15.0079.04000

FISCAL NOTE
Requested by Legislative Council
03/26/2015

Amendment to: HB 1038

1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2013-2015 Biennium		2015-2017 Biennium		2017-2019 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues	$0	$0	$0	$0	$0	$0
Expenditures	$0	$0	$0	$0	$0	$0
Appropriations	$0	$0	$0	$0	$0	$0

1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2013-2015 Biennium	2015-2017 Biennium	2017-2019 Biennium
Counties	$0	$0	$0
Cities	$0	$0	$0
School Districts	$0	$0	$0
Townships	$0	$0	$0

2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

Medical benefits coverage of services provided by a health care provider by means of telemedicine.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

The current NDPERS medical benefits cover healthcare facility based services from provider to members, and BCBS has therefore stated that there would be no cost impact if the coverage parameters are not changed. However, BCBS stated that if the intent is to expand coverage of telemedicine mediums other than what is currently covered, there may be additional cost to the plan.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*

Name: Sparb Collins
Agency: NDPERS
Telephone: 701-328-3900
Date Prepared: 01/05/2015

15.0079.03000

FISCAL NOTE
Requested by Legislative Council
12/19/2014

Amendment to: HB 1038

1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

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Name: Sparb Collins
Agency: NDPERS
Telephone: 701-328-3900
Date Prepared: 01/05/2015

15.0079.02000

FISCAL NOTE
Requested by Legislative Council
12/19/2014

Bill/Resolution No.: HB 1038

1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

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	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
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Expenditures	$0	$0	$0	$0	$0	$0
Appropriations	$0	$0	$0	$0	$0	$0

1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2013-2015 Biennium	2015-2017 Biennium	2017-2019 Biennium
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Cities	$0	$0	$0
School Districts	$0	$0	$0
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2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

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Name: Sparb Collins
Agency: NDPERS
Telephone: 701-328-3900
Date Prepared: 01/05/2015

2015 HOUSE GOVERNMENT AND VETERANS AFFAIRS

HB 1038

2015 HOUSE STANDING COMMITTEE MINUTES

Government and Veterans Affairs Committee
Fort Union, State Capitol

HB 1038
1/22/2015
Job #22357

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature	Beckie Strege

Explanation or reason for introduction of bill/resolution:

Relating to PERS uniform group insurance coverage of telemedicine

Minutes: Attachments #1 - 11

Chairman Kasper opened the hearing on HB 1038.

Rep George Keiser, District 47:
(Attachment 1)

I have an amendment that is a technical amendment, but also substantive. This comes from the Interim Health Committee. It adds optometrists to the list of categories in subsection b, lines 15-18. This was an unintentional oversight in the drafting that the Interim Health Committee had.

6:32
One of the issues we examined at length was the issue of telemedicine and its application. We need to separate telemedicine from the traditional concept to the future of telemedicine. I think you will see the potential significance of this. We've had telemedicine and it's has been operational for a long time in our healthcare delivery systems, within our state and around the country. But it is the old telemedicine, and it is still valuable and it will remain valuable where we can basically take information and transport it electronically to a different sit, such as, from a remote area to a major healthcare facility. We have great telemedicine from ambulances where information on a crash victim can be sent to the healthcare facility as the patient is in transport. That's the old model of telemedicine.

The new model of telemedicine is here. It will be on your iPhone - it is on your iPhone. Scheels has a great display area now for all the different telemetric systems you can buy (bracelets, etc.) that you wear that can regulate many things. Eric Topol, a physician from California, authored a book, 'The Destruction of Modern Medicine', because it is changing that quickly. We are on the horizon, in our state, of a new telemedicine. Apps are available today, and more being designed, as we speak. Under contract we can take a scan from anywhere in the world and have it sent electronically anywhere else, have it read and a

report written, and have it submitted electronically. In some of our healthcare facilities, we are doing that currently.

This is a new revolution, creating an interesting dilemma on reimbursement. Several years ago, Representative Rick Berg and myself, were engaged on a regular basis on healthcare mandates introduced. No one with a mandate came forward who didn't tell us that ultimately it was going to save us a great deal of money. By implementing this mandate it would have a very positive affect. There have been instances, after we were promised great savings in healthcare dollars, where the implementation of a mandate may not of had the affect we wanted, and as a result we passed legislation. It is current legislation in the state of North Dakota, that a mandate must first be tried for two years within the PERS system. That's a system we control, we can require information to be collected and provided to us, as policy makers, to determine if the mandate is working.

11:12
This bill is a compilation of those elements. We are trying to address the reimbursement of telemedicine. Should it be reimbursed at the same standard rate as other provided services? If a physician does an evaluation through telemedicine, should they be able to bill at the same rate as if they saw the individual in person? With emerging technology we need to examine it and look at the impact.

Reimbursement for telemedicine would be at the same rate as a standard evaluations, etc. that it would be limited strictly to the PERS program. And at the end of two years, a report is required, to the legislature, to determine what the fiscal impact is.

There is an amendment that will be offered by Blue Cross Blue Shield that I support entirely. This amendment was discussed at the Interim Committee, after deliberation it was decided to let the legislature decide if they want to incorporate it. It limits the application to a contractual relationship that is established between the healthcare provider and the insurance provider.

14:00
Jennifer Clark, Legislative Council, Legal Counsel for the Interim Healthcare Reform Review Committee (Attachment 2)

This bill went before the Employee Benefits Programs Committee, which reviews bills that may have an impact on our PERS Uniform Group Insurance plan. The committee had an actuary report performed by Deloitte with a final report, and a positive recommendation from the Employee Benefits Committee.

This bill draft was assumed it would be subject to the health insurance mandate law, which reads that if you have a bill that requires particular health insurance services be covered, then the statute says you have to limit it to the PERS Uniform Group for two years. PERS would study it for two year and then it would return the next session with a bill that would expand it to all private policies. There would be analysis provided to determine the public policy. A cost benefit analysis was performed by Milliman.

16:20
In drafting this bill, I looked at whether there was a state that had a similar model to this, because of the Affordable Care Act. The Affordable Care Act says if the state is going to implement a health insurance mandate, if there's a cost increase in your policy, the state might be found financially liable for that increase.

In discovery, Montana has passed legislation like this, and it became effective in 2013. Our Insurance Commissioner's office called and learned that Montana hadn't been found financially liable for any increase in the cost of the policy. And for that reason, this legislation is heavily modeled on Montana. (Attachment # 3)

18:00
(Attachment 4)
This is located in the chapter of law relating to the PERS Uniform Group Plan for public employees. Section 1 explains definitions that relate to this section. The definition of 'Telemedicine' on page two, raises the question if it will be the new generation, the evolution of telemedicine - on your cell phone, Smartphone, etc. Or will it be linked more to the traditional model - where a patient from a remote site is linked up to a specialist in a more urban site.

The mandated language is on page 2, line 16 of the bill. Health benefit coverage under the PERS Uniform Group Plan needs to provide telemedicine coverage, and the coverage needs to be equivalent to that face to face coverage. On lines 23-25, make sure you allow that the coverage can have deductible co-insurance and co-payments. It does not require that your coverage provide something that's not medically necessary. It does not require that a healthcare provider be physically present with the patient at the remote sight, unless the professional who is providing healthcare determines it necessary for the standard of care.

Section 2 describes the health insurance mandate language. It will go to PERS for two years and it will be back in 2017 to introduce a bill, there will be a study, and it will be re-evaluated.

Section 3 is part of the health insurance mandate language. It says this section will expire. It reinforces that if you pass it this time, you will see it next time.

Rep. Schneider: Has Montana had their program in place long enough to have an evaluation and a report?

Jennifer: The legislative history in Montana was effective in 2013. I haven't seen any data on it, though there may be some.

Rep. Laning: I assume there have been some billing problems that this is even necessary?

Jennifer: In the Interim Committee, this was an ongoing discussion that the chairman is especially interested in. We had a presentation by an outfit in South Dakota that has been to a variety of rural hospitals. They set up a link and a cameral. A lot of rural hospitals are contracting with them. They did a presentation and we learned the rural hospitals have a

subscription for that service. The amount of that subscription is based on a variety of factors. When they have an emergency come in, or if they need to transport a patient to another hospital, they link on to a doctor in South Dakota who's directing the care. That North Dakota rural hospital isn't specifically billing for that out-of-state doctor's service because it's covered through their contract. South Dakota feels it would be helpful if they had a statute stating that the out-of-state provider could bill for his/her services directly to the patient's insurer. If this happened it would change the contract with South Dakota telemedicine provider and the rural hospital.

Jennifer: I will provide background information on the Employee Benefits.

25:30
Megan Houn, Director of Government Relations at BCBS ND
(Attachment 5)

Chairman Kasper: Do you know the status of the amendment?

Megan: I'll get the language, it removes that parity requirement and moves it to contractual language.

Chairman Kasper: Are you able to get it before we adjourn this committee hearing?

Megan: Yes.
(Attachment 6)

Megan: Chairman Keiser makes very good points about where telemedicine is going. You could have a visit today with a provider licensed in North Dakota for 49 dollars. We'd like to see North Dakota providers on that platform, and we are getting requests from employer groups to provide this type of benefit. This has great potential for emergency room situations. It would be tremendously helpful to be able to get online and have a 49 dollar visit with a provider here, and have that access to care rather than having to drive to a provider. It has potential to bring healthcare costs down in a way that's very affordable and accessible to people around the state.

Rep. Schneider: Does it also have the potential, if the language is changed, to increase cost if we look at access being to specialists and other folks we might not have in person?

Megan: I think that's where some of this contractual language becomes very important. Rather than saying it all has to cost the same, that telemedicine visit is likely not going to be used if you are going from something affordable and accessible to something you can go see your provider for a one-on-one contact. There are times when you need to be able to talk to somebody, and you can't get an appointment. We are seeing telemedicine visits, especially in behavioral health universe - they are being utilized, covered and reimbursed at parity rate. If the demand for those types of visits becomes increasingly more important, as we are seeing with all the behavioral health activity in our state now, if you lock in at parity you're also not allowing those costs to be reimbursed at a higher rate.

31:43

Jerry Jurena President of the North Dakota Hospital Association
(Attachment 7)

Jerry: I'll turn this over to Matt Grimshaw

33:30
Matt Grimshaw, Williston, ND, President of CHI-Mercy Medical Center
(Attachment 8)

Rep. Mooney: Are you saying, if I go to the doctor for an undiagnosed situation and I receive my diagnoses and after care instructions, etc., are you proposing those after-care type situations might fall into the telemedicine realm, but not if there was a diagnosis first?

Matt: Yes and no. I'll give an example of e-emergency and how it works. If a patient comes in and is evaluated by a nurse, they're evaluated by another in-person provider has to touch the patient. The reason we can't bill for e-emergency visits because we are already billing for the in-person provider. We can't have the e-emergency doctor in Sioux Falls be the only provider seeing that patient. There is an initial evaluation by somebody, in person, and then they engage the e-emergency physician remotely.

From a behavioral health, you see a primary care physician or you're in the emergency department, and they diagnose behavioral health need, then that provider makes a referral to behavioral health, setting up which would be a reimbursement visit.

Cardiology is currently not being used by us or being reimbursed, to my knowledge. This would allow for a primary care visit, and your doctor says you need a cardiologist. I don't have a full-time cardiologist in Williston, but we have them across the state. My suggested change would have a virtual cardiology consult, then once I've been assessed and referred, it is paid at parity. But not a primary care visit.

Rep. Schneider: I understand the sense you are making, but do we have the resources right now in the state? Isn't that what telemedicine was supposed to supplement?

Matt: If it were as simple as resources, it would be an easy answer. Today we don't have enough of nurses, lab techs, etc. We support the intent of expanding telemedicine to meet those needs, it's more the premise of how you pay for it. There's a place for telemedicine, even the urgent care visits. We are working with Blue Cross to partner with an organization to provide an e-urgent care clinic - with a licensed nurse practitioner or physician working in another state providing after-hours access. We are not suggesting to Blue Cross that that should be paid the same as an in-person visit. There is a difference.

This could help, and it might create more unintended consequences than fixes.

Chairman Kasper: Can you give us two examples. The first would be if the bill stayed the way it is, how would the process work? The second example, how would you change the

process to solve the problem you have so that we can get a feel of what it is compared to what you would like to see?

Matt: I was not aware of the Blue Cross nuance proposal - that would reflect part of our concerns. It's the contracts in place that have provisions for different levels of reimbursement that concern us.

I have had venders, and for-profit organizations, in my office chomping at the bit to come to North Dakota and market direct to consumer virtual care, from their home computer or their iPhone. They are not connected to anybody in the state. They don't have a vested interest in the real care delivered in our state. The way this bill is written, and their guaranteed parity for reimbursement, there is nothing to prevent any company from anywhere in the world, to come here and market their services directly to our patients. They don't have to have bricks and mortar locations, they don't have to be connected to a tertiary system in any way. This bill has no restrictions on who can do that. When that visit starts, and they get the consult on their smart phone and think it looks fine, then they prescribe medication. Then, when things go wrong, who fixes it? That's number one.

Chairman Kasper: On that circumstance, how would the out of state entity make connection with customers in North Dakota? Would they set up a kiosk, an office, or all by iPhone? How would they have that contact without going to a care provider in North Dakota first?

Matt: Online marketing. If you want an online consult today, you google it, click on their link, someone comes on, and they do the visit. The difference today is you pay by credit card. Your insurance company does not pay for that. That's a disconnected visit, it's not part of your care team - it's a convenience choice the consumers make.

Chairman Kasper: And you don't have objection to that?

Matt: I have 100% objection to that. That is bad medicine. Direct marketing from party vendors to consumers, with no strings or connection is not appropriate medicine.

A situation where I suggested change would be advantageous to our state, is now the patient has to be seen in person by a physician, and that person determines if they need a higher level of expertise than I can provide. Now it's simple, I can get in touch with Altru, or Sanford, or whoever might have capacity, and now I can do it remotely. We can't do that today because it's not reimbursed. If I have a patient in our emergency room and they need to be screened by a psychiatrist, we eat the cost because there is no reimbursement for that. This change would make all that work and we would be reimbursed. It would allow for networking on specialty services after an in-person evaluation, and take out the opportunity for random companies to come into our state and syphon our services.

Chairman Kasper: Under your example, would there be double billing, or would the remote be paid the 49 dollars? What is the remote paid, under your circumstance, compared to what your hospital would charge?

45:20

Matt: In your bill today, I suggest the language remain. The case of a psychiatrist consult, if we order a consult in Williston and they're not there in person, it's paid zero. If a psychiatrist that consults here in Bismarck, where they have psychiatry, that would be paid X number of dollars. This would allow that to be paid.

We don't do cardiology consults. If they are in Bismarck to get a cardiology consult, that's billed separately. There's an initial health and physical evaluation admitting, and there's consult for a cardiologist, for example. If we could do this, we would be able to be reimbursed at the same level as an in-person specialist - assuming they had an evaluation by a provider.

Chairman Kasper: The billing would be for your consult in your hospital or clinic, that would be a procedure bill. The cost for the telemedicine would be a separate bill, but you would not also bill for the telemedicine, so we're not duplicating billing?

Matt: I don't know exactly how that would work, and that's one of the challenges here. Today's telemedicine language has an origination kind of fee that you can collect. Usually that is done because you can't bill for the professional fee. If, in the case of behavioral health where we're contracting for the service, I would expect the transmission component of telemedicine would go away, and there would just be the professional fee visit for the psychiatrist. We would eat the cost of any kind of transmission or IT infrastructure, and there would just be one professional fee billed as though they were in person. You would not bill twice.

Rep. Wallman: Are there laws and measures in place in North Dakota that would require medical providers that do telemedicine to meet the licensers that are required in North Dakota?

I'm not opposed to a continuum of pricing, certainly the overhead for being seen in a hospital is much higher than access on your internet. If we require in-person visits, the whole point of the Healthcare Reform Review Committee coming forward with this was to promote greater access. If you're requiring an in-person visit, it undermines the spirit in which I think this came forward. If you could speak to the fact of ABC company needing licenser requirements, and perhaps that would be a useful amendment as well.

47:52

Matt: My understanding of state requirements would mandate identical guidelines for a telemedicine provider, as opposed to an in-person provider - you must meet state credentialing guidelines. But, they are not required to be here. From my professional experience, they are the same.

I thought it was interesting when opening remarks were made about access. The comments were all related to specialists, and that's exactly what I'm talking about. I don't believe it's a good solution to improve access, to allow remote telemedicine primary care. It's a clinical risk to those of us in the community of just having a computer screen evaluation, without requiring any other connectivity where you are getting vitals. All you need is a computer screen and the ability to talk to a patient. There are cases when that is

appropriate. Patients come in to the emergency room all the time thinking they have a particular problem, and their problem is actually bigger. So now you're going to go virtual and you're going to pay the same, open the access to everybody - who is going to care for that patient when they really are sick? It will be us, while others syphon off the easy things and get paid the same as we do.

49:34

Chairman Kasper: Have you sat down with Blue Cross or with any other interested parties to try and come to a resolution? Or is this something that you're expressing your concern and leave it up to the committee to come to the resolution?

Matt: No. When this first interim bill was proposed this summer, we raised the same concerns through the Hospital Association and others. We have talked to Blue Cross at length, and we believe they are on the right track, from a contractual standpoint, because they are really going to the heart of the parity question. I talked specifically in my comments about parity being the heart of the problem, and I believe they understand that. And they do anticipate costs going up if parity is in place for all services regardless of in-person or virtual. We have had, and continue to have, conversations. We are working with Blue Cross for a possible pilot study in our market where we would use a virtual urgent care clinic, but it would not be dollar for dollar like an in-person visit.

Chairman Kasper: Do you have any objection working with Blue Cross and other interested parties from this day forward to try to come to a resolution that could be presented to the committee that maybe would solve the problems and concerns?

Matt: No problems. Absolutely, we'll work together on this.

Vice Chair Rohr: Have you followed up with Montana, since they seem to be the experts from 2013?

Matt: I couldn't find any real examples of how it's actually being used.

51:00

Ahren Dosch, RN at Essentia Health, representing Essentia Rural Clinics in North Dakota
(Attachment 9)

Rep. Mooney: Can you describe what Telehome monitoring would look like?

Ahren: Sure, one example is monitoring patients with congestive heart failure. We would use in-home monitoring scales, taking vital signs daily to help monitor their conditions to help keep them out of the hospital. Preventing readmission, and cost-effectiveness is obviously there.

53:40

Marsha Waind, Regional Services Telemedicine manager at Altru Health Systems, representing the North Dakota High Tech Group, Telehealth Workgroup co-chair (Attachment 10)

Telehealth parity is an important issue that's now supported in 20 states across the nation.

Altru Health System has ten rural clinics. We connect over telehealth with approximately with 30 rural facilities, which a majority we do not own. Telemedicine is about delivering the right care to the right patient at the time. We work with the rural facilities to make sure the patient is seen by the right provider. We've kept people in rural hospital beds and out of hospital beds.

Reimbursement to the provider groups is now limited, and this parity bill levels the playing field and enables all the provider groups to be included in the telehealth realm of care. The parity bill itself is good language and a good way to approach this. I think the payment sources and billing issues will fall under that contractual language with the insurers - if a provider has a relationship with that insurance group they can address that level of involvement.

I appreciate the conversation about the biometrics at Scheels. Our electronic medical record is able to take those biometrics in and use them to manage health. We are on the cusp of being responsible as a health system for a population. As a health system we need to be able to manage this efficiently and effectively. In the home-monitoring situation, there's a nurse that can watch that dashboard and know who is out of normal ranges every morning.

The bill, as it states, doesn't include home as a place of service, as does federal medicare. I'm asking you to remove the stipulation of the healthcare facility as an originating site. So in medicare language it's very definitive about where that patient is located if there is reimbursement available. If that language continues in this parity bill, it will limit some opportunities. In the Montana bill, it defines telemedicine "... to deliver healthcare services at a site other than the site where the patient is located". I respectfully present that as an opportunity for consideration of this committee.

I agree with Mr. Grimshaw's concerns. Though I feel this gives us an opportunity for our primary care doctors and rural clinics to be a part of that marketplace. I'm not sure what the answer is, but I know that this is the environment that we're in. This bill to address parity is a good bill. Montana has a rich history of telehealth for many years - they have been a leader in rural telehealth services.

1:01

Vice Chair Rohr: Can you tell me what you are hearing from your patients, regarding the direct to consumer option?

Marsha: They want it. They are actively seeking it. Typically there is a limited number of complaints that they will take. There will be a questionnaire, when completed they will

respond with an outcome (it may be a prescription). Or they may direct you to the emergency room or urgent care clinic.

Chairman Kasper: I'm going to appoint a subcommittee to work on this. There are many areas that have opened up that we didn't get into in the Interim Health Committee. Some testimony today would have been helpful for them to hear. The subcommittee will be working with all interested parties.

Rep. Schneider: Marsha, the problem you identified about not having in-home, and could it as a place of service, is this something that we could fix in discussion with the Hospital Association and Blue Cross Blue Shield as they develop their amendment? Or, is medicare a problem in the federal law, as well?

Marsha: My information from the federal level is medicare is looking to change that. Because within the medical population health model we need to connect with people where they are and where they function. To not include that language would be short-sighted, in my opinion. There are many opportunities to connect in the residential setting, assisted living setting, and the schools. Hopefully we can have that conversation to mitigate any risks and threats.

1:06
Carol Olson, ND Occupational Therapy Association
(Attachment 11)

No Opposition

Neutral Position

Duane Houdek, Executive Secretary for North Dakota State board of Medical Examiners

Duane: We license physicians and physician assistants. We've been working on telemedicine rules and policies for the last 6-8 months.

We require that everyone who treats a North Dakota citizen to be licensed in the state with a full medical license. Anyone who practices within the state goes through a full vetting process.

We currently have a policy in place that addresses some of these issues that were raised. The particularly difficult one is the direct consumer issue. Telemedicine through radiology or emergency rooms, or intensive care unit monitoring has been going on forever, that's largely not problematic in any way.

The new thing is the app on your phone. We currently have a cease and desist order against the largest telemedicine provider in the nation - they provide employee care to

Southwest Airlines, etc., and call it "teledoc". They do a phone only consultation. They get around most states by having the person calling to designate them as their on-call physician. They have no relationship to any facility in the state. We have told another more local facility that online questionnaires do not suffice. We are saying any visit you have, has to parallel what you would do in a personal visit.

Chairman Kasper: Hearing closed on HB 1038.

Chairman Kasper: This is a very important issue for our state. I'm going to appoint a subcommittee of three. The chair will be Rep. Rohr, and on the bill will be Representative Johnson, because she is carrying the bill, and Representative Laning. We will publish all meeting notices they will have. Representative Rohr, I will ask that you have Jennifer Clark sit in with you so she can give you the perspective of our current law and how that might apply to the PERS situation.

Anyone who wishes to have input on the subcommittee, give your info to the intern of how you can be contacted and notified. Minutes will be kept of the meetings, we want all peoples input. We need to move in the direction where we try get telemedicine correct for the state of North Dakota, for our patients and citizens.

Chairman Kasper: We will add Rep. Mooney to the subcommittee.

Minutes of the

(HOUSE) (SENATE) BILL NO. 1038 SUBCOMMITTEE OF THE

HOUSE GVA STANDING COMMITTEE

Meeting location: Fort Union Room

Date of meeting: 1/30

Time meeting called to order: 10:45 AM.

Members present: Rep. MARY JOHNSON Rep Gail Mooney
Rep KAREN ROHR, chair

Others present (may attach attendance sheet):

Topics discussed:
- Defining "ORIGINATING site" and distant site
- Incorporating telehome language in the bill
- Consider BCBS amendment for reimbursement

Motion and vote:
No motion or vote taken

Time of adjournment: 11:40 AM.

Note: If a motion is made, a description of the motion must be provided along with the member seconding the motion. A recorded roll call vote must be taken and reported for any nonprocedural motion.

Minutes of the

(HOUSE) (SENATE) BILL NO. 1038 SUBCOMMITTEE OF THE

HOUSE GVA STANDING COMMITTEE

Meeting location: House Conference Room

Date of meeting: 2/9/2015

Time meeting called to order: 4:00 pm

Members present: Representative Jim Kasper, Rep. Vern Laning Rep. Gail Mooney, Rep. Karen Rohr (Chair)

Others present (mav attach attendance sheet):

Topics discussed:

- Reviewed amendment 15.0079.02002
- Reviewed christmas tree bill with members and others present page by page. No other concerns expressed and amendment accepted as delivered.

Motion and vote:

Time of adjournment: 4:35 pm

Note: If a motion is made, a description of the motion must be provided along with the member seconding the motion. A recorded roll call vote must be taken and reported for any nonprocedural motion.

2015 HOUSE STANDING COMMITTEE MINUTES

Government and Veterans Affairs Committee
Fort Union, State Capitol

HB 1038
2/19/2015
24136

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature	Carmen Hart

Explanation or reason for introduction of bill/resolution:

Relating to PERS uniform group insurance coverage of telemedicine

Minutes:

Attachments 1-6

Chairman Kasper opened the meeting on HB 1038. Amendments and the Christmas tree version were handed out. Attachments 1-2. I will have Rep. Rohr to explain this as she was chair of the subcommittee.

Vice Chair Rohr We had three subcommittee meetings regarding this bill. We had the various stakeholders at the meetings, especially the first one. They had several suggestions for amendments. Between Jennifer Clark from Legislative Council and all our subcommittee members, we came up with several amendments and have been able to consolidate them. We discussed topics such as the telehome, parity issue versus the contractual agreements, and adding optometrist to the list of providers. We are suggesting a do pass with the amendments. However, I have Jennifer here to walk us through the amendment.

Jennifer Clark, Legislative Council, appeared and went through the Christmas tree version of the bill. This is the bill that is going to require a purging of a form group policy plan to reimburse for medical services provided through telemedicine. There was a lot of discussion about how to distinguish between where the patient is located and where the medical provider is located. We went to some proposed legislation in Minnesota that made that distinction. On Page 1, we have the definitions of distant site and originating site. Distant site is where the provider is located. Originating site is where the patient is located. We added optometrist on Page 1, Line 19.

Vice Chair Rohr Explain Line 12 as to why we changed it to medical services.

Jennifer Clark As this bill came out of the interim committee, it was introduced as applying to all health insurance policies. Over the course of the interim, we decided we would design this to comply with our health insurance mandate law that says put it into PERS for two years, have it studied, and then two years later have it roll into the general market. In that evolution we kept the language we would use in the private market. Now that it is

located in PERS, we did a little housekeeping. In PERS we use the term medical services. It is consistent with the language we use in PERS. It will cover all of our healthcare providers.

Rep. Karls Where is optometry added?

Jennifer Clark Page 1, Line 19. On Page 2, Lines 7-8 we are in the definition of store and forward technology which is included as a manner of providing telemedicine. We have said that this term store and forward technology includes telehome monitoring. Page 2, Subsection 2, Line 21, is the beef of your bill. It says that the PERS board shall provide medical benefit coverage under a policy that provides coverage for medical services delivered by means of telemedicine which is the same as the coverage for medical services delivered by in person means.

Rep. Karls Did everyone at the hearing agreed to this?

Vice Chair Rohr That is the controversy. Although we are going to this amendment, that day they were all okay with it, but then there were some private meetings outside the subcommittee meeting, and they want to include more language. The chairman and I encouraged them to bring the language forward and they haven't. So, we are going forward with this, and I am sure it is going to be hammered more in the Senate.

Chairman Kasper What we are careful to do in this bill is not to expand the coverage that the ND PERS health plan currently has. This is to be a try it out where we are at with telemedicine. One of the participants in particular said their legal people didn't really like the wording the way it is, and they have had a week to get back with a proposed amendment and they have not. If they want an amendment, then they are going to have an opportunity over in the Senate to bring it to the committee that hears the bill if that is their desire.

Rep. Schneider Can I ask what entity it was that you were expecting further objection to language from?

Chairman Kasper It was Blue Cross.

Jennifer Clark For clarification, it is the Blues who have the PERS policy. Subsection 3 now reads payment or reimbursement of the expenses for covered medical services delivered by means of telemedicine under this section may be established through negotiations conducted by the board just like they establish reimbursement for face to face. Go out and negotiate with them just like you would for your more traditional services. Page 3, Subsection 4, you can see what is overstruck.

Chairman Kasper The overstrike gets rid of what?

Jennifer Clark It could be perceived as throat clearing, like we really mean it language. Don't provide copayments or deductibles that are different for telemedicine than it would be for in person. Subsection 5, Page 3, we are going to flush it out a little bit more here. We say that this bill doesn't require coverage of something that is not medically necessary. B

focuses on which services are going to be covered. We are not opening the door for telemedicine any more than our in person is. Subdivision c is your provider. It essentially says the same thing, the policy doesn't need to reimburse the healthcare provider or facility for telemedicine if they wouldn't have reimbursed them if it was in person. One of the concerns raised here is Blue Cross/Blue Shield doesn't reimburse natural paths. This bill doesn't say suddenly that just because a natural path provides something by telemedical means that they suddenly are going to be reimbursed. They can still limit the providers if they limit for in person, and the same way for telemedicine.

Rep. Dockter They have to use their same codes?

Jennifer Clark You now know more than I do. I am not certain.

Chairman Kasper It does not expand the scope of coverage.

Rep. Dockter Right. Inaudible.

Chairman Kasper If the policy does not cover vitamins and minerals now, it is not going to be expanded to cover vitamins and minerals by telemedicine in the future.

Rep. Dockter My example would be like a 9004 code, a CP code, or general visit. Under this bill, they will still put that in even though it is telemedicine but they will get reimbursed the same amount?

Chairman Kasper With the caveat the PERS board might negotiate a lesser reimbursement because it is telemedicine and it is offsite compared to what they might pay the provider onsite.

Jennifer Clark That Sub d is just housekeeping.

Chairman Kasper Section 2 just points out that this will be the two year trial with the PERS plan?

Jennifer Clark Correct.

Rep. Wallman Could we go back to the healthcare versus medical services.

Jennifer Clark I can provide Austin with a copy of the section that I am referring to in the PERS law. Attachment 3. In the PERS law when we create that uniform group policy, that is how we describe the medical services the policy covers. As far as drafting goes and as we speak about healthcare, that is the language we use because it is broader. It is not just the practice of medicine. Our insurance policies cover a variety of services. To keep our terminology consistent with our PERS law, we use that same terminology.

Rep. Wallman Is there a substantive reduction in the services that might be available under the previous version of this bill if it said healthcare?

Jennifer Clark I don't think there is any substantive difference in changing from medical services to healthcare. I think it is just using language choice.

Vice Chair Rohr If this passes in the Senate, when would this telemedicine start and when would it end?

Jennifer Clark Page 2, Line 21, it is July 1, 2015, and they go for two years, a biennium.

Rep. Steiner There is a sunset here?

Chairman Kasper Correct. Page 4, there is a sunset of July 31, 2017.

Vice Chair Rohr Page 3, the PERS group would then have to come forward with their recommendation and introduce a bill then to the 65th legislative assembly.

Attachments 4-6 were handed out to the committee since the original hearing.

Rep. Steiner moved to adopt the amendment.

Vice Chair Rohr seconded the motion.

Voice vote. Motion carries.

Rep. Laning made a motion for a DO PASS AS AMENDED.

Rep. Dockter seconded the motion.

Chairman Kasper This will be a pilot now with the ND PERS health plan. After the two-year pilot they will then report back to the next legislative session.

Rep. Karls I hesitate to bring this up, but I know that our PERS group is in negotiations right now for a healthcare provider for the next two years. Are we moving the goal post?

Chairman Kasper No, this would apply to whoever the healthcare provider is. It is specific to how the policy would have to deal with telemedicine.

Vice Chair Rohr There were three or four people from Sanford present at every meeting.

Chairman Kasper There were a lot of people at one of those subcommittee meetings from all over the state.

A roll call vote was taken. 12 Yeas, 1 Nay, 1 Absent.

Vice Chair Rohr will carry the bill.

15.0079.02004
Title.03000

Prepared by the Legislative Council staff for
House Government and Veterans Affairs
Committee

February 17, 2015

2-19-15
1 of 2

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1038

Page 1, line 8, replace "**reimbursement parity for**" with "**coverage of**"

Page 1, line 10, after "a." insert: ""Distant site" means a site at which a health care provider or health care facility is located while providing medical services by means of telemedicine.

b."

Page 1, line 10, replace "health care" with "medical"

Page 1, line 11, remove "or treatment of diseases"

Page 1, line 15, replace "b." with "c."

Page 1, line 17, after "nurse" insert ", 43-13"

Page 1, line 19, replace "c." with:

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

e."

Page 1, line 19, remove the first "a"

Page 1, line 22, replace "d." with "f."

Page 2, line 1, after "includes" insert "telehome monitoring and"

Page 2, line 3, replace "e." with "g."

Page 2, line 5, after "facility" insert "at a distant site"

Page 2, line 6, replace "health care" with "medical"

Page 2, line 6, replace "a site other than the" with "an originating"

Page 2, line 6, remove "at which the patient"

Page 2, line 7, remove "is located"

Page 2, line 16, replace the first "health care" with "medical"

Page 2, line 16, remove "provided by a health care provider or"

Page 2, line 17, replace "health care facility" with "delivered"

Page 2, line 17, replace "are" with "is"

Page 2, line 17, remove "policy"

Page 2, line 18, replace "of" with "for medical services delivered by"

Page 2, line 18, remove "health care services provided by a health care provider or"

Page 2, line 19, replace "health care facility" with "means"

Page 2, line 20, replace "Coverage of health care" with "Payment or reimbursement of expenses for covered medical"

Page 2, line 20, replace "provided" with "delivered"

Page 2, line 21, replace "must" with "may"

Page 2, line 21, replace "equivalent to the coverage for health care" with "established through negotiations conducted by the board or the board's contractor with the medical services providers in the same manner as the board establishes payment or reimbursement of expenses for covered medical"

Page 2, line 21, replace "provided" with "delivered by"

Page 2, line 22, replace "by a health care provider or health care facility" with "means"

Page 2, line 22, after the underscored period insert:

"4."

Page 2, line 23, remove "Special"

Page 2, remove lines 24 through 26

Page 2, line 27, replace "4." with "5."

Page 2, line 28, replace "health care" with "medical"

Page 2, line 29, remove "insured's"

Page 2, line 29, remove "or"

Page 2, line 30, after "b." insert: "A policy to provide coverage for medical services delivered by means of telemedicine if the policy would not provide coverage for the medical services if delivered by in-person means;

c. A policy to reimburse a health care provider or health care facility for expenses for medical services delivered by means of telemedicine if the policy would not reimburse that health care provider or health care facility if the medical services had been delivered by in-person means; or

d."

Page 2, line 30, after the first "the" insert "originating"

Page 2, line 30, remove "where the"

Page 2, line 31, remove "patient is located"

Page 2, line 31, replace "providing health care" with "delivering medical"

Renumber accordingly

Date: 2-19-15
Roll Call Vote #: 1

2015 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 1038

House Government and Veterans Affairs Committee

☐ Subcommittee

Amendment LC# or Description: 15.0079.02004

Recommendation: ☒ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Steiner Seconded By Rohr

Representatives	Yes	No	Representatives	Yes	No
Chairman Jim Kasper			Rep. Bill Amerman		
Vice Chair Karen Rohr			Rep. Gail Mooney		
Rep. Jason Dockter			Rep. Mary Schneider		
Rep. Mary C. Johnson			Rep. Kris Wallman		
Rep. Karen Karls					
Rep. Ben Koppelman					
Rep. Vernon Laning					
Rep. Scott Louser					
Rep. Jay Seibel					
Rep. Vicky Steiner					

Voice Vote motion carries

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-19-15
Roll Call Vote #: 2

2015 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 1038

House Government and Veterans Affairs Committee

☐ Subcommittee

Amendment LC# or Description:

Recommendation:
☐ Adopt Amendment
☒ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☒ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐

Motion Made By Laning Seconded By Dockter

Representatives	Yes	No	Representatives	Yes	No
Chairman Jim Kasper	X		Rep. Bill Amerman	X	
Vice Chair Karen Rohr	X		Rep. Gail Mooney	—	
Rep. Jason Dockter	X		Rep. Mary Schneider	X	
Rep. Mary C. Johnson	X		Rep. Kris Wallman	X	
Rep. Karen Karls		X			
Rep. Ben Koppelman	X				
Rep. Vernon Laning	X				
Rep. Scott Louser	X				
Rep. Jay Seibel	X				
Rep. Vicky Steiner	X				

Total (Yes) 12 No 1

Absent 1

Floor Assignment Rohr

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1038: Government and Veterans Affairs Committee (Rep. Kasper, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (12 YEAS, 1 NAYS, 1 ABSENT AND NOT VOTING). HB 1038 was placed on the Sixth order on the calendar.

Page 1, line 8, replace "**reimbursement parity for**" with "**coverage of**"

Page 1, line 10, after "a." insert: ""Distant site" means a site at which a health care provider or health care facility is located while providing medical services by means of telemedicine.

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c. A policy to reimburse a health care provider or health care facility for expenses for medical services delivered by means of telemedicine if the policy would not reimburse that health care provider or health care facility if the medical services had been delivered by in-person means; or

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Page 2, line 31, remove "patient is located"

Page 2, line 31, replace "providing health care" with "delivering medical"

Renumber accordingly

2015 SENATE FINANCE AND TAXATION

HB 1038

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

HB 1038
3/11/2015
Job # 24665

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Donald Mueller

Explanation or reason for introduction of bill/resolution:

A bill relating to public employees retirement system uniform group insurance coverage of telemedicine.

Minutes:

Attachment #1 Repealer
Attachment #2 Testimony of Cheryl Rising
Attachment #3 Testimony of Marsha Waind
Attachment #4 Testimony by Maureen Ideker

Jennifer Clark, Legislative Council, introduced HB 1038 to Senate Human Services Committee in a neutral capacity. The health care reform review committee looked at a health care delivery system in the state. We looked at several facets. Some related to the Affordable Care Act and some was just looking at how to do it best. There is a need for changing technology as it relates to the health care delivery system. The tele-health was highlighted. In that system you can be live with a physician in another location and they can help facilitate the transfer of patients. Under the current contract with that business, it is not submitting bills for the services in the traditional manner in order to be processed through the insurance carrier. They are charging for those services at a set fee and then the hospital can charge for their services but not specifically for that Doctor that came in and helped with the transfer. That is where this comes from. The chairman of interim committee asked if there was anything the legislature could do with state law and if there were any barriers. The response was that it would be helpful if all states had parity for reimbursement for tele-health. This is an engrossed version of the bill. When we drafted it in committee, because of some limitations with the Affordable Care Act, we looked at other states that have put this into legislation recently so that we would not get stuck in a situation where the federal government said that the change in our health insurance law is considered an addition to our essential health benefits under the Affordable Care Act. Therefore, the state is going to be liable for any increase in the cost of the policy related to that additional mandate. This has not been run by the feds or the insurance commissioner's office to see if there are any problems or liability with the Affordable Care Act. My instinct is that there won't be because we are not requiring that a service be offered. I think it is clearer under this version, but the service isn't. We are not requiring coverage of additional services; it is purely the vehicle by which those services are delivered. Jennifer Clark then walked through the bill, through the North Dakota Public Employees Retirement System (PERS), and the public mandate law, it needs to be limited

to PERS for two years. This was drafted to comply with that. Ms. Clark went through the definitions section.

(Attachment #1) - Repealer

Senator Warner asked if it would be considered tele-health if an insurance company were to offer an incentive for a person to take training in diabetes management as part of the course of treatment.

Chairman Judy Lee stated that it was a good question.

Ms. Clark stated that she was not sure.

Chairman Judy Lee indicated that would be something to check on.

Ms. Clark reminded the committee that what is being talked about was not what the providers are allowed to do but what the insurance company is required to reimburse. It is not scope of practice.

(12:19) Ms. Clark continued definitions and review of bill.

(15:50)Chairman Judy Lee asked if this was this heard in IBL in the House.

Ms. Clark stated that it was GVA.

Senator Warner commented that this remarkable technology is also available in the home with things like FaceTime, Skype, etc. I could see use of those in tele-psychiatry. Is there a way to monitor the effectiveness? It seems like if there is a more formal situation and we are going to a clinic and a specialist is brought in, there is a higher threshold over calling a specialist over Skype or something. Is that relevant issue to this discussion?

Ms. Clark thinks it is a public policy decision that is worth discussing. Not sure I would add it into this. Skype is generic term. We have a federal requirement that talk about how secure that needs to be. I assume Skype will not do that, but I think there are possibly programs out there that meet the security guidelines.

Chairman Judy Lee stated that they had some information about that in the interim committee and that it probably could be provided to the committee. In some cases it has been more effective because people find it private. They sometimes are less comfortable going into a mental health clinic. There shouldn't be a stigma but sometimes there is.

Senator Howard Anderson, Jr. if you are the provider, then you need to have some kind of a secure connection when you are communicating with the patient. Patient can say anything they want to without having to worry about the security of what they are saying because they make that choice to do this for themselves. The person that is providing the service needs to provide the security. The feds in the Department of Health and Human Services has an office for advancement of tele-health, where they use the broader term of

tele-health. You have apparently looked at that and made a decision that tele-medicine is adequate here and we do not need to use the term of tele-health?

Ms. Clark stated that it was her opinion. If we are talking about the clinical side of it, then we are probably covered. The reality of it is that we are defining it as we are defining it. My goal is to use the term used in the industry, so if you decide that the services that we are talking about are broader than the clinical, than perhaps we should change it to tele-health.

(20:40)Cheryl Rising, FNP and legislative liaison for the North Dakota Nurse Practitioner Association, testified IN FAVOR of HB 1038. (Attachment #2)

(22:28)Chairman Judy Lee asked for an example of the change in provider neutral language.

Ms. Rising stated that the version she had took out health care and put in medical services throughout the bill.

Chairman Judy Lee said that it must be the meaning of medical services that are not just provided by physicians. As long as we define medical services to make sure that it is inclusive, that might do it.

Ms. Rising stated that they would be good.

Senator Axness asked if there are Nurse Practitioners doing tele-health currently in the state?

Ms. Rising indicated yes and gave an example of an Nurse Practitioner doing tele-health in Bismarck that has a background in psychiatry that is doing tele-medicine in Iowa.

Senator Axness questioned how that is being reimbursed currently.

Ms. Rising said that it is being reimbursed by billing the insurance.

Senator Dever commented that insurance companies can now cover tele-medicine and that the bill says that they must. This now states "it must" - it would be on PERS.

Ms. Rising confirmed.

(25:22)Marsha Waind, Co-Chair of the Telehealth Domain Workgroup of North Dakota Health Information Technology Advisory Committee and the Telemedicine Manager of Altru Health System, testified IN FAVOR of HB 1038 (Attachment #3)

(30:24)Senator Dever asked if telemedicine was used frequently, and if insurance usually cover this or if they have to be checked with before the services are provided.

Ms. Waind stated that generally it is covered. In the Medicare rules it is limited to certain providers and the one provider is not included is a nurse. There are specific services that are covered. Generally, it is covered quite well. Medical assistance in North Dakota covers

some, and BCBS covers a fair amount of services. The problem is that we don't want to pick and choose those services. If the health insurance provides coverage for this service and it is appropriate for tele-medicine it should be covered. We shouldn't have a situation that we have to go back to check if it can be done over tele-medicine. If insurance pays for it in person, then it should be paid for also in tele-medicine.

Chairman Judy Lee stated that it is a way to increase access in rural areas for a lot of things.

Ms. Waind confirmed. Each rural health hospital may not hire the skills, such as dietician with expertise with diabetes, and that patient cannot travel an hour or two every time. (Gave a couple of additional examples.)

(33:50)Maureen Ideker, System Director for tele-heath with Essentia Health, testified IN FAVOR of HB 1038. The main programs that Essentia provides through tele-medicine are a registered dietician for diabetes and medical weight loss management. The next biggest program is behavioral health, both child and adult psychiatry. My perspective is from the rural hospital, nursing homes, and clinic settings across our Essentia Health North Dakota sites. We currently have four North Dakota clinics and we will be doubling that over the next year due to a USDA grant that was received for equipment. In Fargo, the Innovis emergency room is serving as the hub, where the services for the emergency room are sent out to rural hospitals; such as stroke care and some of the more complex things that come in an emergency room. There are two main areas that I would like to highlight. First, is the broader definition of licensed healthcare provider eligibility. That is an important part of this bill. Currently, without the bill, the following licensed providers are not recognized as eligible reimbursable providers: audiologists, pharmacists, genetic counselors, the certified diabetic educator RN, physical and occupational therapists, and speech language pathologists. So when a person has a stroke part of their aftercare has to do with rehabilitation and speech language pathologists, who are very scarce, should be allowed. Having these restrictions in rural North Dakota means not having access to needed medical specialties. It is also a real burden to travel those long distances. The second main issue relates to the originating site eligibility for reimbursement. Without the legislative changes, group homes, assisted livings, and homes as sites where the patients can be located to be eligible for reimbursement coverage would not be covered. This restriction impacts potential tele-health services to the developmentally disabled living in group homes, behavioral health residents of group homes, and the elderly in assisted living and in their homes. Allowing these would reduce expensive transfer costs and disruption to the patient and it would decrease unnecessary admissions to the emergency room. Tele-home monitoring devices, as was added to the bill, need to be an eligible service in order to maintain chronically ill elderly in independent living longer and that is covered under the strong forward language. **(38:48)**. Ms. Ideker provided written testimony after the hearing (attach #4)

OPPOSITION to HB 1038
No opposing testimony to HB 1038

NEUTRAL on HB 1038
No neutral testimony to HB 1038

Chairman Judy Lee asked Sparb Collins, PERS, if he had any objections to adding additional professionals.

Sparb Collins indicated that the fiscal note was based on the same services provided today in the plan through Blue Cross Blue Shield. If it is expanded beyond what is provided today, it will increase the fiscal note.

Chairman Judy Lee commented that she suspected some of the services mentioned by the previous speaker were not currently covered and asked for those to be checked into.

Senator Howard Anderson, Jr. pharmacists are not covered for a distance visit right now. We do medication therapy management that would have to be in person to be covered. The other benefits that we have with tele-pharmacy are paid by the hospital as part of their cost report. Therefore, they are covered indirectly because they are contracting with the tele-pharmacy provider.

Chairman Judy Lee closed the public hearing on HB 1038.

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

HB 1038
3/11/2015
24688 (14:07)

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Donald Mueller

Explanation or reason for introduction of bill/resolution:

A bill relating to public employees retirement system uniform group insurance coverage of telemedicine.

Minutes:

No attachments

The Senate Human Services Committee met on March 11, 2015 for committee work. The recording is under Job Number 24688, beginning 14:08

Chairman Judy Lee reviewed HB 1038 from this morning's testimony. She assigned the Intern, Femi, to look up the definition of medical services not just what the physician provides, looking for provider neutral language so that nurse practitioners are included.

There was discussion in the committee regarding the licensed professions to be included in the bill. There was also discussion regarding telemedicine term verus tele-health terminology.

Megan Houn, Blue Cross Blue Shield, indicated she needs to look into the differences. The House determined that the terms are different. There could be a different in what is covered by insurance companies. Another term that has been discussed is "tele-home" health, and this is for monitoring certain items, such as weight management. For those type of things, there is not a fee-for-service, so there is no reimbursement and providers would like this. The way we do reimburse that currently is through the accountable care organizations or your blanket disease management type of services.

V. Chairman Oley Larsen indicated his wife, they are doing something that you can bill for mental health, but you can't bill for marital problems that you come into. Mental health may be spurred by this, so they are splitting hairs. So if mental health doesn't cover everything, there could be splitting hairs.

Senator Warner asked about new advanced technologies, such as store-in-forward technologies. The church he works at gives a discount in insurance based on the number

of steps you take in a day. Is advanced technology that tracks this the sort of technology that we are talking about?

Ms. Houn indicated that is some of the gray area that we are talking about. We reimburse for wellness and prevention coverage. The intent of the bill proposed is you could lower the cost of health care with telemedicine. She provided a personal story with her children and how they could use telemedicine. The beauty of telemedicine is you could reduce costs for emergency services. Yet there are still injuries that require care at the emergency room. Tele-behavioral health, direct consumer services with respect face-to-face secure technology and not violating standards, could provide savings from not using emergency services.

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

HB 1038
3/24/2015
25374

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature	Donald Mueller

Explanation or reason for introduction of bill/resolution:

A bill relating to public employees retirement system uniform group insurance coverage of telemedicine.

Minutes:

No attachments

The Senate Human Services Committee met on March 24, 2015 for HB 1038 committee work.

The committee discussed replacing telemedicine with tele-health. **V. Chairman Oley Larsen** indicated his understanding the tele-health would incorporate the behavioral health. The committee concurred that the term should be changed to telehealth.

Chairman Judy Lee also indicated her notes shows concern about medical services and including the appropriate medical providers. This is provider neutral language, so don't see a need for change here. The committee concurred.

Chairman Judy Lee indicated that we need to be sure that the Affordable Care Act essential benefit rules are not affected by the change in term to telehealth. Chairman Judy Lee took the assignment to discuss with **Rebecca Ternes** from the Insurance Department.

Senator Howard Anderson, Jr. asked who keeps track of sunset clauses. **Chairman Judy Lee** responded that is legislative council, and they inform the legislature.

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

HB 1038
3/25/2015
25412

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Donald Mueller

Explanation or reason for introduction of bill/resolution:

A bill relating to public employees retirement system uniform group insurance coverage of telemedicine.

Minutes:

Attach #1: Draft bill with proposed amendment

The Senate Human Services Committee met on March 25, 2015 for HB 1038 committee work.

The draft HB 1038 with the proposed amendments was distributed (attach #1) and reviewed by the committee. The primary changes were to
- change telemedicine to telehealth.
- Health care provider is neutral language and is all inclusive.

Senator Warner moved to ADOPT AMENDMENT as proposed in the draft bill markup. The motion was seconded by **V. Chairman Oley Larsen**. No discussion.

Roll Call Vote to ADOPT AMENDMENT
6 Yes, 0 No, 0 Absent. Motion passes.

Senator Warner moved the Senate Human Services Committee DO PASS for engrossed HB 1038 AS AMENDED. The motion was seconded by **V. Chairman Oley Larsen**. No discussion.

Roll Call Vote to DO PASS as Amended
6 Yes, 0 No, 0 Absent. Motion passes.

Senator Howard Anderson, Jr. will carry HB 1038 to the floor.

15.0079.03001
Title.04000

Adopted by the Human Services Committee

March 25, 2015

TV
3/25/15

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1038

Page 1, line 3, replace the first "telemedicine" with "telehealth"

Page 1, line 3, replace the second "telemedicine" with "telehealth"

Page 1, line 8, replace "**telemedicine**" with "**telehealth**"

Page 1, line 11, replace "telemedicine" with "telehealth"

Page 1, line 12, replace "medical" with "health"

Page 1, line 20, replace "medical" with "health"

Page 1, line 21, replace "telemedicine" with "telehealth"

Page 1, line 22, replace "medical" with "health"

Page 2, line 6, replace "Telemedicine" with "Telehealth"

Page 2, line 9, replace "medical" with "health"

Page 2, line 18, replace "medical" with "health"

Page 2, line 19, replace "medical" with "health"

Page 2, line 19, replace "telemedicine" with "telehealth"

Page 2, line 20, replace "medical" with "health"

Page 2, line 21, replace "medical" with "health"

Page 2, line 22, replace "telemedicine" with "telehealth"

Page 2, line 23, replace "medical" with "health"

Page 2, line 25, replace "medical" with "health"

Page 2, line 29, replace "medical" with "health"

Page 3, line 1, replace "medical" with "health"

Page 3, line 2, replace "telemedicine" with "telehealth"

Page 3, line 2, replace "medical" with "health"

Page 3, line 5, replace "medical" with "health"

Page 3, line 5, replace "telemedicine" with "telehealth"

Page 3, line 6, replace "medical" with "health"

Page 3, line 9, replace "medical" with "health"

Page 3, line 10, replace "telemedicine" with "telehealth"

Page 3, line 12, replace "**TELEMEDICINE**" with "**TELEHEALTH**"

Page 3, line 14, replace "telemedicine" with "telehealth"

Page 3, line 16, replace "telemedicine" with "telehealth"

Renumber accordingly

Date: 03/25 2015
Roll Call Vote #: 1

2015 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1038

Senate Human Services Committee

☐ Subcommittee

Amendment LC# or Description: 15.0079.03001 Title 04000

Recommendation: ☒ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐

Motion Made By Sen. Warner Seconded By Sen Larsen

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee (Chairman)	✓		Senator Tyler Axness	✓	
Senator Oley Larsen (V-Chair)	✓		Senator John M. Warner	✓	
Senator Howard C. Anderson, Jr.	✓				
Senator Dick Dever	✓				

Total (Yes) 6 No 0

Absent 0

Floor Assignment

If the vote is on an amendment, briefly indicate intent:

Date: 03/25 2015
Roll Call Vote #: 2

2015 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1038

Senate Human Services Committee

☐ Subcommittee

Amendment LC# or Description: 15.0079.03001 Title 04000

Recommendation:
☐ Adopt Amendment
☒ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☒ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐

Motion Made By Sen Warner Seconded By Sen Larsen

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee (Chairman)	✓		Senator Tyler Axness	✓	
Senator Oley Larsen (V-Chair)	✓		Senator John M. Warner	✓	
Senator Howard C. Anderson, Jr.	✓				
Senator Dick Dever	✓				

Total (Yes) 6 No 0

Absent 0

Floor Assignment Sen. Anderson

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1038, as engrossed: Human Services Committee (Sen. J. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1038 was placed on the Sixth order on the calendar.

Page 1, line 3, replace the first "telemedicine" with "telehealth"

Page 1, line 3, replace the second "telemedicine" with "telehealth"

Page 1, line 8, replace "**telemedicine**" with "**telehealth**"

Page 1, line 11, replace "telemedicine" with "telehealth"

Page 1, line 12, replace "medical" with "health"

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Page 3, line 10, replace "telemedicine" with "telehealth"

Page 3, line 12, replace "**TELEMEDICINE**" with "**TELEHEALTH**"

Page 3, line 14, replace "telemedicine" with "telehealth"

Page 3, line 16, replace "telemedicine" with "telehealth"

Renumber accordingly

2015 TESTIMONY

HB 1038

15.0079.02001
Title.

#1 HB1038
1-22-2015

Prepared by the Legislative Council staff for
Representative Keiser
January 16, 2015

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1038

Page 1, line 17, after "nurse" insert ", 43-13"

Renumber accordingly

#1
HB1038
1-22-2015

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January 21, 2015

Sheila M. Sandness, CPA
Senior Fiscal Analyst
North Dakota Legislative Council
600 E Boulevard Avenue
Bismarck, ND 58505-0360

Re: Analysis of House Bill No. 1038

Dear Ms. Sandness:

Thank you for your email of December 30, 2014 requesting a cost-benefit analysis of the mandates included in House Bill No. 1038. In accordance with North Dakota Century Code (NDCC) 54-03-28, you asked that we provide information to help determine the following:

a. The extent to which the proposed mandate would increase or decrease the cost of the service;
b. The extent to which the proposed mandate would increase the appropriate use of the service;
c. The extent to which the proposed mandate would increase or decrease the administrative expenses of insurers and the premium and administrative expenses of insureds; and
d. The impact of the proposed mandate on the total cost of health care.

This letter is intended for use by North Dakota legislators and officials for the purpose of considering this proposed legislation. This letter should not be used for other purposes. To the extent that this letter is not subject to disclosure under public records laws, this document should not be distributed to third parties without Milliman's prior written consent. This document may only be released in its entirety. Milliman does not intend to benefit or create a legal duty to any third party recipient of its work.

The results in this letter are technical in nature and are dependent upon specific assumptions and methods. No party should rely upon these results without a thorough understanding of medical insurance policies and how they are priced. Such an understanding may require consultation with qualified professionals.

In doing our work, we have relied on the data and information cited in this letter. This information includes the Senate Bill referenced in your email and various follow up emails between us. If there are changes to the bill, the comments here may no longer be appropriate. This letter is subject to the Professional Services Contract between the State of North Dakota and Milliman executed on December 30, 2014.

Guidelines established by the American Academy of Actuaries require actuaries to include their professional qualifications in actuarial communications. I am a member of the American Academy of Actuaries and meet the qualification standards for performing the analysis in this letter.

Background

House Bill No. 1038 proposes an Act to create section 54-52.1-04.13 of the North Dakota Century Code, regarding coverage for telemedicine services. As requested, we have performed an analysis of the introduced version of the bill.

The definition of telemedicine varies from one source to another, so a detailed definition is essential for understanding and pricing a mandate for coverage of telemedicine services. The introduced version of House Bill No. 1038 stipulates that payors cover health care services provided by means of telemedicine on the same basis as when they are provided in person.

The bill also includes a definition of telemedicine as the use of interactive audio, video, or other telecommunications technology that is used by a health care provider or health care facility to deliver health care services. The health care services must be delivered at a site other than the site at which the patient is located and must be delivered over a secure connection that complies with the requirements of state and federal laws. The bill's definition of telemedicine also includes the use of store-and-forward technology, which permits coverage of telemedicine services that are not administered in real time.

The bill does not appear to explicitly include nor exclude remote patient monitoring devices used to collect and transmit patient data for monitoring and interpretation, commonly referred to as "telemonitoring" services. We have excluded these services from our analysis. If these services are covered under the bill's definition of telemedicine, the results of this analysis may need to be revised.

Analysis

When evaluating coverage mandates, it is often instructive to review how similar coverage is treated under Medicare.

Medicare covers telemedicine services if they are provided through live, interactive videoconferencing between a beneficiary located at a certified rural site and a distant practitioner. In 2006, there were only 26,000 telemedicine visits billed to Medicare, which is less than one visit for every 300 rural Medicare beneficiaries. The number of visits increased to 38,000 in 2009, which is a large percentage increase, but only represents one additional visit for every 700 rural beneficiaries. More than half of the telemedicine services utilized were related to mental health. Proposed explanations for the modest growth in these services range from lack of universal coverage to non-uniform engineering standards to concerns over confidentiality and liability.

Medicare provides two reimbursements for telemedicine services. The first is to the distant site, which is the location of the medical professional. The distant site is reimbursed based on the usual Medicare reimbursement schedule. The second is the originating site, which is the site used by the member. The originating site must meet certain requirements set by CMS and receives a facility fee of approximately $24.[1]

This legislation could potentially increase access to providers for commercial insurance policyholders in rural areas, but that will depend on the willingness of providers to offer and promote these services and the acceptance of these services among beneficiaries. Below we discuss three ways the new coverage could impact insurance costs. In each case, we show results assuming a 0.5%, 2.0%, and 5.0% impact on utilization rates. While we think these values are in a reasonable range, they should be considered illustrative due to lack of experience data to support them.

We expect the introduction of a telemedicine mandate to have multiple effects as discussed below, though the magnitude of each may be minor. First, some members that already use these services in person will use them via telemedicine technology instead. Second, utilization will increase as members that previously did not use in-person services (for example, because they found in-person services to be inconvenient) will be drawn to telemedicine. Finally, we expect the utilization of specialist services may see an additional increase due to the access provided by store-and-forward technology.

We have used the 2014 Milliman *Commercial Health Cost Guidelines*™ to find the average utilization and cost for our illustrative results. We assume that the services affected will be similar to those utilized by Medicare beneficiaries, including mental health, primary care visits, and specialist visits. We also assumed that services would be utilized in non-MSA locations, as telemedicine has typically been used to increase access for rural areas. We have also assumed that services are provided by a distant provider to a patient at an originating site, such as a physician's office or outpatient clinic.

Based on the analysis described below, we expect this mandate may increase insurance costs in the range of $0.24 to $2.38 per member per month (PMPM), depending on the impact on utilization. This assumes that telemedicine services are not currently covered and that implementation of the technology is pursued on a proactive basis. (Of course, if the law is passed, but the technology is not adopted, there will be no additional cost.)

Existing Services Provided Real Time

Services provided in real time through the use of interactive audio, video, or other technology will typically be provided on location at an "originating site." We expect there will be a facility fee paid to the originating site for these services. For the purpose of this analysis, we are assuming a fee of $48 (approximately 200% of Medicare).

Table 1 below shows the additional cost of these fees on a per member per month basis, assuming 0.5%, 2.0%, and 5.0% of services currently provided in person are instead provided through telemedicine. Because these services are already provided in person, the only additional cost is the facility fee to the originating provider. We are showing the additional cost before and after adding a 10% load for insurer administrative costs and margin which we might expect to see flow through to premiums.

The figures in the table represent a statewide average. Approximately half the commercial aged population in North Dakota lives in metropolitan areas and half in rural areas. As mentioned above, we expect these services would be provided primarily to patients living in non-MSA locations. This

means that the costs associated with this bill may be negligible in metropolitan areas, and approximately twice the amounts shown in the table in rural areas.

Table 1
Additional Utilization and Cost from Existing Services

% of Existing Services	Util per 1,000	Fee	Cost PMPM	With 10% Admin
0.5	7.15	$48	$0.03	$0.03
2.0	28.60	$48	$0.11	$0.13
5.0	71.50	$48	$0.29	$0.31

New Services Provided Real Time

In addition, we would expect there are services not currently provided, due to access or convenience issues that will be provided if telemedicine services are covered and available. Table 2 shows the impact of adding these costs. In this case, additional fees include both a professional charge for the additional service and the $48 charge for the originating site. Again, for illustrative purposes, we are assuming increases in utilization of 0.5%, 2.0% and 5.0%.

Table 2
Additional Utilization and Cost from New Services

% of Existing Services	Util per 1,000	Fee*	Cost PMPM	With 10% Admin
0.5	7.15	$222.65	$0.13	$0.15
2.0	28.60	$222.65	$0.53	$0.58
5.0	71.50	$222.65	$1.33	$1.46

*Includes average charge for professional services of $174.65 plus $48 telemedicine fee.

Services Provided Via Store-and-Forward

We expect there will also be services provided via "store-and-forward" technology, which may not have been provided otherwise. For example, a patient with a non-emergent foot condition and no specialist nearby, may receive services via telemedicine instead of delaying or foregoing treatment. We expect these would typically be specialist services, which would have somewhat higher professional fees than services provided by a primary care or mental health professional. Table 3 shows the illustrative impact of these services assuming a 0.5%, 2.0%, and 5.0% increase in utilization of specialist services.

Table 3
Additional Utilization and Cost from Store-and-Forward Services

% of Existing Services	Util per 1,000	Fee*	Claim Cost PMPM	With 10% Admin
0.5	2.69	$245.37	$0.06	$0.06
2.0	10.77	$245.37	$0.22	$0.24
5.0	26.93	$245.37	$0.55	$0.61

*Includes average charge for professional services of $197.37 plus $48 telemedicine fee.

Based on this illustrative analysis, we expect this mandate may increase insurance costs in the range of $0.24 to $2.38 PMPM, depending on the impact on utilization. Given that growth in the area of telemedicine has been modest to-date when covered by Medicare, we anticipate that the short-term costs of adding this coverage will be close to the low end of this projection. In particular, we note that telemedicine usage to-date appears to be higher for mental health services than other services, with mental health services making up only about 10% to 20% of the services reflected in the tables above. The results at the higher end of the range assume significant increases in the use of telemedicine for other services, as well. In the long term, use of these services may grow in popularity and have a greater impact. It should be noted that, as use of origination sites increases, the facility fees that they receive may be negotiated to lower per-use rates.

Conclusion

Our analysis shows that adding telemedicine coverage may increase insurance costs in the range of $0.24 to $2.38 PMPM, though we expect costs to be near the low end of this range upon implementation and increase with time. There is a possibility that the use of telemedicine services will significantly increase over the next few years as patient demand changes and as telemedicine equipment and technology becomes easier to use and less expensive. However, provider adoption of telemedicine will depend on whether the associated revenues will support development and maintenance of the necessary infrastructure.

❖❖❖

This letter contains an estimate that future costs for telemedicine services will be in the range of $0.24 to $2.38 PMPM, based on the assumptions described here. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. If actual experience is different from the assumptions used in the calculations, the actual amounts will also deviate from the projected amounts.

Sheila, I hope this letter is helpful to you as you consider this bill. If you have questions regarding this letter, or would like us to do additional analysis, please feel free to contact me at (952) 820-2481 or leigh.wachenheim@milliman.com.

Sincerely,

Leigh M. Wachenheim

Leigh M. Wachenheim, FSA, MAAA
Principal & Consulting Actuary

LMW/dtd

References

1. "Telehealth and Medicare: Payment Policy, Current Use, and Prospects for Growth", Medicare Payment Advisory Commission, *Medicare & Medicaid Research Review*, 2013: Volume 3, Number 4.

#3 HB1038 1-22-15

HB1038

Montana Code Annotated 2014

33-22-138. Coverage for telemedicine services. (1) Each group or individual policy, certificate of disability insurance, subscriber contract, membership contract, or health care services agreement that provides coverage for health care services must provide coverage for health care services provided by a health care provider or health care facility by means of telemedicine if the services are otherwise covered by the policy, certificate, contract, or agreement.

(2) Coverage under this section must be equivalent to the coverage for services that are provided in person by a health care provider or health care facility.

(3) Nothing in this section may be construed to require:

(a) a health insurance issuer to provide coverage for services that are not medically necessary, subject to the terms and conditions of the insured's policy; or

(b) a health care provider to be physically present with a patient at the site where the patient is located unless the health care provider who is providing health care services by means of telemedicine determines that the presence of a health care provider is necessary.

(4) Coverage under this section may be subject to deductibles, coinsurance, and copayment provisions. Special deductible, coinsurance, copayment, or other limitations that are not generally applicable to other medical services covered under the plan may not be imposed on the coverage for services provided by means of telemedicine.

(5) This section does not apply to disability income, hospital indemnity, medicare supplement, or long-term care policies.

(6) For the purposes of this section, the following definitions apply:

(a) "Health care facility" means a critical access hospital, hospice, hospital, long-term care facility, mental health center, outpatient center for primary care, or outpatient center for surgical services licensed pursuant to Title 50, chapter 5.

(b) "Health care provider" means an individual:

(i) licensed pursuant to Title 37, chapter 3, 6, 7, 10, 11, 15, 17, 20, 22, 23, 24, 25, or 35;

(ii) licensed pursuant to Title 37, chapter 8, to practice as a registered professional nurse or as an advanced practice registered nurse;

1

(iii) certified by the American board of genetic counseling as a genetic counselor; or

(iv) certified by the national certification board for diabetes educators as a diabetes educator.

(c) "Store-and-forward technology" means electronic information, imaging, and communication that is transferred, recorded, or otherwise stored in order to be reviewed at a later date by a health care provider or health care facility at a distant site without the patient present in real time. The term includes interactive audio, video, and data communication.

(d) (i) "Telemedicine" means the use of interactive audio, video, or other telecommunications technology that is:

(A) used by a health care provider or health care facility to deliver health care services at a site other than the site where the patient is located; and

(B) delivered over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. 1320d, et seq.

(ii) The term 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.

(iii) The term does not include the use of audio-only telephone, e-mail, or facsimile transmissions.

History: En. Sec. 1, Ch. 164, L. 2013.

Provided by Montana Legislative Services

2

#4 HB1038 1-22-15 HB1038

SECTION 1. Section 54-52.1-04.13 of the North Dakota Century Code is created and enacted as follows:

54 - 52.1 - 04.13. Insurance reimbursement parity for telemedicine services .

1. As used in this section:

~~a. "Health-care facility" means any office or institution at which health care services or treatment of diseases 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.~~

~~b. "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 - 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 .~~

a. ~~c.~~ "Policy" means a medical benefits coverage under a contract for insurance pursuant to section 54 - 52.1 - 04 or under a sel f - insurance plan pursuant to section 54 - 52.1 - 04.2 .

b. ~~d.~~ "Store - and - forward technology" means 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 interactive audio, video, and data communication.

c. ~~e.~~ "Telemedicine":
(1) Means the use of interactive audio, video, or other telecommunications technology that is used by a health care provider or health care facility to deliver health care services at a site other than the site at which the patient is located; and that is delivered over a secure connection that complies with the requirements of state and federal laws.
(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 .
(3) Does not include the use of audio - only telephone, email, or facsimile transmissions.

2. For all policies that become effective after June 30, 2015, and which do not extend past June 30, 2017, the board shall provide medical benefits coverage under a policy that provides coverage for health care services as provided under the terms of the uniform group insurance program medical benefits policy ~~by a health care provider or health care facility~~ by means of telemedicine which are the same as the policy coverage of in-person health care services for reimbursable health care professionals and institutional providers as defined in the medical benefits policy ~~provided by a health care provider or health care facility~~.

3. Reimbursement for ~~Coverage of~~ health care services provided by means of telemedicine under this section is subject to the reimbursement terms of any uniform group insurance program medical benefits policy in effect and may be established through negotiations conducted between the public employees retirement system or its contractor with ~~must be equivalent to the coverage for health care services that are provided in-person by~~ a health care provider or health care facility. Coverage under this section may be subject to deductible, coinsurance, and copayment provisions. ~~Special deductible, coinsurance, copayment, or other limitations that are not generally applicable to other health care services covered~~

~~under the policy may not be imposed on the coverage for health care services provided by means of telemedicine.~~

4. This section does not require:

a. A policy to provide coverage for health care services that are not medically necessary, subject to the terms and conditions of the insured's policy; or b. A health care provider to be physically present with a patient at the site where the patient is located unless the health care provider who is providing health care services by means of telemedicine determines the presence of a health care provider is necessary.

#5
HB1038
1-22-2015

H.B. 1038
Government and Veterans Affairs Committee
January 22, 2015

Chairman Kasper and committee members, my name is Megan Houn and I am the Director of Government Relations at Blue Cross Blue Shield of North Dakota.

The current healthcare environment is one of exceptional growth, with increasing demands for alternative delivery systems and services. Telemedicine provides the means to realize new care pathways by utilizing technology-based delivery platforms, improving access statewide.

BCBSND's current telemedicine medical policy, which includes the NDPERS group, reimburses providers who utilize telemedicine in a healthcare based facility, meaning both the provider and patient/member need to be in a properly equipped healthcare setting. Telemedicine is largely used for specialty related care at this time and is reimbursed at the same rate as if the individual was seen in person by the provider. Recently with the advent of new technology, our employer groups have been seeking more innovative telehealth benefits Employers are seeking these solutions in hopes of increasing access and convenience for their employees and family members. This has prompted BCBSND to engage our provider partners across the state on future opportunities.

BCBSND's goal is to deliver affordable solutions to improve the care and health of those we serve. While we are generally supportive of this bill, we have concerns with the language included in Section 1, which states "Coverage of health care services provided by means of telemedicine under this section must be equivalent to the coverage for health care services that are provided in - person by a health care provider or health care facility. Coverage under this section may be subject to deductible, coinsurance, and copayment provisions. Special deductible, coinsurance, copayment, or other limitations that are not generally applicable to other health care services covered under the policy may not be imposed on the coverage for health care services provided by means of telemedicine."

This provision appears to require NDPERS to reimburse for telemedicine services at the same rate (or "equivalent" coverage) as reimbursed for services provided in-person by a health care provider or health care facility. BCBSND has concerns that this language will serve to drive costs up for these types of visits. As an example, a national telemedicine provider currently provides an "e-visit" through a cell phone App for an advertised rate of $49; a rate well below the cost of an on-site clinic visit. In addition, we have local providers in the state that have telemedicine capabilities that would be able to provide similar services at a competitive price. Under the current language in Section 1, requiring equivalent reimbursement, the telemedicine e-visit cost will likely increase substantially.

BCBSND supports the amendment proposed by Representative Keiser, which removes the requirement that the reimbursement must be equivalent and which permits NDPERS to

reimburse for health care services under the terms of the current NDPERS health insurance contracts.

If the Keiser amendments are adopted by this committee, BCBSND concerns will be addressed and we can stand in full support of H.B. 1038.

Mr. Chair and members of the committee, this concludes my prepared remarks. I would be happy to answer any questions you may have.

Megan Smith Houn

#6
HB1038
1-28-15

EMPLOYEE BENEFITS PROGRAMS COMMITTEE REPORT TO THE 64TH LEGISLATIVE ASSEMBLY REGARDING PROPOSED HOUSE BILL NO. 1038

Date: October 29, 2014

Original LC#: 15.0079.02000

Sponsor: Legislative Management (Health Care Reform Review Committee)

Proposal: The bill require the medical benefits coverage of services provided by the health care provider by means of telemedicine to be the same as the medical benefits coverage for the same services provided by the health care provider in-person.

Actuarial analysis: There are many different ways and mediums by which telemedicine is delivered today and there will likely continue to be additional advances in this regard. The current PERS medical benefits cover health care facility-based services from provider to members, and Blue Cross Blue Shield of North Dakota has therefore stated that there would be no cost impact if the coverage parameters are not changed. However, Blue Cross Blue Shield of North Dakota has stated that if the intent is to expand coverage of telemedicine mediums other than what is currently covered, there may be additional cost to the plan. Telemedicine providers claim impressive returns on investment; however, the equipment can be expensive. Therefore, the services and mediums by which telemedicine is delivered need to be specifically considered and defined in the plan.

Committee report: Favorable recommendation.

North Dakota Hospital Association

#7
HB 1038
1-22-15

Vision
The North Dakota Hospital Association will take an active leadership role in major Healthcare issues.

Mission
The North Dakota Hospital Association exists to advance the health status of persons served by the membership.

Testimony: HB 1038
Tele-health Parity
House Government & Veterans Affairs Committee
January 22, 2015

Good morning Chairman Kasper and Members of the House Government and Veterans Affairs Committee. I am Jerry E. Jurena, President of the North Dakota Hospital Association. I am here today in support of HB 1038 and also a concern addressed by some of our members.

The concern is centered on the parity of payment of a virtual visit and an in-house visit. We believe there are some long range implications that may impact primary care in rural area.

With me today is Matt Grimshaw CEO of Mercy Medical Center in Williston to explain these concerns.

Respectfully,

Jerry E. Jurena, President
North Dakota Hospital Association

PO Box 7340 Bismarck, ND 58507-7340 Phone 701 224-9732 Fax 701 224-9529

Mercy Medical Center

#8
HB 1038
1-22-15

January 21, 2015

Good Morning.

Thank you for the opportunity to speak with you today regarding House Bill 1038. As the President of CHI-Mercy Medical Center in Williston, we are on the front lines trying to meet the rapidly changing health care needs in our region. Our mission drives us to do everything we can to meet these needs, and that is exactly what we have been doing. In the past 5 years we have recruited nearly 20 full time providers to Williston which has enabled us to significantly expand the services we offer, and we anticipate further expansion as our population grows. Furthermore, we are not only supporters of the idea of telemedicine, but we rely on it every day to help us meet our patients' needs. However, I have significant concerns about the way this current bill is written, and believe it poses a huge risk to the long term viability of not only Mercy, but every rural provider in our State.

CHI-Mercy Medical Center currently partners with several organizations who provide vital telemedicine services to patients in our Emergency Department, Behavioral Health Services and Medical Oncology. We have also explored other virtual health solutions to meet the rapidly growing demand for services, and expect more in the future. However, while I believe the intent behind House Bill 1038 is positive, the potential for very negative consequences is too significant to ignore.

The idea of mandating reimbursement for telemedicine may seem like a positive thing until you look at the economic realities of the existing health care providers across our state. Our costs including providers and support staff are higher than they have ever been, and are inherently different than a vendor who can market a virtual service directly to a consumer via a kiosk or their home computer. Currently the majority of hospitals in North Dakota are operating at a loss, and the high costs we are experiencing are the primary driver of this reality. I am very concerned that this bill would allow anyone with a ND license to provide virtual services from primary care to specialty services and urgent care and mandate that they be reimbursed equal to an in-person visit when their costs are much lower than ours.

While there definitely are clinical services with proven track records and clinical outcomes using telemedicine, there are many others where telemedicine is clinically

1301 15th Avenue West Williston, ND 58801
Phone 701.774.7400 www.mercy-williston.org

inappropriate. For example, there is a good reason why insurance companies and most physicians to not currently offer virtual visits for primary care. It is simply not good medicine. The idea that there is seemingly no distinction between an office visit where you have a nurse and physician performing a comprehensive evaluation and a provider who uses a computer screen and camera to have a conversation about symptoms is inconceivable. If this bill were to pass, why would anyone ever provide face-to-face medical services? Quite simply, I believe this bill would open the floodgates to organizations who offer direct to consumer services who would leave us to pick up the pieces when there is a serious problem. Not only does this bill create an opportunity for substandard care to be reimbursed in a way that is not the national standard, but more than that, it will siphon vital revenue from the physicians and organizations our communities rely on.

So what can be done? I propose a simple solution. If the language were modified to only cover specialty providers, and then only after an initial evaluation has been completed by an in-person provider who makes the referral, we would support House Bill 1038.

Thank you for your time, and I would be happy to answer any questions you may have.

Matt Grimshaw, President

CHI-Mercy Medical Center

copy 801 JK

Essentia Health

HB1038
1-22-2015

Hand Delivered & Electronic Mail

#9

January 22, 2015

Chairman Kasper and Members of the Committee,

Thank you for the opportunity to comment in support of House Bill 1038 -- Telehealth Reimbursement Parity legislation.

Essentia Health currently provides specialty medical and health professional services using Telehealth from Fargo & Minot to four North Dakota clinics located in Jamestown, Lisbon, Valley City and Wahpeton. The two focus areas are mental health and diabetes care. Diabetes is one of the State and nation's most prevalent diseases; it is costly and leads to other complex health problems. Emergency room videoconferencing is also provided. It is used to connect rural nurses, nurse practitioners and physician assistants to the Fargo ER to provide immediate, effective expertise and support in the rural setting. More outreach programs are needed to improve access to care for people living in rural areas of North Dakota. Specialist providers are scarce and using technology stretches their "reach".

Stroke is a leading cause of disability and is the #4 leading cause of death in North Dakota. Consequently, the economic burden weighs heavily on health care with costs for stroke care projected to climb to from $71 billion to $183 billion nationally by the year 2030, according to a recent study. TeleStroke technology is capable of delivering expedited treatment, reducing cost and improving quality of care for stroke patients. Essentia Health supports the advancement of this bill to improve collaboration of care throughout North Dakota in an effort to promote optimal stroke patient outcomes and reduce the negative impact of stroke in our state. Rehab therapies are needed after a stroke occurs and access in rural health care facilities can be limited. Telehealth outreach augments this and provides additional expertise. The language in the House Bill 1038 includes coverage for rehab specialists.

House Bill 1038 does not include coverage for tele-home monitoring. The North Dakota Health Information Network and Essentia Health recommend that additional coverage language be added. Best practices are methods used in health care to bring about the best quality outcomes at the lowest costs. Using tele-home monitoring devices are a proven best practice example and are used to maintain people with complex health problems independently in their homes. Often used after hospital discharge, vital signs are taken daily by the patient and downloaded to a central station that is monitored by nurses. When a problem is identified immediate intervention occurs. The elderly patient avoids costly emergency room visits and re-admissions to the hospital or nursing home. This technology can maintain their independence for several years. With the annual cost of assisted living or long term care being from $36,000 to $60,000 a year, every avoided month is important to the citizens of North Dakota and also for ND Medical Assistance cost-savings.

Please feel free to contact us for further information.

Respectfully submitted,

Maureen Ideker

Maureen Ideker MBA, RN BSN
Essentia Health
Director of Telehealth
Maureen.ideker@essentiahealth.org
Co- Chair ND Health Information Network Telehealth Workgroup

Ahren Dosch

Ahren Dosch MSN, RN
Essentia Health-Fargo
Stroke & Telemedicine Coordinator
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ahren.dosch@essentiahealth.org

HB1038
1-22-2015

#10

January 20, 2015

Chairman Kasper and members of the Government and Veterans Affairs Committee.

My name is Marsha Waind. I am the Regional Services and Telemedicine Manager at Altru Health System in Grand Forks, ND. I appreciate the opportunity to speak in support of HB 1038 Telehealth Parity.

Altru has been a Telemedicine provider to rural North Dakota and Minnesota residents for more than 8 years. Last year, Altru provided more than 2500 patient provider visits connecting to more than 30 locations. We connect via secure interactive 2 way video-audio connections to rural hospitals, nursing homes, rural clinics and patient homes for daily monitoring. Both customer and provider surveys have excellent satisfaction ratings.

Altru providers include physicians and advance practice nurses, dieticians, behavioral health counselors, diabetes educators, speech therapists. They have seen Telemedicine visits improve outcomes by providing **service at the right time to the right patient at the right place**. Telemedicine technology strips away barriers of travel time and expense, and allows the family or direct care provider to be a part of the visit. This improves care planning and health care decision making. The store-and-forward provision is well thought out as a provision of care and relevant to North Dakota care.

Connections to a rural hospital inpatient may keep that patient in the rural hospital bed while being supported with care from a specialist hundreds of miles away. Shared electronic medical records provide accurate and timely medical information as tools for assessment and advanced care. This decreases the need for transfer and **improves the economic status** of our rural facilities. **Provider networking relationships** grow from these encounters to provide professional support to the rural provide.

Telehealth Parity Bill No.1038 is a positive step in reaching North Dakotans throughout the State with quality care wherever they may be. A recommendation for consideration would be to **remove the stipulation of a healthcare facility as an originating site.** An example of how this affects patient care: Altru Neurologist connects to the Developmental residential facility to observe a resident in their environment for seizure activity and care plan with the staff a medication protocol. Telemedicine enhances this resident's care. Similarly, a child in a psychiatric residential center could have an appointment with his psychiatrist from the safety and security of the residential center. Or, Hospice care in the home currently has the ability to connect over secure video with a Palliative care physician to provide assessment and care in the end stages of life. This provides comfort and reduces stress, and may keep someone out of a hospital bed. These service would not be reimbursed under the current language.
Schools: School telehealth clinics: Children in rural schools do not have advantage of a school nurse on-site. A school telehealth clinic could connect the children to providers such as behavioral health counselors, psychiatrists, diabetes educators, dieticians. These providers would connect with the school teachers, administration and others to devise the best educational plan for children. This has been extremely efficient in other States.

To make this positive change to Bill 1038, I suggest that on Page No. 1, delete line 10 through 14; Page 2, line 5,delete "or health care facility"; Page 2, Line 19, delete " or health care facility" ; Page 2, line 22 "or health care facility".

Thank you for your consideration for changes to the HB 1038. The work of the Committee will enhance opportunities for North Dakotan's to access their healthcare.

Marsha Waind, MOTR/L, CHT, CLT
Manager of Regional Services and Telemedicine & Co-chair of the Telehealth Workgroup NDHIN
Altru Health System Grand Forks, ND

#11
HB 1038
1-22-15

January 22, 2015

Dear Representative Keiser and Chairman Kasper,

On behalf of the North Dakota Occupational Therapy Association, I am writing to you regarding House Bill 1038. NDOTA recognizes the rural nature of our state and the positive implications that telehealth can have on residents in the state.

First, we have concern regarding 'home' not being listed as an originating site for telehealth. The Medicare telehealth Parity Act of 2014 HR 5380 covers "remote patient management for Chronic Health Conditions". In addition, it further clarifies that Home telehealth Site is defined with respect to telehealth service described in clause (ii) furnished to an individual, in place of residence used as the home of such individual. In addition, telehealth services described in this clause include services that relate to the provision of hospice care, home dialysis, home health services, or durable medical equipment and shall include the use of video conferencing. Without listing "home" in the bill as it is, this limits what services residents of North Dakota might receive. For example, if an individual resides in a very rural area he/she may not have access to follow-up services to address secondary concerns of stroke, such as post-stroke fatigue which could be addressed through telehealth services.

A lack of primary care providers, specialty providers, and transportation continues to be a significant barrier to access health care in medically underserved rural and urban areas. Even getting to an actual facility can be very difficult. North Dakota rural areas have difficulty attracting and retaining health professionals, as well as supporting local health facilities to provide a continuum of health care. We thank you for your attention to this issue in studying healthcare in North Dakota and hope that you might capitalize on telehealth service delivery to ensure that the great people of North Dakota have access to services in remote and underserved areas. Therefore, we are asking that you support an amendment that would clarify that in addition to "health care facilities," telemedicine should be allowed from the home of a patient.

Thank you for your time.

Carol Olson, PhD, OTR/L, FAOTA
North Dakota Occupational Therapy Association

#1 1038
2-19-15

15.0079.02004
Title.

Prepared by the Legislative Council staff for
House Government and Veterans Affairs
Committee

February 17, 2015

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1038

Page 1, line 8, replace "**reimbursement parity for**" with "**coverage of**"

Page 1, line 10, after "a." insert: ""Distant site" means a site at which a health care provider or health care facility is located while providing medical services by means of telemedicine.

b."

Page 1, line 10, replace "health care" with "medical"

Page 1, line 11, remove "or treatment of diseases"

Page 1, line 15, replace "b." with "c."

Page 1, line 17, after "nurse" insert ", 43-13"

Page 1, line 19, replace "c." with:

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

e."

Page 1, line 19, remove the first "a"

Page 1, line 22, replace "d." with "f."

Page 2, line 1, after "includes" insert "telehome monitoring and"

Page 2, line 3, replace "e." with "g."

Page 2, line 5, after "facility" insert "at a distant site"

Page 2, line 6, replace "health care" with "medical"

Page 2, line 6, replace "a site other than the" with "an originating"

Page 2, line 6, remove "at which the patient"

Page 2, line 7, remove "is located"

Page 2, line 16, replace the first "health care" with "medical"

Page 2, line 16, remove "provided by a health care provider or"

Page 2, line 17, replace "health care facility" with "delivered"

Page 2, line 17, replace "are" with "is"

Page 2, line 17, remove "policy"

Page 2, line 18, replace "of" with "for medical services delivered by"

Page 2, line 18, remove "health care services provided by a health care provider or"

Page 2, line 19, replace "health care facility" with "means"

Page 2, line 20, replace "Coverage of health care" with "Payment or reimbursement of expenses for covered medical"

Page 2, line 20, replace "provided" with "delivered"

Page 2, line 21, replace "must" with "may"

Page 2, line 21, replace "equivalent to the coverage for health care" with "established through negotiations conducted by the board or the board's contractor with the medical services providers in the same manner as the board establishes payment or reimbursement of expenses for covered medical"

Page 2, line 21, replace "provided" with "delivered by"

Page 2, line 22, replace "by a health care provider or health care facility" with "means"

Page 2, line 22, after the underscored period insert:

"4."

Page 2, line 23, remove "Special"

Page 2, remove lines 24 through 26

Page 2, line 27, replace "4." with "5."

Page 2, line 28, replace "health care" with "medical"

Page 2, line 29, remove "insured's"

Page 2, line 29, remove "or"

Page 2, line 30, after "b." insert: "A policy to provide coverage for medical services delivered by means of telemedicine if the policy would not provide coverage for the medical services if delivered by in-person means;

c. A policy to reimburse a health care provider or health care facility for expenses for medical services delivered by means of telemedicine if the policy would not reimburse that health care provider or health care facility if the medical services had been delivered by in-person means; or

d."

Page 2, line 30, after the first "the" insert "originating"

Page 2, line 30, remove "where the"

Page 2, line 31, remove "patient is located"

Page 2, line 31, replace "providing health care" with "delivering medical"

Renumber accordingly

15.0079.02004

#2 1038
2-19-15

Sixty-fourth
Legislative Assembly
of North Dakota

HOUSE BILL NO. 1038

Introduced by

Legislative Management

(Health Care Reform Review Committee)

A BILL for an Act to create and enact section 54-52.1-04.13 of the North Dakota Century Code, relating to public employees retirement system uniform group insurance coverage of telemedicine; to require a report regarding coverage of telemedicine; and to provide an expiration date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Section 54-52.1-04.13 of the North Dakota Century Code is created and enacted as follows:

54-52.1-04.13. Insurance ~~reimbursement parity for~~coverage of telemedicine ser ices.

1. As used in this section:

   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 telemedicine.

   b. "Health care facility" means any office or institution at which ~~health care~~medical services ~~or treatment of diseases~~ 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.

   ~~b.~~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.

   ~~c.~~d. "Originating site" means a site at which a patient is located at the time medical services are provided to the patient by means of telemedicine.

e. "Policy" means ~~a~~ medical benefits coverage under a contract for insurance pursuant to section 54-52.1-04 or under a self-insurance plan pursuant to section 54-52.1-04.2.

~~d.~~f. "Store-and-forward technology" means 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.

~~e.~~g. "Telemedicine":

(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 care~~medical services at ~~a site other than the~~an originating site ~~at which the patient is located~~; and that is delivered over a secure connection that complies with the requirements of state and federal laws.

(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.

(3) Does not include the use of audio-only telephone, email, or facsimile transmissions.

2. For all policies that become effective after June 30, 2015, and which do not extend past June 30, 2017, the board shall provide medical benefits coverage under a policy that provides coverage for ~~health care~~medical services ~~provided by a health care provider or health care facility~~delivered by means of telemedicine which ~~are~~is the same as the ~~policy~~ coverage ~~of~~for medical services delivered by in-person ~~health care services provided by a health care provider or health care facility~~means.

3. ~~Coverage of health care~~Payment or reimbursement of expenses for covered medical services ~~provided~~delivered by means of telemedicine under this section ~~must~~may be ~~equivalent to the coverage for health care~~established through negotiations conducted by the board or the board's contractor with the medical services providers in the same manner as the board establishes payment or reimbursement of expenses for covered

medical services that are ~~provided~~delivered by in-person ~~by a health care provider or health care facility~~means.

4. Coverage under this section may be subject to deductible, coinsurance, and copayment provisions. ~~Special deductible, coinsurance, copayment, or other limitations that are not generally applicable to other health care services covered under the policy may not be imposed on the coverage for health care services provided by means of telemedicine.~~

~~4.~~5. This section does not require:

a. A policy to provide coverage for ~~health care~~medical services that are not medically necessary, subject to the terms and conditions of the ~~insured's~~ policy; ~~or~~

b. A policy to provide coverage for medical services delivered by means of telemedicine if the policy would not provide coverage for the medical services if delivered by in-person means;

c. A policy to reimburse a health care provider or health care facility for expenses for medical services delivered by means of telemedicine if the policy would not reimburse that health care provider or health care facility if the medical 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 ~~where the patient is located~~ unless the health care provider who is ~~providing health care~~delivering medical services by means of telemedicine determines the presence of a health care provider is necessary.

SECTION 2. PUBLIC EMPLOYEES RETIREMENT SYSTEM - COVERAGE OF TELEMEDICINE SERVICES. Pursuant to section 54-03-28, the public employees retirement system shall prepare and submit for introduction a bill to the sixty-fifth legislative assembly to repeal the expiration date for section 1 of this Act and to extend the coverage of telemedicine services to apply to all group and individual health insurance policies. The public employees retirement system shall append to the bill a report regarding the effect of the telemedicine coverage 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 continue.

1 **SECTION 3. EXPIRATION DATE.** Section 1 of this Act is effective through July 31, 2017,
2 and after that date is ineffective.

#3 1038
2-19-15

NDLA, H GVA - Hart, Carmen

From: NDLA, Intern 06 - Lafferty, Austin
Sent: Thursday, February 19, 2015 11:37 AM
To: -Grp-NDLA House Government & Veterans Affairs
Cc: NDLA, H GVA - Hart, Carmen
Subject: HB1038 Follow-up

Chairman Kasper and Committee Members

While the committee did already give HB1038 a Do Pass as Amended recommendation, Jen Clark sent down the following explanation to answer Rep. Walkman's question regarding word usage:

54-52.1-01 provides the definitions, including "medical benefits coverage", and 54-52.1-04 goes on to use that term when it directs the PERS board to contract for insurance, thus the change to "medical services" as opposed to "health care services"

Thanks

Austin

#4 1038
2-19-15

Avera eCARE™

eHelm
4500 N Lewis Avenue
Sioux Falls, SD 57104
(605) 322-4767
Fax (605) 322-2091

www.Avera.org/eCARE

January 20, 2015

Chairman Jim Kasper
North Dakota State Capitol
600 East Boulevard
Bismarck, ND 58505-0360

Re: Support for Telemedicine Parity - ND House Bill No. 1038 - LC Number 15.0079.02000

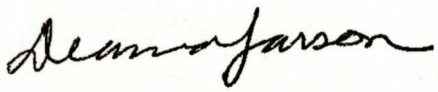
Dear Chairman Kasper and Government and Veterans Affairs Committee,

I am writing to register our support for the Telemedicine Party Bill which goes to committee for testimony this Thursday, January 22nd. Currently, twenty states and the District of Columbia specify that state-regulated health benefit plans need to pay for telehealth as a way of delivering services covered using "traditional" means. We support your bill which recognizes the benefits and efficiencies telemedicine has to offer. Telemedicine is especially beneficial in rural, frontier and underserved areas where we have found that 17-30% of patients wouldn't get care without a telemedicine option.

Payment parity provides the right incentives for providers to begin a telemedicine practice and extend access to care. Without parity, the variety of payment rules by different payers makes it difficult for providers to understand when and how, and even if, they will be paid. This creates a substantial disincentive to even try to attempt telemedicine. We applaud North Dakota for addressing this issue in passing parity legislation for telemedicine payment.

We appreciate your time and are very thankful for the positive relationships and impact we are having on the residents of North Dakota with our eCARE services. Currently, we support 29 hospitals in North Dakota with our eEmergency program. Please feel free to call us for any telehealth-related concerns or questions you may have.

Sincerely,



Deanna Larson, Sr. VP Quality and eCARE
Avera Health
deanna.larson@avera.org
605-322-2387

CC: Deb Fischer-Clemens, Danielle Hamann, David Erickson, MD, Lynette Dickson

#5 1038
2-19-15

15.0079.02002
Title.

Prepared by the Legislative Council staff for
Representative Rohr
February 5, 2015

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1038

Page 1, line 8, replace "**reimbursement parity for**" with "**coverage of**"

Page 1, line 10, after "a." insert: ""Distant site" means a site at which a health care provider or health care facility is located while providing medical services by means of telemedicine.

b."

Page 1, line 10, replace "health care" with "medical"

Page 1, line 11, remove "or treatment of diseases"

Page 1, line 15, replace "b." with "c."

Page 1, line 19, replace "c." with:

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

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Page 2, after line 22, insert:

"4."

Page 2, line 23, remove "Special"

Page 2, remove lines 24 through 26

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Page 2, line 29, remove "insured's"

Page 2, line 29, remove "or"

Page 2, line 30, after "b." insert: "A policy to provide coverage for medical services delivered by means of telemedicine if the policy would not provide coverage for the medical services if delivered by in-person means;

c. A policy to reimburse a health care provider or health care facility for expenses for medical services delivered by means of telemedicine if the policy would not reimburse that health care provider or health care facility if the medical services had been delivered by in-person means; or

d."

Page 2, line 30, after the first "the" insert "originating"

Page 2, line 30, remove "where the"

Page 2, line 31, remove "patient is located"

Page 2, line 31, replace "providing health care" with "delivering medical"

Renumber accordingly

15.0079.02002

#6 1038
2-19-15

Sixty-fourth
Legislative Assembly
of North Dakota

HOUSE BILL NO. 1038

Introduced by

Legislative Management

(Health Care Reform Review Committee)

A BILL for an Act to create and enact section 54-52.1-04.13 of the North Dakota Century Code, relating to public employees retirement system uniform group insurance coverage of telemedicine; to require a report regarding coverage of telemedicine; and to provide an expiration date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Section 54-52.1-04.13 of the North Dakota Century Code is created and enacted as follows:

54-52.1-04.13. Insurance ~~reimbursement parity for~~coverage of telemedicine services.

1. As used in this section:

   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 telemedicine.

   b. "Health care facility" means any office or institution at which ~~health care~~medical services ~~or treatment of diseases~~ 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.

   ~~b.~~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, 43-15, 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.

   ~~c.~~d. "Originating site" means a site at which a patient is located at the time medical services are provided to the patient by means of telemedicine.

e. "Policy" means ~~a~~ medical benefits coverage under a contract for insurance pursuant to section 54-52.1-04 or under a self-insurance plan pursuant to section 54-52.1-04.2.

~~d.~~f. "Store-and-forward technology" means 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.

~~e.~~g. "Telemedicine":

(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 care~~medical services at ~~a site other than the~~an originating site ~~at which the patient is located~~; and that is delivered over a secure connection that complies with the requirements of state and federal laws.

(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.

(3) Does not include the use of audio-only telephone, email, or facsimile transmissions.

2. For all policies that become effective after June 30, 2015, and which do not extend past June 30, 2017, the board shall provide medical benefits coverage under a policy that provides coverage for ~~health care~~medical services ~~provided by a health care provider or health care facility~~delivered by means of telemedicine which ~~are~~is the same as the ~~policy~~ coverage ~~of~~for medical services delivered by in-person ~~health care services provided by a health care provider or health care facility~~means.

3. ~~Coverage of health care~~Payment or reimbursement of expenses for covered medical services ~~provided~~delivered by means of telemedicine under this section ~~must~~may be ~~equivalent to the coverage for health care~~established through negotiations conducted by the board or the board's contractor with the medical services providers in the same manner as the board establishes payment or reimbursement of expenses for covered

medical services that are ~~provided~~delivered by in-person ~~by a health care provider or health care facility~~means.

4. Coverage under this section may be subject to deductible, coinsurance, and copayment provisions. ~~Special deductible, coinsurance, copayment, or other limitations that are not generally applicable to other health care services covered under the policy may not be imposed on the coverage for health care services provided by means of telemedicine.~~

~~4.~~5. This section does not require:

a. A policy to provide coverage for ~~health care~~medical services that are not medically necessary, subject to the terms and conditions of the ~~insured's~~ policy; ~~or~~

b. A policy to provide coverage for medical services delivered by means of telemedicine if the policy would not provide coverage for the medical services if delivered by in-person means;

c. A policy to reimburse a health care provider or health care facility for expenses for medical services delivered by means of telemedicine if the policy would not reimburse that health care provider or health care facility if the medical 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 ~~where the patient is located~~ unless the health care provider who is ~~providing health care~~delivering medical services by means of telemedicine determines the presence of a health care provider is necessary.

SECTION 2. PUBLIC EMPLOYEES RETIREMENT SYSTEM - COVERAGE OF TELEMEDICINE SERVICES. Pursuant to section 54-03-28, the public employees retirement system shall prepare and submit for introduction a bill to the sixty-fifth legislative assembly to repeal the expiration date for section 1 of this Act and to extend the coverage of telemedicine services to apply to all group and individual health insurance policies. The public employees retirement system shall append to the bill a report regarding the effect of the telemedicine coverage 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 continue.

1 **SECTION 3. EXPIRATION DATE.** Section 1 of this Act is effective through July 31, 2017,
2 and after that date is ineffective.

Attach #1
HB 1038
03/11/2015
J#24665

26.1-36-08.1. Alternative group health policy and health service contract substance abuse coverage.

1. As an alternative to the substance abuse coverage required under subsection 2 of section 26.1-36-08, an insurance company, a nonprofit health service corporation, or a health maintenance organization may provide substance abuse coverage under this section.

2. The provisions of section 26.1-36-08 apply to this alternative, except:

a. In addition to the inpatient treatment, treatment by partial hospitalization, and outpatient treatment coverage required under section 26.1-36-08, the coverage must include residential treatment.

b. In the case of coverage for inpatient treatment, the benefits must be provided for a minimum of forty-five days of services covered under this section and section 26.1-36-09 in any calendar year.

c. For the purpose of computing the period for which benefits are payable for a combination of inpatient and partial hospitalization, no more than twenty-three days of inpatient treatment benefits required under subdivision a may be traded for treatment by partial hospitalization.

d. In the case of coverage for residential treatment, the benefits must be provided for a minimum of sixty days of services covered under this section in any calendar year. This residential treatment must be provided by an addiction treatment program licensed under chapter 50-31. If an individual receiving residential treatment services requires more than sixty days of residential treatment services, unused inpatient treatment benefits provided for under subdivision b may be traded for residential treatment benefits. For the purpose of computing the period for which benefits are payable, each day of inpatient treatment is equivalent to two days of treatment by a residential treatment program, provided that no more than twenty-three days of inpatient treatment benefits required by this section may be traded for residential treatment benefits required under this section.

History.

S.L. 2003, ch. 255, § 2.

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Attach #2
HB 1038
03/11/2015
J#24665

TESTIMONY ON HB 1038

Madam Chairperson Senator Lee and Committee Members,

I am Cheryl Rising, FNP and legislative liaison for the North Dakota Nurse Practitioner Association (NDNPA). We do support HB 1038 that speaks to telemedicine.

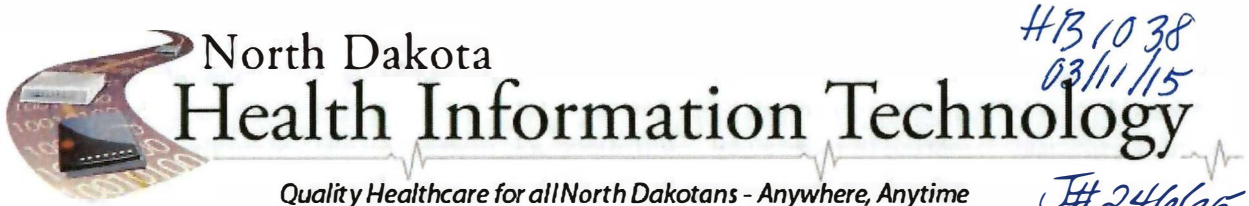
On page one line 17 c, health care provider does include a registered nurse or advanced practice registered nurse and we support this.

We do not support the change in provider neutral language. Several areas were changed from health care to medical services. However; in our inquiring about this change we were told that the change needed to occur due to the 2 year trial this bill will have and meeting the language standards. If there is a way to have provider neutral language we would prefer that.

Cheryl Rising, FNP

701-527-2583

Attach #3
HB 1038
03/11/15
J#24665



Testimony in Support of HB 1038

March 11, 2015

Chairman Lee and members of the Senate Human Services Committee:

My name is Marsha Waind. I am the Co-Chair of the Telehealth Domain Workgroup of North Dakota Health Information Technology Advisory Committee and the Telemedicine Manager of Altru Health System, Grand Forks, ND. I appreciate the opportunity to speak in support of HB 1038 Telehealth Parity. The Workgroup has thoroughly discussed the bill, provided testimony in support of the bill to the House Committee Health Care Reform Review Committee.

Telehealth Parity Bill No.1038 is a positive step in reaching North Dakotans throughout the State with healthcare that is the right level of care, at the right time and conveniently available.

Concerns were raised to the House committee in regards to the language addressing the "health care facility" Line 10, in that those facilities listed would be the only locations telemedicine services would be reimbursed from. It was clarified that this is not an inclusive list and that Telemedicine may be reimbursed from other locations in addition to those on the list.
Of importance is three areas of service potential:

1) **Home** as a location: Remote patient management for chronic disease populations. Potentially this may eliminate telemedicine connections that would support home health patients, hospice care, home dialysis, and durable medical equipment. Patients in all these categories would benefit from telemedicine connections to their providers from their place of residence.
2) **School** telehealth clinics: Children in rural schools do not have advantage of a school nurse on-site. A school telehealth clinic could connect the children to providers such as behavioral health counselors, psychiatrists, diabetes educators, dieticians. These providers would connect with the school teachers, administration and others to devise the best educational plan for children.
3) Telemedicine to **Residential facilities** for the Developmental Needs and those in Behavioral care. Addition of "Home Telehealth Site described as site furnished to an individual in their place of residence used as the home of such individual" would provide care for North Dakotan's who would benefit greatly from these situations.

The proposed bill includes a wide variety of medical providers that would be considered Telemedicine providers. The committee supports the list as written in HB 1038.

Altru providers include physicians and advance practice nurses, dieticians, behavioral health counselors, social workers, diabetes educators, speech therapists. Our providers had more than 2600 Telemedicine encounters in 2014 to 40 rural sites. They have seen Telemedicine visits improve patient care outcomes by providing service in conjunction with local care providers.

3.2

Telemedicine technology strips away barriers of travel time, travel costs and allows the family or direct care provider to be a part of the visit. This improves care planning and health care decision making. Connections to a rural hospital may keep a patient in the rural hospital bed while being supported with care from a specialist hundreds of miles away. With electronic medical records, accurate and timely medical information provides tools for assessment and advanced care. This decreases the need for transfer and improves the economic status of our rural facilities. This provides professional support to the rural provider while creating networking relationships that also improves patient care.

Overall:

- Parity for Medical Services provided via Telemedicine will support services for all residents in North Dakota.
- Telehealth technologies can transform health care delivery by improving access to quality care by removing tradition travel barriers to health care delivery such as distance, mobility and time constraints.
- The use of information and telecommunication technologies to deliver health care has the potential to reduce costs, improve quality, change conditions of practice, and improve access to health care, particularly in rural and medically underserved areas.
- A lack of primary care providers, specialty provider, and transportation continues to be a significant barrier to access to health care in medically underserved rural and urban areas.
- North Dakota areas have difficulty attracting and retaining health professionals, as well as supporting local health facilities to provide a continuum of health care.
- Many health care providers in medically underserved areas are isolated from mentors, colleagues, and the information resources necessary to support them personally and professionally.

Thank you for your consideration of this important step in providing quality healthcare for North Dakota

Marsha Waind
Altru Health System
mawaind@altru.org

Maureen D Ideker
Essentia Health
Maureen.Ideker@EssentiaHealth.org

HB1038
Attach#4
03/11/15
J# 24665

Essentia Health

March 11, 2015

Via Email - shms@nd.gov

Chairman Lee & Members of the Senate Human Services Committee

RE: Testimony in Support of HB1038

My name is Maureen Ideker, RN, System Director of Telehealth at Essentia Health – Fargo, ND. My perspective is from 20 years of experience with telemedicine and from the rural hospital, nursing home and clinic settings across Essentia Health. Telehealth services are currently provided at 4 rural clinics in North Dakota and the number of clinics will double over the next year. The main telehealth specialty services used are for behavioral health & diabetes management (Dietician, & Medical Weight Loss MD). Also, the Essentia Health Fargo – Innovis Hospital Emergency Room provides Emergency Medicine & Stroke Specialists by connecting to rural hospitals emergency rooms using videoconferencing. These newly developed sites are projected to provide over 250 telehealth visits in the first year.

There are two areas in the proposed HB1038 Telemedicine Parity legislation that are of utmost importance. The first relates to a broader definition of licensed health care provider eligibility. Currently the following licensed providers are not recognized as eligible for reimbursement. Those excluded from reimbursement are: audiologists, pharmacists, genetic counselors, RN certified diabetic educators, physical therapists, occupational therapists and speech language pathologists, dentists and optometrists. This limitation results in rural North Dakota citizens not having access to needed medical specialties unless they travel long distances -- which is difficult for many for a number of reasons including time, comfort and finances. The HB1038 Bill supports these additions.

The second main issue relates to the originating site eligibility. Currently the rules exclude: group homes, assisted living facilities and homes as sites where the patients can be located to be eligible for reimbursement coverage. This restriction impacts potential telehealth services to the developmentally disabled living in group homes, behavioral health residents of group homes and the elderly in assisted living facilities. Allowing group homes and assisted living facilities to be eligible sites for patients would reduce expensive transfer cost and decrease unnecessary admissions to emergency rooms, especially after daytime business hours. Tele-home monitoring devices should be an eligible service in order to maintain the chronically ill and elderly in independent living environments.

Thank you, and I encourage you to support this patient centered initiative.

Maureen Ideker R.N.

Maureen Ideker RN, BSN, MBA
System Director of Telehealth
Essentia Health
C: 218-371-0596
maureen.ideker@essentiahealth.org

Attach #1
03/25/15
HB 1038 J#25412

Prepared by Intern on March 25, 2015

PROPOSED AMENDMENTS TO REENGROSSED HOUSE BILL NO. 1038

A BILL for an Act to create and enact section 54-52.1-04.13 of the North Dakota Century Code, relating to public employees retirement system uniform group insurance coverage of ~~telemedicine~~telehealth; to require a report regarding coverage of ~~telemedicine~~telehealth; and to provide an expiration date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Section 54-52.1-04.13 of the North Dakota Century Code is created and enacted as follows:

54-52.1-04.13. Insurance coverage of ~~telemedicine~~ telehealthservices.

1. As used in this section:

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 ~~telemedicine~~telehealth.

b. "Health care facility" means any office or institution at which ~~medical~~ 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 ~~medical~~ health services are provided to the patient by means of ~~telemedicine~~telehealth.

e. "Policy" means ~~medical~~ health benefits coverage under a contract for insurance pursuant to section 54-52.1-04 or under a self-insurance plan pursuant to section54-52.1-04.2.

f. "Store-and-forward technology" means 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.

g. "~~Telemedicine~~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 ~~medical~~ health services at an originating site; and that is delivered over a secure connection that complies with the requirements of state and federal laws.

(2) Includes the use of electronic media for consultation relating to the healthcare diagnosis or treatment of a patient in real time or through the use of store-and-forward technology.

(3) Does not include the use of audio-only telephone, email, or facsimile transmissions.

2. For all policies that become effective after June30, 2015, and which do not extend past June30, 2017, the board shall provide ~~medical~~ health benefits coverage under a policy that provides coverage for ~~medical~~ health services delivered by means of ~~telemedicine~~

telehealth which is the same as the coverage for ~~medical~~ health services delivered by in-person means.

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

4. Coverage under this section may be subject to deductible, coinsurance, and copayment provisions.

5. This section does not require:

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

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

   c. A policy to reimburse a health care provider or health care facility for expenses for ~~medical~~ health services delivered by means of telemedicine if the policy would not reimburse that health care provider or health care facility if the ~~medical~~ 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 medical services by means of ~~telemedicine~~ telehealth determines the presence of a health care provider is necessary.

SECTION 2. PUBLIC EMPLOYEES RETIREMENT SYSTEM - COVERAGE OF ~~TELEMEDICINE~~ TELEHEALTH SERVICES. Pursuant to section 54-03-28, the public employees retirement system shall prepare and submit for introduction a bill to the sixty-fifth legislative assembly to repeal the expiration date for section1 of this Act and to extend the coverage of ~~telemedicine~~ telehealth services to apply to all group and individual health insurance policies. The public employees retirement system shall append to the bill a report regarding the effect of the ~~telemedicine~~ telehealth coverage 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 continue.

SECTION 3. EXPIRATION DATE. Section 1 of this Act is effective through July 31, 2017, and after that date is ineffective.