing and monitoring the patient's medical condition or status.

2. The board shall provide health insurance benefits coverage that provides coverage for health services delivered by means of telehealth which is the same as the coverage for covered medically necessary health services delivered by in-person means.

a. This subsection does not require a health care provider to provide telehealth services if the provider determines the delivery of a health service through telehealth is not appropriate or if a patient chooses not to receive a health care service through telehealth.

b. The coverage may provide criteria a health care provider is required to meet to demonstrate safety or efficacy of delivering a health care service through telehealth if the coverage does not already reimburse other health care providers for delivery of that health service through telehealth.

c. The coverage may provide reasonable medical management techniques if a particular technique is not unduly burdensome or unreasonable for a particular health service.

d. The coverage may require documentation or billing practices designed to protect the insurer or patient from fraudulent claims if the practices are not unduly burdensome or unreasonable for a particular health service.

e. This section does not require coverage of an audio-only communication unless the communication was a scheduled appointment and the standard of care for that service can be met through the use of audio-only communication.

f. The coverage may not require a patient to pay a fee to download a specific communication technology or application.

3. Payment or reimbursement of expenses for covered health services delivered by means of telehealth under subsection 2 may be established through negotiations with the health services providers in the same manner as the coverage establishes payment or reimbursement of expenses for covered health services that are delivered by in-person means.

4. The coverage must provide the same rate of reimbursement for behavioral health services delivered by means of telehealth as the rate of reimbursement for the same behavioral health services delivered by in-person means.

   a. Under this subsection, the coverage may not deny or limit the rate of reimbursement based solely on the technology and equipment used by the health care provider to deliver the behavioral health services or consultation through telehealth, if the technology and equipment used by the behavioral health provider meets the requirements of this section and is appropriate for the health service.

   b. This subsection does not prohibit a value-based reimbursement arrangement for the delivery of covered health services that may include services delivered through telehealth, and the arrangement does not constitute a violation of this section.

   c. Under this subsection, notwithstanding subsection 2, behavioral health services delivered through telehealth are covered regardless of whether provided by means of audio-only communication and regardless of whether provided as part of a scheduled appointment if the communication was initiated by the patient while in an emergency or crisis situation and a scheduled appointment was not possible due to the need for an immediate response.

5. Coverage under this section may be subject to deductible, coinsurance, and copayment provisions that are no different from the provisions for in-person means. Coverage under this section may be subject to prior authorization if prior authorization is required before the delivery of the same health care service by in-person means. Coverage may include utilization review for health services delivered through telehealth if the utilization review is conducted in the same manner and uses the same clinical review criteria as a utilization review for the same services delivered through in-person means.

6. This section does not require:

a. Coverage for health services that are not medically necessary, subject to the terms and conditions of the health benefits coverage;

b. Coverage for health services delivered by means of telehealth if the coverage would not provide coverage for the health services if delivered by in-person means;

c. Reimbursement of a health care provider or health care facility for expenses for health services delivered by means of telehealth if the coverage would not reimburse that health care provider or health care facility if the health services had been delivered by in-person means; or

d. A health care provider to be physically present with a patient at the originating site unless the health care provider who is delivering health services by means of telehealth determines the presence of a health care provider is necessary.

SECTION 2. APPLICATION. This Act applies to public employees retirement system health benefits coverage that begins after June 30, 2023, and which does not extend past June 30, 2025.

SECTION 3. PUBLIC EMPLOYEES RETIREMENT SYSTEM - EXPANDED TELEHEALTH COVERAGE - REPORT. Pursuant to section 54-03-28, the public employees retirement system shall prepare and submit for introduction a bill to the sixty-ninth legislative assembly to repeal the expiration date for this Act and to extend the coverage of expanded telehealth coverage to all group and individual health insurance policies. The public employees retirement system shall append a report to the bill regarding the effect of the expanded telehealth benefits requirement on the system's health insurance programs, information on the utilization and costs relating to the coverage, and a recommendation regarding whether the coverage should be continued.

SECTION 4. EXPIRATION DATE. This Act is effective through July 31, 2025, and after that date is ineffective.

SECTION 5. EMERGENCY. This Act is declared to be an emergency measure."

Renumber accordingly

REPORT OF STANDING COMMITTEE

SB 2160: Human Services Committee (Sen. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO NOT PASS** (4 YEAS, 2 NAYS, 0 ABSENT AND NOT VOTING). SB 2160 was placed on the Sixth order on the calendar. This bill does not affect workforce development.

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact a new section to chapter 54-52.1 of the North Dakota Century Code, relating to public employee telehealth benefits; to provide for a report; to provide for application; to provide an expiration date; and to declare an emergency.

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   b. "Distant site" means a site at which a health care provider or health care facility is located while providing medical services by means of telehealth.

   c. "Health care facility" means any office or institution at which health services are provided. The term includes hospitals; clinics; ambulatory surgery centers; outpatient care facilities; nursing homes; nursing, basic, long-term, or assisted living facilities; laboratories; and offices of any health care provider.

   d. "Health care provider" includes an individual licensed under chapter 43-05, 43-06, 43-12.1 as a registered nurse or as an advanced practice registered nurse, 43-13, 43-15, 43-17, 43-26.1, 43-28, 43-32, 43-37, 43-40, 43-41, 43-42, 43-44, 43-45, 43-47, 43-58, or 43-60.

   e. "Originating site" means a site at which a patient is located at the time health services are provided to the patient by means of telehealth.

   f. "Store-and-forward technology" means asynchronous electronic transfer or transmission of a patient's medical information or data from an originating site to a distant site for the purpose of diagnostic and therapeutic assistance in the care of a patient.

   g. "Telehealth":

      (1) Means the delivery of health services or consultations through the use of real-time two-way interactive audio and visual communications to provide or support health care delivery and facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care.

      (2) Includes the application of secure video conferencing, store-and-forward technology, and synchronous interactions between a patient located at an originating site and a health care provider located at a distant site.

(3) Includes audio-only communication between a health care provider and a patient as authorized under this section.

(4) Does not include communication between health care providers which consists solely of a telephone conversation, electronic mail, or facsimile transmission.

(5) Does not include communication between a health care provider and a patient which consists solely of an electronic mail or facsimile transmission.

(6) Includes telemonitoring services if the:

(a) Telemonitoring services are medically appropriate based on the patient's medical condition or status;

(b) Patient is cognitively and physically capable of operating the monitoring device or equipment, or the patient has a caregiver who is willing and able to assist with the monitoring device or equipment; and

(c) Patient resides in a setting suitable for telemonitoring services and not in a setting that has health care staff on site.

h. "Telemonitoring services" means the remote monitoring of clinical data related to the patient's vital signs or biometric data by a monitoring device or equipment that transmits the data electronically to a health care provider for analysis. Telemonitoring is intended to collect a patient's health-related data for the purpose of assisting a health care provider in assessing and monitoring the patient's medical condition or status.

2. The board shall provide health insurance benefits coverage that provides coverage for health services delivered by means of telehealth which is the same as the coverage for covered medically necessary health services delivered by in-person means.

a. This subsection does not require a health care provider to provide telehealth services if the provider determines the delivery of a health service through telehealth is not appropriate or if a patient chooses not to receive a health care service through telehealth.

b. The coverage may provide criteria a health care provider is required to meet to demonstrate safety or efficacy of delivering a health care service through telehealth if the coverage does not already reimburse other health care providers for delivery of that health service through telehealth.

c. The coverage may provide reasonable medical management techniques if a particular technique is not unduly burdensome or unreasonable for a particular health service.

d. The coverage may require documentation or billing practices designed to protect the insurer or patient from fraudulent claims if the practices are not unduly burdensome or unreasonable for a particular health service.

e. This section does not require coverage of an audio-only communication unless the communication was a scheduled

appointment and the standard of care for that service can be met through the use of audio-only communication.

f. The coverage may not require a patient to pay a fee to download a specific communication technology or application.

3. Payment or reimbursement of expenses for covered health services delivered by means of telehealth under subsection 2 may be established through negotiations with the health services providers in the same manner as the coverage establishes payment or reimbursement of expenses for covered health services that are delivered by in-person means.

4. The coverage must provide the same rate of reimbursement for behavioral health services delivered by means of telehealth as the rate of reimbursement for the same behavioral health services delivered by in-person means.

a. Under this subsection, the coverage may not deny or limit the rate of reimbursement based solely on the technology and equipment used by the health care provider to deliver the behavioral health services or consultation through telehealth, if the technology and equipment used by the behavioral health provider meets the requirements of this section and is appropriate for the health service.

b. This subsection does not prohibit a value-based reimbursement arrangement for the delivery of covered health services that may include services delivered through telehealth, and the arrangement does not constitute a violation of this section.

c. Under this subsection, notwithstanding subsection 2, behavioral health services delivered through telehealth are covered regardless of whether provided by means of audio-only communication and regardless of whether provided as part of a scheduled appointment if the communication was initiated by the patient while in an emergency or crisis situation and a scheduled appointment was not possible due to the need for an immediate response.

5. Coverage under this section may be subject to deductible, coinsurance, and copayment provisions that are no different from the provisions for in-person means. Coverage under this section may be subject to prior authorization if prior authorization is required before the delivery of the same health care service by in-person means. Coverage may include utilization review for health services delivered through telehealth if the utilization review is conducted in the same manner and uses the same clinical review criteria as a utilization review for the same services delivered through in-person means.

6. This section does not require:

a. Coverage for health services that are not medically necessary, subject to the terms and conditions of the health benefits coverage;

b. Coverage for health services delivered by means of telehealth if the coverage would not provide coverage for the health services if delivered by in-person means;

c. Reimbursement of a health care provider or health care facility for expenses for health services delivered by means of telehealth if the coverage would not reimburse that health care provider or health

care facility if the health services had been delivered by in-person means; or

d. A health care provider to be physically present with a patient at the originating site unless the health care provider who is delivering health services by means of telehealth determines the presence of a health care provider is necessary.

SECTION 2. APPLICATION. This Act applies to public employees retirement system health benefits coverage that begins after June 30, 2023, and which does not extend past June 30, 2025.

SECTION 3. PUBLIC EMPLOYEES RETIREMENT SYSTEM - EXPANDED TELEHEALTH COVERAGE - REPORT. Pursuant to section 54-03-28, the public employees retirement system shall prepare and submit for introduction a bill to the sixty-ninth legislative assembly to repeal the expiration date for this Act and to extend the coverage of expanded telehealth coverage to all group and individual health insurance policies. The public employees retirement system shall append a report to the bill regarding the effect of the expanded telehealth benefits requirement on the system's health insurance programs, information on the utilization and costs relating to the coverage, and a recommendation regarding whether the coverage should be continued.

SECTION 4. EXPIRATION DATE. This Act is effective through July 31, 2025, and after that date is ineffective.

SECTION 5. EMERGENCY. This Act is declared to be an emergency measure."

Renumber accordingly

TESTIMONY

SB 2160

TESTIMONY OF SCOTT MILLER

Senate Bill 2160 – Telehealth Parity

Good Morning, my name is Scott Miller. I am the Executive Director of the North Dakota Public Employees Retirement System, or NDPERS. I am submitting this written testimony in a neutral position regarding Senate Bill 2140.

SB 2160 modifies coverage of telehealth services. The bill updates definitions and provisions related to telehealth services, and in so doing, aligns the North Dakota Century Code to accommodate current technology, health plan and provider operations, and developing market practices.

Our actuary, Deloitte, sees no material financial impact on the State's uniform group health insurance program as a result of this bill.

Deloitte.

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Memo

Date: January 5, 2023

To: Scott Miller
Executive Director, North Dakota Public Employees Retirement System

From: Tim Egan & Dan Plante & Drew Rasmussen, Deloitte Consulting LLP

Subject: **ACTUARIAL REVIEW OF PROPOSED BILL 23.0547.02000**

The following summarizes our review of the proposed legislation as it relates to the financial impact to the uniform group insurance program administered by NDPERS as well as other considerations that may contribute to the evaluation of the legislation.

OVERVIEW OF PROPOSED BILL

The bill modifies coverage of telehealth services. The bill updates definitions and provisions related to telehealth services, and in so doing, aligns the North Dakota Century Code to accommodate current technology, health plan and provider operations, and developing market practices.

ESTIMATED FINANCIAL IMPACT

Section 1 of the bill updates the language in the legislation in the following provisions. Deloitte does not expect a financial impact on the uniform group insurance program as a result of the updates to the language as updates are primarily providing more specificity around telehealth visits and the technology used to enable such services.

- The term "E-visit" and corresponding definition is removed (page 1, lines 10-11). The updated definition of Telehealth is inclusive of the "E-visit" and the term "E-visit" is removed from the text of the proposed legislation.
- The term "Nonpublic facing product" and corresponding definition is removed (page 1, lines 20-21). The term is removed from the text of the proposed legislation.
- The term "Secure connection" and corresponding definition is removed (page 2, lines 3-6).
- The term "Store-and-forward technology" is clarified to be "asynchronous electronic transfer or transmission of a patient's medical information or data from an originating site to a distant site for the purpose of diagnostic and therapeutic assistance in the care of a patient" (page 2, lines 7-14).
- The definition of Telehealth:
    - is clarified to mean "delivery of health services or consultations through the use of real-time two-way interactive audio and visual communication to provide or support

health care deliver and facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care" (page 2, lines 16-24)

- is clarified to include "the application of secure video conferencing, store-and-forward technology, and synchronous interactions between a patient located at an originating site and a health care provider located at a distant site" (page 2 line 25-30)

- is clarified to include "audio-only communication between a health care provider and a patient" (page 3, line 1-2) however section 2e. on page 4, lines 7-9 specify that audio-only communication is not required to be covered unless the communication was a scheduled appointment and the standard of care for that service can be met through the use of audio-only communication

- is clarified to not include "communication between health care providers (or patient) which consists solely of a telephone conversation, electronic mail, or facsimile transmission" (page 3, line 3-8)

- is clarified to not include telemonitoring services (page 3, line 9). A definition of "Telemonitoring" is added (page 3, lines 13-18) and includes remote monitoring of clinical data.

- The term "Virtual check-in" and corresponding definition is removed (page 3, lines 10-12). The term is removed from the text of the proposed legislation.

Section 2 clarifies the role of the insurers and health care providers with respect to telehealth services (page 3, line 23-30 and page 4, line 1-11). Deloitte does not expect a material financial impact on the uniform group insurance program as a result of the clarifications. The use of medical management techniques or other administrative requirements may have some effect on program cost if they result in changes to in-person utilization.

- A health care provider is not required to provide telehealth services if the provider determines the delivery of a health service through telehealth is not appropriate or if a patient chooses not to receive a health care service through telehealth (2a., page 3, lines 23-26)

- An insurer may establish criteria a health care provider is required to meet to demonstrate safety or efficacy of delivering a health care service through telehealth if the insurer does not already reimburse other health care providers for delivery of that health service through telehealth (2b., page 3, line 27-30)

- An insurer may establish reasonable medical management techniques if a particular technique is not unduly burdensome or unreasonable for a particular health service (2c., page 4, lines 1-3)

- An insurer may require documentation or billing practices designed to protect the health insurer or patient from fraudulent claims if the practices are not unduly burdensome or unreasonable for a particular health service (2d., page 4, lines 4-6)

- An insurer may not require a patient to pay a fee to download a specific communication technology or application (2f., page 4, lines 10-11)

Section 4 is added to require parity for behavioral health services provided through in-person means and telehealth. The section will likely have a small financial impact on the uniform group insurance program.

- Section 4, page 4, lines 17-22 says "An insurer may not deliver, issue, execute, or renew a policy that provides health benefits coverage for behavioral health unless that policy provides the same coverage and reimbursement for medically necessary health services for behavioral health services delivered by means of telehealth which is the same as the coverage and reimbursement for covered medically necessary behavioral health services delivered by in-person means". Deloitte estimates a 0.1% cost increase if reimbursement of telehealth services for behavioral health is required to be no less than in-person visits.

- Section 4c., page 5, lines 1-5 allows for health insurers and providers to enter into a value-based reimbursement arrangement for the delivery of covered behavioral health services delivered through telehealth. The financial impact of any future value-based reimbursement arrangements would need to be evaluated to determine a financial impact on the uniform group insurance program. It is not likely that there will be enough participants or claims volume in a value-based reimbursement arrangement to have a material impact on cost.

Section 5 is expanded to clarify that "Coverage under this section may be subject to deductible, coinsurance, and copayment provisions that are no different from the provisions for in-person means" (page 5, lines 12-13). On December 23, US Congress approved a year-end omnibus legislative package, Consolidated Appropriations Act, 2023 (CAA 2023). The healthcare provisions of CAA 2023 extend the temporary telehealth safe harbor for High Deductible Health Plans (HDHP) first-dollar coverage through December 31, 2024. The temporary safe harbor permits HDHPs to cover telehealth on a first-dollar basis without requiring them to first meet the minimum required deductible, with the goal of increasing access to telehealth.

NDPERS offers state employees the option to enroll in a HDHP with a Health Savings Account (HSA). The requirement that deductible, coinsurance, and copayment provisions are the same for telehealth and in-person visits could be inconsistent with the CAA 2023 safe harbor extension that allows HDHP participants to receive telehealth services prior to the application of the deductible. The CAA telehealth safe harbor extension is not a requirement, and the uniform group insurance program may choose not to allow first-dollar coverage for telehealth in the HDHP.

January 6, 2023

Analysis of LC 23.0547.0200 Relating to Health Insurance Coverage of Telehealth

Prepared for the North Dakota Legislative Council
Pursuant to North Dakota Century Code 54-03-28

Amanda Rocha
Richard Cadwell, ASA, MAAA
Donna Novak, FCA, ASA, MAAA

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NovaRest
ACTUARIAL CONSULTING

Table of Contents

I. Evaluation of Proposed Mandated Health Insurance Services

The North Dakota Legislative Council (NDLC) was asked to perform a cost benefit analysis of LC 23.0547.0200 (Draft Bill) for the standing Legislative Assembly pursuant to the North Dakota Century Code (NDCC) 54-03-28. This Draft Bill amends and reenacts section 26.1-36-09.15. As proposed, the Draft Bill adds clarification for providing medically necessary health services through telehealth and requires policies that provide health benefits coverage for behavioral health provide the same coverage and reimbursement for medically necessary health services for behavioral health services through both telehealth and in-person means.

NovaRest, Inc. has been contracted as the NDLC's consulting actuary, and has prepared the following evaluation of medically necessary telehealth services.

This report includes information from several sources to provide more than one perspective on the proposed mandate to provide a totally unbiased report. As a result, there may be some conflicting information within the contents. Although we only used sources that we considered credible, we do not offer any opinions regarding whether one source is more credible than another, leaving it to the reader to develop his/her conclusions.

We note the proposed bill does not define behavioral health services. There may be differences between insurers in the definition of behavioral health services.

NovaRest estimates the impact on requiring behavioral health services to be reimbursed at the same rate for telehealth and in-person ranges from 0.1% to 0.3% on a percentage of premium basis, and $0.62 to $1.73 on a per member per month (PMPM) basis.

The Draft Bill does not appear to require new services or an expansion of services, and therefore we do not believe it will result in defrayal costs to the state. However, this is not a legal interpretation, nor should it be considered legal advice.

II. Process

NovaRest was charged with addressing the following questions regarding this Draft Bill:

- The extent to which the coverage will increase or decrease the cost of the service;
- The extent to which the coverage will increase the appropriate use of the service;
- The extent to which the coverage will increase or decrease the administrative expenses of insurers, including health maintenance organizations, or other organizations authorized to provide health benefit plans in the State, and the premium and administrative expenses of policyholders and contract holders; and
- The impact of this coverage on the total cost of health care.

III. Coverage of Telehealth Benefits

26.1-36-09.15 of the North Dakota Century Code currently requires medically necessary health services delivered by telehealth be the same as in-person, if services are currently covered and reimbursed in-person. The proposed amendments include:

1. Providers are not required to provide services using telehealth if they determined telehealth is inappropriate or patient chooses not to receive services through telehealth.
2. Insurers may require providers to demonstrate safety and efficacy if the insurer does not currently cover that service through telehealth.
3. Insurers may establish medical management if not unduly burdensome or unreasonable for a service.
4. Insurers may require documentation or billing practices to protect from fraudulent claims if not unduly burdensome or unreasonable for a service.
5. Insurers are not required to cover audio-only unless it was a scheduled appointment and service can be met through audio-only.
6. Insurers may not require patient to pay a fee to download software to facilitate telehealth.

We do not believe these proposed amendments will have a significant impact on premiums. The addition of medical management may lower premiums, but we do not have data on the use of the medical management that is currently used by insurers and cannot estimate the premium savings if medical management is not currently used. Additionally, restrictions on audio-only may have an impact on premiums, however, we do not have data on the use of audio-only services if they are currently covered and cannot estimate an impact.

The Draft Bill also requires that insurers that provide behavioral health services must provide the same coverage and reimbursement for medically necessary behavioral health using telehealth as in-person

1. Insurers may not limit or deny reimbursement based solely on providing telehealth instead of in-person.
2. Insurers may not limit or deny reimbursement based solely on technology used if it is appropriate for a service.
3. Insurers or providers are not prohibited from entering into a contract that includes value-based reimbursement arrangement that may include telehealth.
4. Behavioral health through telehealth must be covered through audio-only if a scheduled appointment is not possible, i.e. emergency or crisis.

Unlike other telehealth services, the Draft Bill specifies reimbursement for behavioral health services provided through telehealth must be the same as in-person, which we believe will have a slight premium impact.

Prevalence of Coverage

Per 26.1-36-09.15 of the North Dakota Century Code, medically necessary health services are currently delivered by telehealth same as in-person, if services are currently covered and reimbursed in-person. We do not believe the Draft Bill would add health services that are not currently covered, instead it adds clarification around telehealth services and requires medically necessary behavioral health services provided via telehealth be reimbursed at the same rate as in-person.

Insurer Comments About Bill Language

1. No insurer indicated any material benefits or savings due to the Draft Bill.
2. The Draft Bill would not allow insurers to offer behavioral health services provided by telehealth at more favorable cost-sharing to members. Currently some behavioral health services provided by telehealth are provided at lower cost-sharing for members. Consider modifying bill to allow insurers to provide behavioral health services provided by telehealth at more favorable cost sharing for members.
3. Allowing providers and plans to negotiate reimbursement can result in savings to consumers. By establishing reimbursement requirements for behavioral health services delivered via telehealth, this bill may not allow for those savings.
4. Demand for behavioral health services – in-person and virtually – has been and will continue to be at a very heightened state. Due in part to a lack of providers in this practice area, members and patients are experiencing wait times to see these providers. The current landscape of providers and other access barriers must be noted in scoping the larger context of this legislative proposal.
5. Two sets of criteria (one for behavioral health and another for non-behavioral health) for audio-only as included in the Draft Bill could cause confusion.
6. Audio-only medical visits are not the same level of care as an in-person visit. Exceptions for audio-only should include when patient and provider are having connectivity issues or where there is medical evidence that indicates that an audio-only visit will meet the patient's needs. There are fraud/waster/abuse concerns with audio-only.

Questions Concerning Mandated Coverage for Public Employee Fertility Health Benefits

The extent to which the coverage will increase or decrease the cost of the service.

Mandating a service or product increases the demand for that service or product, which typically increases the cost of the service, where allowed. Insurers can offset this upward pressure on price by contracting with providers and/or using managed care protocols.

Medically necessary health services are already covered via telehealth if provided in-person. Implementation of medical management and additional criteria around audio-only services may cause a decrease in the usage of services, however, we do not believe the decrease will be significant enough to change the cost of a service.

The Draft Bill will require medically necessary behavioral health services to be reimbursed at the same rate for telehealth and in-person, which will increase the cost of behavioral health services for insurers that currently do not reimburse at the same rate, which is most of the market.

Insurers in the data call noted they did not believe there were benefits or savings from the Draft Bill. They also noted mandating reimbursement limits the potential savings to consumers related to negotiating telehealth reimbursement.

The extent to which the coverage will increase the appropriate use of the service.
The Draft Bill will allow insurers to implement medical management techniques if not unduly burdensome or unreasonable for a particular health service. We are not clear on how unduly burdensome or unreasonable is determined, although it appears to be written to allow insurers to reduce inappropriate use of services.

If reimbursement rates for behavioral health services delivered by telehealth are required to increase to meet the in-person reimbursement rates, we expect higher out-of-pocket member costs could decrease use of the service, although this may be offset by the reduction in transportation costs members pay for in-person visits.

There is insurer concern about fraud/waste/abuse with audio only visits. Also, because audio only requirements vary between behavioral health and non-behavioral health services, there is concern this will cause confusion.

The extent to which the coverage will increase or decrease the administrative expenses of insurers, including health maintenance organizations, or other organizations authorized to provide health benefit plans in the State, and the premium and administrative expenses of policyholders and contract holders.
Depending on the level of medical management techniques implemented, there may be an increase in administrative costs, although there is no requirement that medical management is used so we cannot estimate the cost.

Requiring behavioral health services to be reimbursed at the same rate for telehealth and in-person may decrease negotiation time with telehealth providers but may increase negotiation time with in-person providers so we cannot estimate any cost impact. Additionally, increasing reimbursement may increase the number of behavioral health claims which may impact claims processing administrative costs, but we do not believe that the increase will be significant.

The impact of this coverage on the total cost of health care.

Changes to the cost of the service or utilization of the service would impact the total cost of health care, some of this cost may be offset by the use of medical management. Increasing the reimbursement for telehealth behavioral health services will cause the largest increase in the total cost of health care as estimated below.

NovaRest Estimate

Data

- 2021 National Association of Insurance Commissioners (NAIC) Supplemental Health Care Exhibit (SHCE) for insurers in North Dakota
- Plan year 2023 Unified Rate Review Template (URRT) for insurers in North Dakota
- Data call to North Dakota insurers regarding current behavioral health telehealth reimbursement and expectations regarding the Draft Bill.

Assumptions

- Percentage of total health spending for behavioral health services is between 4.4%[1] and 8.2%.[2]
- Assume inpatient medically necessary behavioral health services could not be provided through telehealth.
- 20% of behavioral health services are inpatient.[3]
- Percentage of outpatient behavioral health provided through telehealth is between 36%[4] and 40%.[5]
- Average reimbursement for medically necessary behavioral health services provided through telehealth is approximately 93% of in-person reimbursement.[6]
- Assume an 83% loss ratio.[7]
- An annual trend factor of 5.5% was applied to both incurred claims PMPM and premiums PMPM.[8]
- Assume copay or coinsurance % would not change for behavioral health as a result of the proposed benefit.
- Assume in-person reimbursement will not decrease to match telehealth impact.

[1] https://www.nationalalliancehealth.org/www/initiatives/initiatives-national/workplace-mental-health/pathforward/milliman-report
[2] https://www.axios.com/2022/09/14/mental-health-spending-rises-chart
[3] https://store.samhsa.gov/sites/default/files/d7/priv/bhsua-2006-2015-508.pdf
[4] https://www.kff.org/coronavirus-covid-19/issue-brief/telehealth-has-played-an-outsized-role-meeting-mental-health-needs-during-the-covid-19-pandemic/
[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9412131/
[6] Based on insurer data call responses
[7] Medical loss ratio threshold for individual and small group ACA is 80%, while the medical loss ratio threshold for large group is 85%. Our assumption of 83% is a members weighted average based on market size.
[8] Projected Private Health Insurance Spending Per Enrollee 2021. National Health Care Expenditures: Table 17 Health Insurance Enrollment and Enrollment Growth Rates.

Methodology

- Percentage of total health spending related to behavioral health applied against the market average incurred claims provides the estimated claims related to behavioral health.
- Removing inpatient behavioral health and applying the percentage of outpatient behavioral health delivered through telehealth to the estimated claims related to behavioral health provides the estimated behavioral health claims delivered through telehealth.
- Increase behavioral health claims delivered through telehealth by the difference between the reimbursement for telehealth versus in-person behavioral health services to determine the claim impact of increasing reimbursement for behavioral health services provided through telehealth.
- Apply loss ratio to determine premium impact of increasing reimbursement for behavioral health services provided through telehealth.

Cost

We estimate the Draft Bill would increase premiums by an average of 0.1% to 0.3%, or $0.62 PMPM to $1.73 PMPM. We note that this impact will vary by insurer, based on reimbursement levels and usage of behavioral health services delivered through telehealth.

Insurers Estimate

Insurers included in our data call estimated an impact of 0.0% to 0.2% of fully insured premium.

Difficulties in insurers providing estimates included the timeframe of the data call and the Public Health Emergency which permitted flexibility in provider coding for telehealth services making it difficult to estimate claims, utilization, and financial trends on currently or recently available claims data.

IV. Other State Telemedicine Laws

Forty-three states and the District of Columbia, require "service parity" requiring commercial insurers to cover telehealth.[9] This includes North Dakota. The only states without a reference to service parity are Alabama, Idaho, North Carolina, Pennsylvania, South Carolina, Wisconsin, and Wyoming.[10] This, however, does not require services provided by telehealth be reimbursed at the same rate as services provided by in-person means, which we call "payment parity."

[9] "Understanding The Case For Telehealth Payment Parity", Health Affairs Blog, May 10, 2021. DOI: 10.1377/hblog20210503.625394

[10] "Private Payer Parity." CCHP. https://www.cchpca.org/topic/parity/ . Accessed January 4, 2023.

Compared to service parity only 27 states offer some form payment parity.[11] Of these states, Connecticut, Maryland, New York, and Vermont are offering payment parity for a temporary amount of time.[12] Additionally, of these 27 states: Arizona, Illinois (after a temporary period), Iowa, Massachusetts, Nebraska, and Utah all appear to require payment parity only for behavioral health services or mental health services consistent with the Draft Bill. [13]

V. Limitations

NovaRest has prepared this report in conformity with its intended use by persons technically competent to evaluate our estimate regarding the Draft Bill. Any judgments as to the data contained in the report or conclusions about the ramifications of that data should be made only after reviewing the report in its entirety, as the conclusions reached by review of a section or sections on an isolated basis may be incorrect. Appropriate staff is available to explain and/or clarify any matter presented herein. It is assumed that any user of this report will seek such explanations as to any matter in question.

NovaRest did not have access to actual insurer claims data by service type or reimbursement rates. NovaRest has developed projections in conformity with what we believe to be the current and proposed operating environments and are based on best estimates of future experience within such environments. It should be recognized that actual future results may vary from those projected in this report. Factors that may cause the actual results to vary from the projected include new insurance regulations, differences in implementation of the required coverage by insurer, changes in medical treatments and practices, accounting practices, changes in federal and/or local taxation, external economic factors such as inflation rates, investment yields and ratings, and inherent potential for normal random fluctuations in experience.

VI. Reliance and Qualifications

We are providing this report to you solely to communicate our findings and analysis of the Draft Bill. The reliance of parties other than the North Dakota Legislative Council (NDLC) on any aspect of our work is not authorized by us and is done at their own risk.

To arrive at our estimate, we made use of information provided by insurers included in the data call and other public sources. We did not perform an independent investigation or verification. If this information was in any way inaccurate, incomplete, or out of date, the findings and conclusions in this report may require revision.

This memorandum has been prepared in conformity with the applicable Actuarial Standards of Practice.

We have no conflicts of interest in performing this review and providing this report.

[11] Ibid.
[12] Ibid.
[13] Ibid.

We are members of the American Academy of Actuaries and meet that body's Qualification Standards to render this opinion. We meet the Qualification Standards promulgated by these professional organizations to perform the analyses and opine upon the results presented in this Actuarial Report.

Appendix A: Definitions

a) "Distant site" means a site at which a health care provider or health care facility is located while providing medical services by means of telehealth.

b) "Health care facility" means any office or institution at which health services are provided. The term includes hospitals; clinics; ambulatory surgery centers; outpatient care facilities; nursing homes; nursing, basic, long-term, or assisted living facilities; laboratories; and offices of any health care provider.

c) "Health care provider" includes an individual licensed under chapter 43-05, 43-06, 43-12.1 as a registered nurse or as an advanced practice registered nurse, 43-13, 43-15, 43-17, 43-26.1, 43-28, 43-32, 43-37, 43-40, 43-41, 43-42, 43-44, 43-45, 43-47, 43-58, or 43-60.

d) "Originating site" means a site at which a patient is located at the time health services are provided to the patient by means of telehealth.

e) "Policy" means an accident and health insurance policy, contract, or evidence of coverage on a group, individual, blanket, franchise, or association basis.

f) "Store-and-forward technology" means asynchronous electronic transfer or transmission of a patient's medical information or data from an originating site to a distant site for the purpose of diagnostic and therapeutic assistance in the care of a patient.

g) "Telehealth":

1) Means the delivery of health services or consultations through the use of real-time two - way interactive audio and visual communications to provide or support health care delivery and facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care.

2) Includes the application of secure video conferencing, store-and-forward technology, and synchronous interactions between a patient located at an originating site and a health care provider located at a distant site.

3) Includes audio-only communication between a health care provider and a patient as authorized under this section.

4) Does not include communication between health care providers which consists solely of a telephone conversation, electronic mail, or facsimile transmission.

5) Does not include communication between a health care provider and a patient which consists solely of an electronic mail or facsimile transmission.

6) Does not include telemonitoring services.

h) "Telemonitoring services" means the remote monitoring of clinical data related to the patient's vital signs or biometric data by a monitoring device or equipment that transmits the data electronically to a health care provider for analysis.

Telemonitoring is intended to collect a patient's health-related data for the purpose of assisting a health care provider in assessing and monitoring the patient's medical condition or status.

www.ataaction.org

ata ACTION
Telehealth Policy to Transform Healthcare

January 23, 2023

Chair Lee
jlee@ndlegis.gov
Senate Committee on Human Services
State Capitol
600 East Boulevard
Fort Lincoln Room
Bismarck, ND 58505-0360

RE: ATA ACTION SUPPORT WITH AMENDMENT FOR SENATE BILL 2160

Dear Chair Lee and the North Dakota Senate Committee on Human Services,

On behalf of ATA Action, I am writing you to express our support for and offer comments on Senate Bill 2160 relating to health insurance coverage of telehealth.

ATA Action, the American Telemedicine Association's affiliated trade association focused on advocacy, advances policy to ensure all individuals have permanent access to telehealth services across the care continuum. ATA Action supports the enactment of state and federal telehealth coverage and fair payment policies to secure telehealth access for all Americans, including those in rural and underserved communities. ATA Action recognizes that telehealth and virtual care have the potential to truly transform the health care delivery system – by improving patient outcomes, enhancing safety and effectiveness of care, addressing health disparities, and reducing costs – if only allowed to flourish.

Senate Bill 2160 serves as a step forward for ensuring patient access to telehealth in North Dakota, however there are some changes to the bill language ATA Action suggests the Committee adopt. ATA Action appreciates your efforts to clarify rules on telehealth and safeguard the ability for patients to receive insurance coverage for telehealth services. However, ATA Action recommends clarifying the language regarding audio only modality and including telemonitoring services for purposes of telehealth coverage.

We appreciate the inclusion of "audio-only" communication for purposes of authorized telehealth service, however, we find this appears to conflict with section g(4) which states that telehealth does not include care provided solely via a "telephone conversation." As telephone conversations are an "audio-only" modality, ATA Action recommends striking "telephone conversation" from subsection g(4). Not doing so, and passing this legislation as is, risks considerable provider confusion over what types of audio-only modalities may be allowed.

Overall, ATA Action supports a modality neutral approach so that patients and doctors have the freedom to decide the most effective care delivery that works for them on a case-by-case basis.

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ata ACTION
Telehealth Policy to Transform Healthcare

So long as the standard of care is met, audio-only or asynchronous care increases access to care, particularly for vulnerable communities. Rural and low-income populations often experience difficulty receiving care because of technological or convenience barriers, which can be overcome by different telehealth modalities, especially audio-only telephone calls.

Additionally, it appears the bill creates a new definition of "telemonitoring services", commonly referred to as "remote patient monitoring" ("RPM"), and then excludes these telemonitoring services from the definition of telehealth. RPM is simply another way for providers to efficiently gather patient data and better inform healthcare decision making. RPM can especially assist patients who deal with chronic or acute health illnesses. Evidence shows RPM is increasingly an invaluable component of providing healthcare, especially in rural areas.[1] RPM can be used to bridge the gap between rural/low income North Dakotans and effective healthcare by eliminating the need for extensive travel or a large time commitment to receive care. Highlighting this rural impact, a recent healthcare publication even noted "RPM is helping to bring about the efficiency short-staffed rural hospitals so desperately need through a technology-based team approach to patient care."[2]

In line with the above-mentioned tech neutral policy principles and given the evidence showing the effectiveness of using RPM, ATA Action believes that RPM is an integral part of the future of telehealth that should by covered by insurance as with any other healthcare service. Therefore, ATA Action suggests including telemonitoring services for the purposes of the definition of telehealth.

ATA Action is not alone in its opinion of RPM; the Federation of State Medical Boards, founded in 1912 and comprised of 71 state medical and osteopathic boards, recommended including RPM for purposes of telehealth delivery in their recently released model telemedicine guidelines, stating remote patient monitoring can "permit physicians to obtain medical histories, give medical advice and counseling, and prescribe medication and other treatments."[3]

The North Dakota Division of Medical Assistance Regulations also endorses RPM for purposes of Medicaid coverage in their revised regulations released in October 2022, which provide for similar coverage of "Home Health Telemonitoring."[4] ATA Action recommends that coverage for telehealth services should be tech-neutral, whether that coverage is public or private payer reimbursed.

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[1] See Managed Healthcare Executive, " How Rural Hospitals Are Benefiting from Remote Patient Monitoring", March 30, 2022, https://www.managedhealthcareexecutive.com/view/how-rural-hospitals-are-benefiting-from-remote-patient-monitoring

[2] Id.

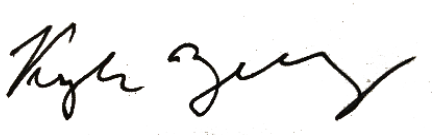
[3] See Federation of State Medical Boards, "The Appropriate Use of Telemedicine Technologies in the Practice of Medicine", page 3, April 2022, https://www.fsmb.org/siteassets/advocacy/policies/fsmb-workgroup-on-telemedicineapril-2022-final.pdf.

[4] See North Dakota HHS, "North Dakota Medicaid and Other Medical Assistance Programs General Information for Providers", page 65, October 2022, https://www.nd.gov/dhs/services/medicalserv/medicaid/docs/general-information-medicaid-provider-manual.pdf

Telehealth Policy to Transform Healthcare

Thank you again for your support for telehealth. We support the passage of this bill with the revisions outlined above in the interest of expanding North Dakotans' access to affordable, high-quality care. Please let us know if there is anything that we can do to assist you in your efforts to adopt practical telehealth policy in North Dakota. If you have any questions or would like to engage in additional discussion regarding the telemedicine industry's perspective, please contact me at kzebley@ataaction.org.

Kind regards,



Kyle Zebley
Executive Director
ATA Action

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The North Dakota Rural Health Association's mission is to bring together diverse interests and provide a unified voice to promote and enhance the quality of rural health through leadership, advocacy, coalition building, education and communication.

Visit the NDRHA website at ndrha.org!

Senate Human Services Committee
SB 2160
February 14, 2023

Chair Lee and committee members, thank you for this opportunity to weigh in on this important issue to healthcare in North Dakota. My name is Kylie Nissen and I am the executive director of the North Dakota Rural Health Association.

The North Dakota Rural Health Association's (NDRHA) mission is to bring together diverse interests and provide a unified voice to promote and enhance the quality of rural health through leadership, advocacy, coalition building, education and communication. Our vision is to be an effective advocate for improving health for rural North Dakotans and to promotes public awareness and understanding of North Dakota's rural healthcare problems.

NDRHA supports measures that help the state's rural providers utilize the telehealth services that have been shown throughout the pandemic to facilitate stable and consistent medical care without a patient ever stepping foot into a clinic or facility. For rural communities throughout North Dakota, the full use of telehealth can de-escalate crises, refill needed medications and provide guidance to other practitioners to make better diagnostic decisions and referrals. Increased telehealth utilization will also help alleviate the already limited healthcare workforce and ensure patients have timely access to quality behavioral health services.

For these reasons, NDRHA asks this committee to take up the Schulte Report's recommendations to address any regulatory hurdles preventing the full usage of tele-behavioral health services in rural North Dakota. Making sure that tele-behavioral health services are reimbursed at the same levels as in-person behavioral services is critical to ramp up tele-behavioral health services. We, therefore, urge a DO PASS recommendation for SB 2160.

Thank you for your time and consideration.

Sincerely,

Kylie Nissen, Executive Director
North Dakota Rural Health Assocaition

NORTH DAKOTA PSYCHIATRIC SOCIETY
A District Branch of the American Psychiatric Association

February 14th, 2023
From: ND Psychiatric Society and ND Medical Association
Re: In Support of SB 2160

Madam Chair Lee, esteemed Committee Members,

My name is Gabriela Balf, I am a psychiatrist in Bismarck who serves patients from everywhere in this state, of ages 11 through 91, with a flexible schedule to accommodate people of all professions, schedule made possible by telehealth availability. I speak on my behalf and also on behalf of NDMA and NDPS.

We are writing you to express our full support for SB 2160. This is such an important bill for our rural state, that has experienced an unprecedented relief in access to care since telehealth was made possible.

We are still learning about the full impact of telehealth availability on patients' health outcomes, satisfaction, decision to seek and stay engaged in therapy, as well as the outcomes on decreasing ED visits, need for hospitalization, etc. There have been recent attempts at quantifying the costs and benefits of telehealth (Hilty et al 2023) and, in US, where reporting rules and insurer coverages vary widely, it has been a complicated proposition. We do not routinely calculate into the costs and benefits the patient's side variables like avoided mortality, increased medical adherence, reduced medical complications, gain in statistical life year value, missed work/school/time away from family, reduced child/family care costs, etc. Nor do we routinely collect data about the provider/healthcare costs: provider's windshield time, avoided referrals, reduced hospital length of stay, etc. There are costs to the healthcare systems like implementing the new systems required for telehealth (largely in place by now), and benefits like increased productivity (less no-shows, etc), increased access to care for special groups like elderly, veterans, rural areas, etc. (see Appendix.)

In countries where there are a single payer and homogenous reporting rules and care guidelines, and in the Veteran Administration System with its contained and well documented care delivery, we have learned that:

- Telehealth used to triage pre-hospital, primary care conditions has resulted in reducing the number of ED visits by 6.7% AND cost savings of $2,468 savings per ED visit (Langabeer et al, 2017)
- In Australia, a study of pre-hospital video triage of mental health calls for adults over 14 months showed a reduction in ED visits of 17%, and a proportional cost reduction- (a video visit costs half of an ED evaluation) with no negative outcomes (Nehme et al 2022)
- In a recent Ontario-based study (Serhal et al 2020), Telepsychiatry vs Psychiatrist Outreach vs patient travel reimbursement for in-person visits yielded costs of CAD$360 vs CAD$558 vs CAD$620, respectively. In studies using real-data-based Computer simulations, telepsychiatry was the least costly program in 71.2% of the simulations.
- In VA, veterans sought substance use disorder treatment in telepsychiatry vs in person ratio of 58% vs 28%, and remained engaged in the telepsychiatry cohort over 6 months 2.6 more likely than the in-person cohort (Sistad et al 2023)

- In VA, where telehealth for geriatric care was implemented on a large scale since 2014, the degree of satisfaction, quality of life, number of medication adverse effects and diabetes, heart failure, hypertension and mental health outcomes have improved significantly (the GRECC Connect project VA- Rural Health Outreach 2022)

  There are several well-designed and conducted studies that attest the superiority of treating even high-intensity treatment requiring adolescents with eating disorders via telehealth vs in-person, reduction in odds of fatal overdoses due to telehealth availability for medication assisted treatment for opioid use disorder, (Jones at al 2022), etc.

  Finally, Project ECHO® (Extension for Community Healthcare Outcomes) invented in 2003 and now expanded internationally, is an online collaboration specialist-primary care, "Moving knowledge, not people," that has reduced wait times from months to days. It is currently implemented in ND for Geriatrics, Infectious Diseases, Psychiatry, Pediatrics, Gastrointestinal diseases.

  In my experience, I have seen the same costs of running a business on telehealth and in person – since many high costs are fixed: electronic health records, employee salary, employee benefits, malpractice insurance, rent, time spent on prior authorizations etc.

  The benefits, however, are huge:

- Increased access to care:
  - Elderly who otherwise would not be able to come for regular visits;
  - People who depend on others for transportation;
  - People who would need to find child or adult care for visits;
  - Children/adolescents who would need to miss school, and have their parent miss work to bring them to the office;
  - People with PTSD who avoid crowds, office settings, etc.;
- My no-show rate went down from 10% (usual rate in clinics is 25%) to 1 / year.
- Increased availability on my part- I can now easily offer evening or weekend hours.
- Avoided hospitalizations: I can see a person even daily, without the side effect of this intense monitoring being a financial burden – we have avoided inpatient level of care so many times this way.
- Services offered to patients who otherwise may avoid seeking care: people with substance use disorder, professionals, etc.

Thank you for your proactive thinking in keeping the telehealth available in our rural state.

I stand for questions.

Gabriela Balf, MD, MPH
Clin Assoc Prof UND Dept of Psychiatry and Behavioral Science
Project ECHO® partner
NDPS Past-President

Table 3. Clinical (Patient), Administrative (Provider, System), and Economic Measures and Outcomes for Health Care and Telehealth

	PATIENT/FAMILY/ CARETAKER	UNIT (MONETARY CONVERSION)	PROVIDER/ HEALTH CARE ORGANIZATIONS	UNIT (MONETARY CONVERSION)	GOVERNMENT/ HEALTH CARE SYSTEM	UNIT (MONETARY CONVERSION)
Costs						
Fixed	N/A	N/A	Equipment/technology/ depreciation Facilities/office expenses	$	Cost to the taxpayer	$
Variable	N/A	N/A	Maintenance and repairs Telecommunications costs Admin support/staffing Sundry office expenses	$	Cost to private insurers	$
Other	Time/money	$	Travel Stipends Training Promotion	$	Loss of productivity to employers	Hours of lost productivity ($ to pay others to complete work)
Outcomes						
Clinical	Reduced morbidity Avoided mortality Increased access to health care Increased health knowledge/ability for self-care Faster/more accurate diagnosis and treatment Increased medical adherence	Change in QALY/DALY/ LYGS (value of a statistical life year from the value of a statistical life)	Reduced length of stay Avoided hospitalizations/ readmission Avoided laboratory costs Avoided patient transport Avoided physician visits Avoided referrals Avoided ED visits Reduced length of visit Increased medical adherence Increased knowledge transfer (between providers) Increased accuracy	Average context-specific charges for hospitalizations/ readmission, ED visit, laboratory tests, patient transport, physician/specialist fee, health care services	Increased productivity	Avoided missed days/hours of employment time (average or minimum context-specific wage rate-hourly/daily)
Nonclinical	Increased earnings Decreased risk of job loss/less time away from work Reduced child/family care costs Increased employment/ leisure/classroom/family time Reduced wait time or consultation time	Missed hours/days work/class/time away from family avoided (average or minimum context-specific wage rate-hourly or daily)	Increased productivity	Wages ($ by day/ hour)	More efficient access to health for special groups, reduced patient travel costs, and staff costs	Distance to referral facility and days/ hours of work for staff (mileage allowance rate for transportation and average daily/hourly staffing rate)
Travel costs	Avoided travel expenditures (transportation/ accommodation, etc.)	Average cost for hotel, transportation, meals (dollars)	Avoided travel costs, reduced transportation time, avoided travel stipends, or lost income from travel	($ by mileage/costs of transportation or accommodations, travel stipends)	Avoided cases of communicable disease or chronic illnesses	Cases of: average medical costs (e.g., health care utilization, per case), average avoided loss of wages, and reduced wages for temporary staff
Satisfaction	Patient satisfaction	Willingness to pay	Provider satisfaction with the model	Willingness to pay		

Adapted from Dávalos et al.[10]

DALY, disability-adjusted life year; ED, emergency department; LYGS, life years gained.

Appendix

Hilty, D. M., Serhal, E., & Crawford, A. (2023). A Telehealth and Telepsychiatry Economic Cost Analysis Framework: Scoping Review. Telemedicine and E-Health, 29(1), 23–37. https://doi.org/10.1089/tmj.2022.0016

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February 14, 2023

Senator Judy Lee, Chairman
Senate Human Services Committee
North Dakota State Capitol, Pioneer Room
600 East Boulevard Avenue
Bismarck, North Dakota 58505

Senator Sean Cleary, Vice-Chairman
Senate Human Services Committee
North Dakota State Capitol, Pioneer Room
600 East Boulevard Avenue
Bismarck, North Dakota 58505

RE: AHIP Concerns on SB 2160 *Health Insurance Coverage of Telehealth*

Dear Chairman Lee, Vice-Chairman Cleary, and Committee members,

I am writing on behalf of AHIP to submit comments on SB 2160 *Health Insurance Coverage of Telehealth*. We appreciate the opportunity to provide feedback on the legislation and your consideration of our concerns.

Everyone deserves access to effective, affordable, and equitable mental health support and counseling, at a price they can afford. For years, health insurance providers have offered access to virtual health services and competed to bring new, cutting-edge, innovative tools to their members. Telehealth delivers convenient access to affordable, high-quality care. Tele-mental health support has been the single biggest area for growth since the COVID-19 crisis and has continued at a high level, as many new patients decided to engage with a mental health specialist via telehealth.

Health insurance providers are committed to ensuring that telehealth and other forms of virtual care are used to improve affordable access to care for all patients. Telehealth provides a unique opportunity to improve both affordability and access to mental health support and counseling for North Dakotans.

Telehealth can be a tool to reduce costs for both patients and providers. As health care costs continue to escalate, health insurance providers use every opportunity to deliver the administrative cost savings that telehealth brings to consumers and patients. Some of the shared cost-saving benefits of telehealth include more convenient appointment times for patients and reduced travel times. By delivering high-quality care through a convenient medium and at an affordable price, providers view telehealth as an effective and efficient way to improve care outcomes and make certain that patients get the right care, at the right time, and in the right setting. Telehealth for mental health support can also help reduce stigma as individuals can access care from the privacy of their home.

AHIP is concerned SB 2160 may increase premiums and impede access to affordable mental health support provided through telehealth services. As noted by NovaRest[1] in the analysis of SB 2160, AHIP is concerned the payment parity provisions of SB 2160 will increase health care costs and increase North Dakotans' out-of-pocket costs for mental health support provided through telehealth services. We respectfully request for this provision to be removed.

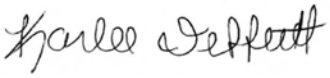
[1] NovaRest, Analysis of LC 23.0547.0200 Relating to Health Insurance Coverage of Telehealth, January 6, 2023.

Telehealth visits do not always require the same level of intensity, same amount of time, or the same equipment as in-person visits and thus should not be required to be reimbursed equally. In order to maintain the cost saving potential of telehealth, health insurance providers should not be mandated to provide payment parity between virtual and in-person visits.

For patients with coinsurance or who have not met their deductible, mandating a higher reimbursement rate for a telehealth visit may directly translate to higher out-of-pocket costs to the patient. Telehealth savings are passed on to employers and consumers through lower premium rates or more robust health insurance coverage benefits, and directly to patients through lower cost-shares, such as coinsurance or unmet deductibles. This requirement in SB 2160 will negatively impact health plans' ability to design benefits that meet patients' needs while offering lower cost alternatives.

We appreciate the opportunity to share our concerns and your consideration of our comments. We urge the Human Services Committee to allow health insurance providers the flexibility in negotiating appropriate payment rates for telehealth services.

Sincerely,



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AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone. Visit www.ahip.org to learn how working together, we are Guiding Greater Health.

23.0547.02001
Title.

Prepared by the Legislative Council staff for
Senator Lee
February 13, 2023

PROPOSED AMENDMENTS TO SENATE BILL NO. 2160

Page 1, line 8, after "a." insert ""Behavioral health" has the same meaning as provided under section 50-06-01.

b."

Page 1, line 10, overstrike "b."

Page 1, line 12, remove the overstrike over "~~c.~~" and insert immediately thereafter ""Health benefit plan" has the same meaning as provided under section 26.1-36.3-01.

d."

Page 1, line 16, replace "c." with "e."

Page 1, line 22, remove the overstrike over "~~f.~~"

Page 1, line 22, remove "d."

Page 2, line 1, remove "e."

Page 2, line 1, overstrike ""Policy" means an accident and health insurance policy, contract, or evidence of"

Page 2, overstrike line 2

Page 2, line 7, replace "f." with "g."

Page 2, line 15, replace "g." with "h."

Page 3, line 13, replace "h." with "i."

Page 3, line 19, overstrike "policy" and insert immediately thereafter "health benefit plan"

Page 3, line 20, overstrike "policy" and insert immediately thereafter "health benefit plan"

Page 3, line 20, remove "medically necessary"

Page 4, line 17, replace "policy" with "health benefit plan"

Page 4, line 17, after "provides" insert "behavioral"

Page 4, line 18, remove "for behavioral health"

Page 4, line 18, replace "policy" with "health benefit plan"

Page 4, line 18, remove the second "coverage"

Page 4, line 19, replace "and" with "rate of"

Page 4, line 19, remove "for medically necessary health services"

Page 4, line 20, remove "which is the same"

Page 4, line 20, replace "coverage and" with "rate of"

Page 4, line 21, remove "medically necessary"

Page 4, line 23, remove "Under this subsection, an insurer may not deny or limit reimbursement based"

Page 4, remove lines 24 and 25

Page 4, line 26, remove "b."

Page 4, line 26, after "limit" insert "the rate of"

Page 4, line 28, after the first "the" insert "behavioral"

Page 4, line 28, remove "care"

Page 4, line 29, after the first "the" insert "behavioral"

Page 4, line 29, remove "care"

Page 5, line 1, replace "c." with "b."

Page 5, line 6, replace "d." with "c."

Page 5, line 21, overstrike "policy" and insert immediately thereafter "health benefit plan"

Page 5, line 22, overstrike "policy" and insert immediately thereafter "health benefit plan"

Page 5, line 23, overstrike "policy" and insert immediately thereafter "health benefit plan"

Page 5, line 24, overstrike "policy" and insert immediately thereafter "health benefit plan"

Page 5, line 26, overstrike "policy" and insert immediately thereafter "health benefit plan"

Page 5, line 27, overstrike "policy" and insert immediately thereafter "health benefit plan"

Renumber accordingly

23.0547.02001

Sixty-eighth
Legislative Assembly
of North Dakota

SENATE BILL NO. 2160

Introduced by

Senators Lee, Hogan, K. Roers

Representatives Dobervich, Porter, Weisz

A BILL for an Act to amend and reenact section 26.1-36-09.15 of the North Dakota Century Code, relating to health insurance coverage of telehealth.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-36-09.15 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36-09.15. Coverage of telehealth services.

1. As used in this section:

   a. "Behavioral health" has the same meaning as provided under section 50-06-01.

   b. "Distant site" means a site at which a health care provider or health care facility is located while providing medical services by means of telehealth.

   ~~b. "E-visit" means a face-to-face digital communication initiated by a patient to a provider through the provider's online patient portal.~~

   c. "Health benefit plan" has the same meaning as provided under section 26.1-36.3-01.

   d. "Health care facility" means any office or institution at which health services are provided. The term includes hospitals; clinics; ambulatory surgery centers; outpatient care facilities; nursing homes; nursing, basic, long-term, or assisted living facilities; laboratories; and offices of any health care provider.

   ~~d.~~~~c.~~e. "Health care provider" includes an individual licensed under chapter 43-05, 43-06, 43-12.1 as a registered nurse or as an advanced practice registered nurse, 43-13, 43-15, 43-17, 43-26.1, 43-28, 43-32, 43-37, 43-40, 43-41, 43-42, 43-44, 43-45, 43-47, 43-58, or 43-60.

   ~~e. "Nonpublic facing product" means a remote communication product that, as a default, allows only the intended parties to participate in the communication.~~

f.~~d.~~ "Originating site" means a site at which a patient is located at the time health services are provided to the patient by means of telehealth.

~~g.e. "Policy" means an accident and health insurance policy, contract, or evidence of coverage on a group, individual, blanket, franchise, or association basis.~~

~~h. "Secure connection" means a connection made using a nonpublic facing remote communication product that employs end-to-end encryption, and which allows only an individual and the person with whom the individual is communicating to see what is transmitted.~~

~~i.f.~~g. "Store-and-forward technology" means asynchronous electronic ~~information, imaging, and communication that is transferred, recorded, or otherwise stored in order to be reviewed at a distant site at a later date by a health care provider or health care facility without the patient present in real time. The term includes telehome monitoring and interactive audio, video, and data communication~~transfer or transmission of a patient's medical information or data from an originating site to a distant site for the purpose of diagnostic and therapeutic assistance in the care of a patient.

~~j.g.~~h. "Telehealth":

(1) Means the ~~use of interactive audio, video, or other telecommunications technology that is used by a health care provider or health care facility at a distant site to deliver health services at an originating site and that is delivered over a secure connection that complies with the requirements of state and federal laws~~delivery of health services or consultations through the use of real-time two-way interactive audio and visual communications to provide or support health care delivery and facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care.

(2) Includes the ~~use of electronic media for consultation relating to the health care diagnosis or treatment of a patient in real time or through the use of store-and-forward technology~~application of secure video conferencing, store-and-forward technology, and synchronous interactions between a

patient located at an originating site and a health care provider located at a distant site.

(3) Includes audio-only communication between a health care provider and a patient as authorized under this section.

(4) Does not include ~~the use of electronic mail, facsimile transmissions, or audio-only telephone unless for the purpose of e-visits or a virtual check-in~~communication between health care providers which consists solely of a telephone conversation, electronic mail, or facsimile transmission.

(5) Does not include communication between a health care provider and a patient which consists solely of an electronic mail or facsimile transmission.

(6) Does not include telemonitoring services.

~~k. "Virtual check-in" means a brief communication via telephone or other telecommunications device to decide whether an office visit or other service is needed~~

~~h.~~i. "Telemonitoring services" means the remote monitoring of clinical data related to the patient's vital signs or biometric data by a monitoring device or equipment that transmits the data electronically to a health care provider for analysis. Telemonitoring is intended to collect a patient's health-related data for the purpose of assisting a health care provider in assessing and monitoring the patient's medical condition or status.

2. An insurer may not deliver, issue, execute, or renew a ~~policy~~health benefit plan that provides health benefits coverage unless that ~~policy~~health benefit plan provides coverage for ~~medically necessary~~ health services delivered by means of telehealth which is the same as the coverage for covered medically necessary health services delivered by in-person means.

a. This subsection does not require a health care provider to provide telehealth services if the provider determines the delivery of a health service through telehealth is not appropriate or if a patient chooses not to receive a health care service through telehealth.

b. An insurer may establish criteria a health care provider is required to meet to demonstrate safety or efficacy of delivering a health care service through

telehealth if the insurer does not already reimburse other health care providers for delivery of that health service through telehealth.

c. An insurer may establish reasonable medical management techniques if a particular technique is not unduly burdensome or unreasonable for a particular health service.

d. An insurer may require documentation or billing practices designed to protect the health insurer or patient from fraudulent claims if the practices are not unduly burdensome or unreasonable for a particular health service.

e. This section does not require coverage of an audio-only communication unless the communication was a scheduled appointment and the standard of care for that service can be met through the use of audio-only communication.

f. An insurer may not require a patient to pay a fee to download a specific communication technology or application.

3. Payment or reimbursement of expenses for covered health services delivered by means of telehealth under ~~this section~~subsection 2 may be established through negotiations conducted by the insurer with the health services providers in the same manner as the insurer establishes payment or reimbursement of expenses for covered health services that are delivered by in-person means.

4. An insurer may not deliver, issue, execute, or renew a ~~policy~~health benefit plan that provides behavioral health benefits coverage ~~for behavioral health~~ unless that ~~policy~~health benefit plan provides the same ~~coverage and~~rate of reimbursement ~~for medically necessary health services~~ for behavioral health services delivered by means of telehealth ~~which is the same~~ as the ~~coverage and~~rate of reimbursement for covered ~~medically necessary~~ behavioral health services delivered by in-person means.

a. ~~Under this subsection, an insurer may not deny or limit reimbursement based solely on a health care provider delivering the service or consultation through telehealth instead of through in-person means.~~

~~b.~~ Under this subsection, an insurer may not deny or limit the rate of reimbursement based solely on the technology and equipment used by the health care provider to deliver the behavioral health ~~care~~ services or consultation through telehealth, if

the technology and equipment used by the behavioral health ~~care~~ provider meets the requirements of this section and is appropriate for the health service.

~~c.~~b. This subsection does not prohibit a health insurer and health care provider from entering a contract that includes a value-based reimbursement arrangement for the delivery of covered health services that may include services delivered through telehealth, and the arrangement does not constitute a violation of this section.

~~d.~~c. Under this subsection, notwithstanding subsection 2, behavioral health services delivered through telehealth are covered regardless of whether provided by means of audio-only communication and regardless of whether provided as part of a scheduled appointment if the communication was initiated by the patient while in an emergency or crisis situation and a scheduled appointment was not possible due to the need for an immediate response.

5. Coverage under this section may be subject to deductible, coinsurance, and copayment provisions that are no different from the provisions for in-person means. Coverage under this section may be subject to prior authorization if prior authorization is required before the delivery of the same health care service by in-person means. An insurer may require utilization review for health services delivered through telehealth if the utilization review is conducted in the same manner and uses the same clinical review criteria as a utilization review for the same services delivered through in-person means.

~~5.~~6. This section does not require:

a. A ~~policy~~health benefit plan to provide coverage for health services that are not medically necessary, subject to the terms and conditions of the ~~policy~~health benefit plan;

b. A ~~policy~~health benefit plan to provide coverage for health services delivered by means of telehealth if the ~~policy~~health benefit plan would not provide coverage for the health services if delivered by in-person means;

c. A ~~policy~~health benefit plan to reimburse a health care provider or health care facility for expenses for health services delivered by means of telehealth if the

~~policy~~health benefit plan would not reimburse that health care provider or health care facility if the health services had been delivered by in-person means; or

d. A health care provider to be physically present with a patient at the originating site unless the health care provider who is delivering health services by means of telehealth determines the presence of a health care provider is necessary.

Amendment to amendment 23.0547.02001

SB 2160

Page 4, starting at line 19. Subsection 4. will read:

"4. An insurer may not deliver, issue, execute, or renew a health benefit plan that provides behavioral health benefits coverage unless that health benefit plan provides the same rate of reimbursement for behavioral health services delivered by means of telehealth which is the same as the rate of reimbursement for the same behavioral health services delivered by in-person means."

4. An insurer may not deliver, issue, execute, or renew a ~~policy~~ health benefit plan that provides behavioral health benefits coverage ~~for behavioral health~~ unless that ~~policy~~ health benefit plan provides the same ~~coverage and~~ rate of reimbursement ~~for medically necessary health services~~ for behavioral health services delivered by means of telehealth ~~which is the same~~ as the ~~coverage and~~ rate of reimbursement for ~~covered~~ the same ~~medically necessary~~ behavioral health services delivered by in-person means."

ignore! - oops!

23.0547.02002
Title.

Prepared by the Legislative Council staff for
Senate Human Services Committee
February 15, 2023

PROPOSED AMENDMENTS TO SENATE BILL NO. 2160

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact a new section to chapter 54-52.1 of the North Dakota Century Code, relating to public employee telehealth benefits; to provide for a report; to provide for application; to provide an expiration date; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 54-52.1 of the North Dakota Century Code is created and enacted as follows:

Coverage of telehealth services.

1. As used in this section:

   a. "Behavioral health" has the same meaning as provided under section 50-06-01.

   b. "Distant site" means a site at which a health care provider or health care facility is located while providing medical services by means of telehealth.

   c. "Health care facility" means any office or institution at which health services are provided. The term includes hospitals; clinics; ambulatory surgery centers; outpatient care facilities; nursing homes; nursing, basic, long-term, or assisted living facilities; laboratories; and offices of any health care provider.

   d. "Health care provider" includes an individual licensed under chapter 43-05, 43-06, 43-12.1 as a registered nurse or as an advanced practice registered nurse, 43-13, 43-15, 43-17, 43-26.1, 43-28, 43-32, 43-37, 43-40, 43-41, 43-42, 43-44, 43-45, 43-47, 43-58, or 43-60.

   e. "Originating site" means a site at which a patient is located at the time health services are provided to the patient by means of telehealth.

   f. "Store-and-forward technology" means asynchronous electronic transfer or transmission of a patient's medical information or data from an originating site to a distant site for the purpose of diagnostic and therapeutic assistance in the care of a patient.

   g. "Telehealth":

      (1) Means the delivery of health services or consultations through the use of real-time two-way interactive audio and visual communications to provide or support health care delivery and facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care.

(2) Includes the application of secure video conferencing, store-and-forward technology, and synchronous interactions between a patient located at an originating site and a health care provider located at a distant site.

(3) Includes audio-only communication between a health care provider and a patient as authorized under this section.

(4) Does not include communication between health care providers which consists solely of a telephone conversation, electronic mail, or facsimile transmission.

(5) Does not include communication between a health care provider and a patient which consists solely of an electronic mail or facsimile transmission.

(6) Includes telemonitoring services if the:

(a) Telemonitoring services are medically appropriate based on the patient's medical condition or status;

(b) Patient is cognitively and physically capable of operating the monitoring device or equipment, or the patient has a caregiver who is willing and able to assist with the monitoring device or equipment; and

(c) Patient resides in a setting suitable for telemonitoring services and not in a setting that has health care staff on site.

h. "Telemonitoring services" means the remote monitoring of clinical data related to the patient's vital signs or biometric data by a monitoring device or equipment that transmits the data electronically to a health care provider for analysis. Telemonitoring is intended to collect a patient's health-related data for the purpose of assisting a health care provider in assessing and monitoring the patient's medical condition or status.

2. The board shall provide health insurance benefits coverage that provides coverage for health services delivered by means of telehealth which is the same as the coverage for covered medically necessary health services delivered by in-person means.

a. This subsection does not require a health care provider to provide telehealth services if the provider determines the delivery of a health service through telehealth is not appropriate or if a patient chooses not to receive a health care service through telehealth.

b. The coverage may provide criteria a health care provider is required to meet to demonstrate safety or efficacy of delivering a health care service through telehealth if the coverage does not already reimburse other health care providers for delivery of that health service through telehealth.

c. The coverage may provide reasonable medical management techniques if a particular technique is not unduly burdensome or unreasonable for a particular health service.

d. The coverage may require documentation or billing practices designed to protect the insurer or patient from fraudulent claims if the practices are not unduly burdensome or unreasonable for a particular health service.

e. This section does not require coverage of an audio-only communication unless the communication was a scheduled appointment and the standard of care for that service can be met through the use of audio-only communication.

f. The coverage may not require a patient to pay a fee to download a specific communication technology or application.

3. Payment or reimbursement of expenses for covered health services delivered by means of telehealth under subsection 2 may be established through negotiations with the health services providers in the same manner as the coverage establishes payment or reimbursement of expenses for covered health services that are delivered by in-person means.

4. The coverage must provide the same rate of reimbursement for behavioral health services delivered by means of telehealth as the rate of reimbursement for the same behavioral health services delivered by in-person means.

a. Under this subsection, the coverage may not deny or limit the rate of reimbursement based solely on the technology and equipment used by the health care provider to deliver the behavioral health services or consultation through telehealth, if the technology and equipment used by the behavioral health provider meets the requirements of this section and is appropriate for the health service.

b. This subsection does not prohibit a value-based reimbursement arrangement for the delivery of covered health services that may include services delivered through telehealth, and the arrangement does not constitute a violation of this section.

c. Under this subsection, notwithstanding subsection 2, behavioral health services delivered through telehealth are covered regardless of whether provided by means of audio-only communication and regardless of whether provided as part of a scheduled appointment if the communication was initiated by the patient while in an emergency or crisis situation and a scheduled appointment was not possible due to the need for an immediate response.

5. Coverage under this section may be subject to deductible, coinsurance, and copayment provisions that are no different from the provisions for in-person means. Coverage under this section may be subject to prior authorization if prior authorization is required before the delivery of the same health care service by in-person means. Coverage may include utilization review for health services delivered through telehealth if the utilization review is conducted in the same manner and uses the same clinical review criteria as a utilization review for the same services delivered through in-person means.

6. This section does not require:

a. Coverage for health services that are not medically necessary, subject to the terms and conditions of the health benefits coverage;

b. Coverage for health services delivered by means of telehealth if the coverage would not provide coverage for the health services if delivered by in-person means;

c. Reimbursement of a health care provider or health care facility for expenses for health services delivered by means of telehealth if the coverage would not reimburse that health care provider or health care facility if the health services had been delivered by in-person means; or

d. A health care provider to be physically present with a patient at the originating site unless the health care provider who is delivering health services by means of telehealth determines the presence of a health care provider is necessary.

SECTION 2. APPLICATION. This Act applies to public employees retirement system health benefits coverage that begins after June 30, 2023, and which does not extend past June 30, 2025.

SECTION 3. PUBLIC EMPLOYEES RETIREMENT SYSTEM - EXPANDED TELEHEALTH COVERAGE - REPORT. Pursuant to section 54-03-28, the public employees retirement system shall prepare and submit for introduction a bill to the sixty-ninth legislative assembly to repeal the expiration date for this Act and to extend the coverage of expanded telehealth coverage to all group and individual health insurance policies. The public employees retirement system shall append a report to the bill regarding the effect of the expanded telehealth benefits requirement on the system's health insurance programs, information on the utilization and costs relating to the coverage, and a recommendation regarding whether the coverage should be continued.

SECTION 4. EXPIRATION DATE. This Act is effective through July 31, 2025, and after that date is ineffective.

SECTION 5. EMERGENCY. This Act is declared to be an emergency measure."

Renumber accordingly