Private Payer Parity in Telemedicine Reimbursement: How State-Mandated Coverage Can Be the Catalyst for Telemedicine Expansion

CARL BENJAMIN LEWIS*

I. INTRODUCTION

Telemedicine, or the use of telecommunications for the delivery of health care services when the health care practitioner and patient are not in the same physical location, is growing in popularity across the nation and around the world. It is safe to say that telemedicine is the future of health care in a culture consumed with technological advancement and interconnectivity. Telemedicine has numerous benefits, but barriers exist that stymie its proliferation. Foremost among these barriers is reimbursement and, more specifically, private insurance reimbursement.

Some states have been proactive in their approach by enacting laws that mandate private insurance coverage of telemedicine. These laws are often referred to as "private payer parity" statutes.[1] Private payer parity is classified as "comparable coverage and reimbursement [by private insurers] for telemedicine-provided services to that of in-person services."[2] Twenty-nine states and the District of Columbia have enacted some form of private payer parity laws.[3] While most of these states have full private payer parity laws, two states have partial parity laws, which seriously limit payment for telemedicine services.[4]

Telemedicine is a fully realized mechanism for providing effective and efficient care, yet advocates for telemedicine have been unable to facilitate its spread throughout the United States. Reimbursement is one of the most often—if not *the* most often—

---

* J.D. Candidate, The University of Memphis Cecil C. Humphreys School of Law, May 2016; *The University of Memphis Law Review*, Senior Articles Editor, Vol. 46; B.A., Political Science, Samford University, 2013. I would like to thank Professor David Romantz, Professor Amy Campbell, Lacy Ward, and Matthew Schwimmer for their invaluable insight throughout the writing of this Note. The reader should note that the information contained in this Note is current as of August 2015. Telemedicine is a rapidly changing field and it is quite possible that there have been changes to the law since this time.

1. *See* LATOYA THOMAS & GARY CAPISTRANT, AM. TELEMED. ASS'N, STATE TELEMEDICINE GAPS ANALYSIS: COVERAGE & REIMBURSEMENT 6–7 (2015), http://www.americantelemed.org/docs/default-source/policy/50-state-telemedicine-gaps-analysis---coverage-and-reimbursement.pdf.

2. *Id.* at 6.

3. ATA STATE TELEMEDICINE TOOLKIT: IMPROVING ACCESS TO COVERED SERVICES FOR TELEMEDICINE, AM. TELEMED. ASS'N 3 (2015), http://www.americantelemed.org/docs/default-source/policy/ata-state-telemedicine-toolkit---coverage-and-reimbursement.pdf?sfvrsn=4 [hereinafter STATE POLICY TOOLKIT]. Arizona, Arkansas (effective January 1, 2016), California, Colorado, Connecticut (effective January 1, 2016), Delaware (effective January 1, 2016), Georgia, Hawaii, Indiana (effective July 1, 2015), Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota (effective January 1, 2017), Mississippi, Missouri, Montana, Nevada (effective July 1, 2015), New Hampshire, New Mexico, New York, Oklahoma, Oregon, Tennessee, Texas, Vermont, Virginia, Washington (effective January 1, 2017), and the District of Columbia have enacted laws mandating the coverage of telemedicine services under private health insurance plans. *Id.*

4. *See id.*; ARIZ. REV. STAT. § 20-841.09 (LexisNexis 2013); COLO. REV. STAT. § 10-16-123(1)–(3) (West 2015).

cited barrier to effective proliferation of telemedicine services.[5] For this reason, private insurance parity legislation is more important than ever if telemedicine is going to enjoy an expansive adoption.

Most importantly, telemedicine is a highly effective means of health care delivery and it should be an integral part of the future of America's health care system. Empirical data shows that mandating private insurance coverage for telemedicine services is the most effective way to facilitate widespread adoption.[6] The current state of telemedicine legislation does not achieve this goal.

There should be nationwide enactment of private payer parity legislation in order to facilitate telemedicine expansion because telemedicine can help to remedy our costly, private-insurance centered healthcare system. Not only should every state enact a private payer parity law, but also the laws should be enacted uniformly to avoid a statutory maze for practitioners in order to overcome the current issues confronting telemedicine statutes. Private payer parity laws will not serve their purpose without a nationwide, standardized adoption. For this reason, this Note proposes model legislation to serve as a guide for states to either revise their private payer parity laws or enact one if they have not already. Part II of this Note provides a history and background on telemedicine, clarifies the difference between telemedicine and telehealth, and explains the benefits of telemedicine use. Part III discusses the current state of private payer parity legislation and highlights why these laws are currently ineffective. Part IV proposes model legislation for states to use when creating their statutes and explains

---

5. *See* Julia Adler-Milstein et al., *Telehealth Among US Hospitals: Several Factors, Including State Reimbursement and Licensure Policies, Influence Adoption*, 33 HEALTH AFF. 207, 210 (2014) (examining factors associated with telehealth adoption among U.S. hospitals using data from the American Hospital Association's 2012 annual survey of acute care hospitals); Stacey Butterfield, Telemedicine Connects Remote Areas with Care, ACP INTERNIST (Apr. 2008), http://www.acpinternist.org/archives/2008/04/one.htm ("All of the interviewed experts listed reimbursement as the biggest hurdle to [telemedicine] implementation.").

6. Adler-Milstein et al., *supra* note 5, at 213 ("[P]olicies—in particular, those that require private payers to reimburse telehealth services to the same extent as face-to-face services—may give hospitals more latitude to choose the type of telehealth to pursue and make it more likely that any type of investment in telehealth will pay off for them.").

how the model law solves the issues in current legislation. Finally, Part V provides concluding remarks on private payer parity legislation as a whole.

II. BACKGROUND, HISTORY, & BENEFITS OF TELEMEDICINE

Telemedicine is a recent and technologically advanced area of health care. Unfortunately, many people, health care providers included, do not understand telemedicine or its benefits.[7] This section explains what telemedicine is and clarifies the difference between telemedicine and telehealth. A brief history of telemedicine is provided to show that the concept is not necessarily a new one. Lastly, this section highlights a few of the innumerable benefits that telemedicine can provide to our health care system.

A. What is Telemedicine/Telehealth?

Most simply put, telemedicine is "the use of technology [or] telecommunications for the delivery of health care services when the health care practitioner and the patient are not in the same physical location."[8] There is little consensus on the definition of telemedicine in the academic and medical community, and the term is often used interchangeably with telehealth.[9] The World Health Organization, which provides a commonly cited definition, defines telemedicine as:

---

7. AM. TELEMED. ASS'N, ATA STATE TELEMEDICINE TOOLKIT: WORKING WITH MEDICAL BOARDS: ENSURING COMPARABLE STANDARDS FOR THE PRACTICE OF MEDICINE VIA TELEMEDICINE, 3−5 (2015), http://www.americantelemed.org/docs/default-source/policy/ata-state-telemedicine-toolkit-medical-boards.pdf.

8. Vanessa Reynolds, *Opportunities and Challenges of Telemedicine*, LAW360 (Oct. 30, 2012, 1:00 PM), http://www.law360.com/articles/390083/opportunities-and-challenges-of-telemedicine.

9. *See, e.g.*, Bradley J. Kaspar, Note, *Legislating for a New Age in Medicine: Defining the Telemedicine Standard of Care to Improve Healthcare in Iowa*, 99 IOWA L. REV. 839, 844 (2014) (noting that telemedicine is often referred to as either telehealth or e-health); *Telemedicine Frequently Asked Questions (FAQs)*, AM. TELEMED. ASS'N, http://www.americantelemed.org/about-telemedicine/faqs#.VGKMrpV0xMs (last visited Dec. 14, 2015) (stating that the American Telehealth Association treats "telemedicine" and "telehealth" as synonyms and uses them interchangeably).

> The delivery of health care services, where distance is a critical factor, by all health care professionals using information and communication technologies for the exchange of valid information for diagnosis, treatment and prevention of disease and injuries, [and] research and evaluation, . . . all in the interests of advancing the health of individuals and their communities.[10]

The broader term "telehealth" normally encompasses telemedicine, but also includes a variety of other services, such as community and professional health-related education, public health, and health administration.[11]

Telemedicine is not a new form of health care, but simply a more modern mode of delivering the same services.[12] The technological aspect of telemedicine consultation is the only variant from

---

10. WORLD HEALTH ORG., TELEMEDICINE: OPPORTUNITIES AND DEVELOPMENTS IN MEMBER STATES 9 (2010), http://www.who.int/goe/publications/goe_telemedicine_2010.pdf (quoting WORLD HEALTH ORG., A HEALTH TELEMATICS POLICY IN SUPPORT OF WHO'S HEALTH-FOR-ALL STRATEGY FOR GLOBAL HEALTH DEVELOPMENT: REPORT OF THE WHO GROUP CONSULTATION ON HEALTH TELEMATICS 10 (1998), http://apps.who.int/iris/bitstream/10665/63857/1/WHO_DGO_98.1.pdf). For other definitions of telemedicine, see Amy E. Zillis, Note, *The Doctor Will Skype You Now: How Changing Physician Licensure Requirements Would Clear the Way for Telemedicine to Achieve the Goals of the Affordable Care Act*, 2012 U. ILL. J.L. TECH & POL'Y 193, 196 (2012) (stating that telemedicine is "the use of electronic communication and information technologies to provide or support clinical care at a distance," and can be "divided into three subsets: interactive, store-and-forward, and remote monitoring"); *For The Media*, AM. TELEMED. ASS'N, http://www.americantelemed.org/about-ata/for-the-media (last visited Dec. 14, 2015) (defining telemedicine as "the delivery of any healthcare service or transmission of wellness information using telecommunications technology.").

11. U.S. DEP'T OF HEALTH & HUMAN SERVS. & DEP'T OF COMMERCE, TELEMEDICINE REPORT TO CONGRESS (Jan. 31, 1997), http://www.ntia.doc.gov/legacy/reports/telemed/execsum.htm [hereinafter 1997 REPORT TO CONGRESS]; *see also* U.S. DEP'T OF HEALTH & HUMAN SERVS., THE ROLE OF TELEHEALTH IN AN EVOLVING HEALTH CARE ENVIRONMENT: INSTITUTE OF MEDICINE REPORT (Nov. 20, 2012), http://www.nap.edu/read/13466/chapter/1.

12. *See* Kristen R. Jakobsen, Note, *Space-Age Medicine, Stone-Age Government: How Medicare Reimbursement of Telemedicine Services is Depriving the Elderly of Quality Medical Treatment*, 8 ELDER L.J. 151, 156 (2000).

traditional health care.[13] State statutes concerning telemedicine most often use the term telemedicine interchangeably with telehealth.[14] Therefore, this Note will refer to telemedicine, but the term is also interchangeable with telehealth.

Telemedicine is generally divided into three subsets: interactive, store-and-forward, and remote monitoring.[15] Interactive telemedicine allows for real-time interaction through office visits, home visits, consultations, and various examinations and procedures when a health care provider and patient are separated geographically and want to communicate in real-time.[16] Interactive telemedicine, while not the most common form, is the most similar to an in-person visit with a health care provider. Another technology, store-and-forward, is one of the most widespread uses of telemedicine.[17] It allows a health care provider at one location to capture, store, and send images, information, and video of the patient; which is then forwarded to another health care provider for them to evaluate at their convenience.[18] Remote patient monitoring is another popular use of telemedicine. It allows health care professionals to regularly monitor patient health while the patient remains at home, leading to fewer office visits for those with chronic or acute illnesses.[19]

---

13. *Id.*

14. *Compare* TENN. CODE ANN. § 56-7-1002 (2014) (referring to coverage for "Telehealth" services, but using the definition of Telemedicine), *with* GA. CODE ANN. § 33-24-56.4 (2014) (referring to payment for Telemedicine services, but defining it similarly to the Tennessee statute).

15. Zillis, *supra* note 10, at 196.

16. *See* AGENCY FOR HEALTHCARE RESEARCH & QUALITY, U.S. DEP'T HEALTH & HUMAN SERVS., TELEMEDICINE FOR THE MEDICARE POPULATION: UPDATE 1 (Feb. 2006), http://archive.ahrq.gov/downloads/pub/evidence/pdf/telemedup/telemedup.pdf [hereinafter MEDICARE UPDATE].

17. *See* Symposium, *Roundtable on Legal Impediments to Telemedicine: Legal Impediments to the Diffusion of Telemedicine*, 14 J. HEALTH CARE L. & POL'Y 1, 2−3 (2011) (discussing store-and-forward technology and its numerous uses); *see also* Paul Spradley, Comment, *Telemedicine: The Law is the Limit*, 14 TUL. J. TECH. & INTELL. PROP. 307, 314 (2011) ("Store-and-forward . . . . [has] been exhaustively tested, and successfully implemented.").

18. *See* MEDICARE UPDATE, *supra* note 16, at 1.

19. *See Home Telehealth & Remote Monitoring SIG*, AM. TELEMED. ASS'N, http://www.americantelemed.org/members/ata-members/ata-member-gro

B. A Brief History of Telemedicine

The first recorded use of telemedicine coincided with the invention of the telephone by Alexander Graham Bell.[20] In 1897, a physician diagnosed a child with croup during a telephone conversation.[21] The case was reported in the medical journal, *Lancet*, and marked the arrival of telemedicine as it is now conceived.[22] Despite some hesitancy about using the telephone for such personal matters, patients swiftly accepted the new technology in order to receive better medical care.[23] Almost a century later, the interest in further developing telemedicine was so great that a national conference was held in Ann Arbor, Michigan, during which attendees discussed the technical specifications of telemedicine, the economic and psychological effects of telemedicine, and the scientific evaluation of telemedicine programs.[24] Unfortunately, the attendees found that the high costs and poor quality of the technology at the time outweighed the benefits of health care efficiency, resulting in many organizations withdrawing their support for telemedicine development.[25] Although the conference was unsuccessful, telemedicine continued to be utilized in various forms and by various entities. The National Aeronautics and Space Agency ("NASA"), remote survey stations, offshore oil rigs, and the United States military all continued to develop technology for their employees who, because of location and conditions, had limited access to quality health care.[26] Since the turn of the millennium, interest in telemedicine reignited in the United States due to the rapidly increasing costs of health care and massive strides in technology that significantly reduced the costs of healthcare delivery.[27]

---

ups/special-interest-groups/home-telehealth-remote-monitoring#.VNvUBJV0z4g (last visited Dec. 14, 2015) [hereinafter *Remote Monitoring SIG*].

20. ADAM WILLIAM DARKINS & MARGARET ANN CARY, TELEMEDICINE AND TELEHEALTH: PRINCIPLES, POLICIES, PERFORMANCE, AND PITFALLS 6 (2000).

21. *Id.*

22. *Id.*

23. *Id.* at 7.

24. *Id.* at 6–7.

25. *Id.* at 7.

26. *Id.* at 8–9.

27. *Id.* at 11–12.

So why are we only now beginning to push for the expansion of telemedicine? Rapid technological advancements and decreases in the cost of telemedicine technology have led to calls for telemedicine expansion. At its inception, telemedicine was facilitated through multi-million-dollar NASA equipment, which literally required a rocket scientist to operate.[28] Today, due mostly to extraordinary technological leaps, the population demands its information be delivered immediately. Whether it be social media or the twenty-four hour news cycle, today's culture is obsessed with rapid delivery of information. Coincidentally, the same technology that provides us with instantaneous updates on social networks can also improve our health care system.[29]

Numerous industries utilize telemedicine to provide medical care for hard-to-reach and traditionally underserved populations. The United States Department of Justice has used telemedicine as a means of reducing health care costs for inmates.[30] Deepwater drilling platforms use telemedicine applications to treat employees located hundreds of miles offshore.[31] Rural communities in the United States have begun to use telemedicine to reduce expenses and travel, provide care in remote regions, and provide access to otherwise inaccessible or unavailable specialists.[32] These are only a few examples of the growing role that telemedicine plays in our health care system.

---

28. *See* Spradley, *supra* note 17, at 314−15.

29. *See* Sam Servello, *Is Telemedicine the Next Big Thing . . . Again?*, 10 ABA SCITECH LAW 4, 5–6 (2014) ("[B]oth patients and physicians are becoming more adept and familiar with technologies such as smart phones, iPads, and various forms of video chat . . . . For the younger population, there is every possibility that they will grow to expect telemedicine services from their physicians . . . ."); Spradley, *supra* note 17, at 315.

30. U.S. DEP'T OF JUSTICE, TELEMEDICINE CAN REDUCE CORRECTIONAL HEALTH CARE COSTS: AN EVALUATION OF A PRISON TELEMEDICINE NETWORK 2 (1999), https://www.ncjrs.gov/pdffiles1/175040.pdf.

31. *See, e.g.*, Oscar W. Boultinghouse, *Telemedicine Technologies Enhance Offshore Healthcare, Reduce Illness-Related Drilling Contractor*, DRILLINGCONTRACTOR.ORG (Nov. 2, 2009), http://www.drillingcontractor.org/telemedicine-technologies-enhance-offshore-healthcare-reduce-illness-related-departures-1853. This article is based upon a presentation given by the author at the 2009 IADC Drilling HSE Europe Conference & Exhibition, September 23−24, 2009, in Amsterdam. *Id.*

32. Spradley, *supra* note 17, at 308.

C. Benefits of Telemedicine

Telemedicine has the unique capability of increasing the quality of care and improving patient access while also reducing costs.[33] Certain medical issues and emergencies are most effectively handled through face-to-face consultation; however, the availability of telemedicine will make healthcare professionals more accessible for patients who do not require in-person medical attention.[34] For example, rural areas have long suffered as an underserved medical population.[35] In situations when the nearest health care provider may be hundreds of miles away, a remote interactive consultation can provide access to distant specialists and is the alternative to receiving subpar care or no care at all.[36]

Telemedicine also increases the quality of care by providing continuous monitoring for chronic illnesses or following hospital discharge. Nearly one in every two adults has at least one chronic illness, which equates to more than seventy-five percent of all healthcare costs and eighty-one percent of all hospital visits.[37] Home monitoring of chronically ill patients allows physicians to rapidly receive information, detect problems earlier, and employ preventative medicine.[38] Medical staff is able to contact the patient if an abnormality is discovered and subsequently provide instruction on how to improve the condition.[39] The patient is able to

---

33. *See id.*

34. Gabrielle Lee, Note, *A Telehealth Technicality: Pennsylvania's Outdated Insurance Reimbursement Policies Deter Investment in Modern Telehealth Technology*, 15 PITT. J. TECH. L. & POL'Y 115, 119 (2014).

35. *See* Lindsey T. Goehring, *H.R. 2068: Expansion of Quality or Quantity in Telemedicine in the Rural Trenches of America?*, 11 N.C. J.L. & TECH. ON. 99, 103 (2009); Daniel McCarthy, *The Virtual Health Economy: Telemedicine and the Supply of Primary Care Physicians in Rural America*, 21 AM. J.L. & MED. 111, 116 (1995).

36. *See* Kaspar, *supra* note 9, at 844.

37. P'SHIP TO FIGHT CHRONIC DISEASE, THE GROWING CRISIS OF CHRONIC DISEASE IN THE UNITED STATES 1, http://www.fightchronicdisease.org/sites/fightchronicdisease.org/files/docs/GrowingCrisisofChronicDiseaseintheUSfactsheet_81009.pdf (last visited Feb. 18, 2016).

38. Kim A. Schwartz & Bonnie Britton, *Use of Telehealth to Improve Chronic Disease Management*, 72 N.C. MED. J. 216, 216–18 (2011), http://www.researchgate.net/publication/51627770_Use_of_telehealth_to_improve_chronic_disease_management.

39. Lee, *supra* note 34, at 121.

stay home where she is more comfortable, while her quality of care is similar to that of an inpatient stay and she avoids the higher cost of a hospital setting.[40] Likewise, patients are able to avoid physical trips to the doctor, which often result in the spread of viruses and infections, as many patients become sick through exposure to illness within the hospital or clinic.[41]

In addition to improved access and quality of care, telemedicine is a cost-effective mode of healthcare delivery. Providers and patients will be interested in utilization of telemedicine where the services can help a patient avoid more expensive hospitalization, emergency room care, or lengthy hospital stays.[42] Empirical studies show that "costs frequently are reduced in avoiding unnecessary services . . . . [T]he costly complications of chronic illnesses may be reduced, yielding improved health outcomes among more informed patients . . . ."[43] Data also shows that telemedicine can decrease treatment costs below traditional methods of health care delivery.[44] When using telemedicine technology, the average savings per consultation range from $62 for a primary care physician consultation to $712 for an emergency room visit.[45] While some commentators suggest a potential misuse or overbilling from telemedicine, many state statutes have addressed this by mandating reimbursement only for services that are deemed medically necessary.[46]

---

40. *Id.*; *see also* Zillis, *supra* note 10, at 197 ("Remote monitoring reduces the use of hospital and emergency services, enabling patients to continue to live in their homes instead of in higher cost hospital settings.").

41. Kaspar, *supra* note 9, at 857−58.

42. *See* Servello, *supra* note 29, at 8.

43. Rashid Bashshur et al., *Telemedicine for Chronic Disease Management*, 20 TELEMED. & E-HEALTH 769, 793 (2014).

44. Kirsten R. Smolensky, *Telemedicine Reimbursement: Raising the Iron Triangle to a New Plateau*, 13 HEALTH MATRIX 371, 385 (2003).

45. TELADOC, HEALTH CARE AND BUSINESS: USING NEW TECHNOLOGIES TO REDUCE COSTS, IMPROVE ACCESS, AND INCREASE EMPLOYEE SATISFACTION, 7 (2010), http://communications.teladoc.com/www/Telehealth-Special-Report.pdf.

46. *See* Lee, *supra* note 34, at 123.

III. LEGAL BARRIERS TO TELEMEDICINE EXPANSION

Traditionally, private insurers have not reimbursed providers for telemedicine services. Recently, states enacted laws that mandate coverage of telemedicine services by private insurers. This section discusses why private reimbursement is a barrier to telemedicine proliferation and highlights the major problems in current private payer parity statutes.

A. Private Reimbursement

"The successful development and expansion of telemedicine depends on the extent to which [health care providers] are reimbursed by payors."[47] A seventy-two institution survey determined which obstacles hindered the success of their telemedicine programs.[48] The number one hindrance that healthcare providers cited was reimbursement.[49]

Private insurers have not traditionally reimbursed for telemedicine services, and when they have it has generally been limited reimbursement.[50] A mixture of "doubt regarding telemedicine's efficacy and concerns with costs of and compliance with states' regulatory insurance requirements are likely responsible for" the historical lack of coverage.[51] In recent years private insurers have begun to voluntarily reimburse for telemedicine services. Additionally, states have begun to pass legislation that requires private insurers in that state to provide reimbursement.

According to the United States Census Bureau's 2013 report on Health Insurance Coverage, sixty-four percent of the population was covered by private insurance, with fifty-four percent covered by employment-based health insurance policies.[52] Private

47. Servello, *supra* note 29, at 8.

48. DARKINS & CARY, *supra* note 20, at 14–15.

49. *Id.* This Note is concerned with private payer parity statutes among the states, and since Medicare and Medicaid are federal programs, they will not be the focus, although they will be touched upon for a few reasons.

50. 1997 Report to Congress, *supra* note 11.

51. Amar Gupta & Deth Sao, *The Constitutionality of Current Legal Barriers to Telemedicine in the United States: Analysis and Future Directions of its Relationship to National and International Health Care Reform*, 21 HEALTH MATRIX 385, 405 (2011).

52. JESSICA C. SMITH & CARLA MEDALIA, U.S. CENSUS BUREAU, HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2013, 2 (2014). The

health insurance is generally made available to employees and their families through employers, COBRA,[53] or a commercially advertised plan, although it can also be purchased individually from a private company.[54] Since such a large majority of the United States population is covered by private insurance,[55] it is imperative that private insurance reimburse for telemedicine.

Federal programs have been unsuccessful in promoting telemedicine expansion,[56] but if private insurers are required to reimburse for telemedicine services it will promote telemedicine as an efficient means of health care delivery.[57] In states where private insurance providers are forced to recognize that telemedicine practices constitute legitimate medical procedures, patients are "encouraged to explore and utilize these services without the concern that their health-care provider will deny reimbursement."[58]

States have the ability, under the Tenth Amendment of the United States Constitution,[59] to force private insurers within that

---

64.2 percent covered by private insurance is a vast majority compared with Medicare and Medicaid, which cover 15.6 and 17.3 percent respectively. *Id.* The remaining percentage is uninsured at 13.4 percent of the population and military health insurance at 4.5 percent. *Id.* at 3.

53. COBRA stands for the Consolidated Omnibus Budget Reconciliation Act of 1985. COBRA is a federal law requiring all employer-sponsored health plans to allow certain employees and their families the opportunity to continue health insurance at their own expense under the group plan after their insurance coverage would normally have ceased due to the death of the qualifying employee, divorce, or another qualifying event. Smolensky, *supra* note 44, at 380 n.40. *See generally* Mary Ross & Carol Hayes, *Consolidated Omnibus Budget Reconciliation Act of 1985*, 49 Soc. Sec. Bulletin 8 (1986).

54. *See* SMITH & MEDALIA, *supra* note 52 at 1.

55. *See id.* at 2.

56. *See* Smolensky, *supra* note 44, at 378−80 (discussing Medicare and Medicaid reimbursement schemes and why they are barriers to telemedicine expansion and adoption).

57. *See* Servello, *supra* note 29, at 8.

58. Spradley, *supra* note 17, at 315−16.

59. U.S. CONST. amend. X. Under the United States Constitution, the states have the unenumerated power to regulate activities that affect the health of its citizens; the history of legal challenges to health care regulation has resulted in overwhelming support for state authority. Gupta & Sao, *supra* note 51, at 413*; see also* Smolensky, *supra* note 44, at 383 ("[S]tates have the ability to force private insurers to cover telemedicine services within their states.").

state to reimburse for telemedicine services.[60] Many statutes, however, have exceptions that render them ineffective, and the differences between each state law make it difficult to provide effective guidance to multi-state providers.[61] Often, doctors are unaware of telemedicine reimbursement statutes or unable to confidently comprehend the legal jargon.[62] Currently twenty-three states and the District of Columbia have enacted telemedicine private insurance parity statutes, but they are rife with issues and limitations.[63]

B. Problems in Private Payer Parity Statutes

Private payer parity statutes have many problems that render them ineffective and difficult to implement. While all of the statutes mandate coverage by private insurers for telemedicine services in some way, not all of them do so fully or clearly. The most serious limitations on private payer parity statutes include non-medical restrictions on reimbursement, lack of clarity in what services are covered, absence of definitions, and a general lack of uniformity among the states. This Section will parse through the laws, highlighting four major limitations in state statutes, and then explain how these limitations keep the statutes from being effective.

---

60. *See* Gupta & Sao, *supra* note 51, at 405 ("One of the main reasons for this change in [reimbursement] policy is because some states have begun to require private insurers to provide reimbursement.").

61. *See, e.g.*, ARIZ. REV. STAT. § 20-841.09 (LexisNexis 2013); COLO. REV. STAT. § 10-16-123(1)–(3) (West 2015). Both Arizona and Colorado have enacted partial parity laws that require coverage and reimbursement but limit coverage to a certain geographic area or a predefined list of health care services. *See* THOMAS & CAPISTRANT, *supra* note 1, at 6.

62. Jennifer Bresnick, *State Laws Vary Widely on Telehealth Insurance Coverage*, EHR INTELLIGENCE (June 4, 2013), https://ehrintelligence.com/2013/06/04/state-laws-vary-widely-on-telehealth-insurance-coverage/ ("[P]hysicians who wish to offer telehealth consults will need to pay close attention to their state's current guidelines as they navigate an ever-changing maze of legislation.").

63. THOMAS & CAPISTRANT, *supra* note 1, at 6–7.

1. Full Parity & Non-Medical Restrictions

Full parity is classified as comparable to in-person services with regards to coverage and reimbursement for telemedicine services.[64] States, like most payors, often impose a variety of restrictions on telemedicine that prevent full parity.[65] "These restrictions are often arbitrary and provide no consideration for professional medical discretion, provider shortages or patient limitations."[66] In state private payer parity statutes, the most common restrictions are geographical limitations, limits on applicable technology, requirements for an established patient-provider relationship, and provider-type constraints.[67]

Two states have serious geographical limitations on telemedicine reimbursement. Arizona mandates that telemedicine services be "provided to a subscriber receiving the service in a *rural region* of this state."[68] Similarly, Colorado's statute provides that the intent is "to recognize the practice of telemedicine as a legitimate means by which an individual in a rural area may receive medical services from a provider without person-to-person contact with the provider."[69] Colorado's statute goes on to state that "no health benefit plan . . . for a person residing in a county with one hundred fifty thousand or fewer residents may require face-to-face contact between a provider and a covered person for services appropriately provided through telemedicine."[70] The geographical limitations in private payer parity statutes mean that a person in a non-rural area cannot be reimbursed for telemedicine services even though the need and efficacy of those services match that of a patient within the geographically covered area; this is not full parity.[71]

---

64. *Id.* at 6.

65. STATE POLICY TOOLKIT, *supra* note 3, at 1.

66. *Id.*

67. *Id.*

68. ARIZ. REV. STAT. § 20-841.09(A) (LexisNexis 2013) (emphasis added).

69. COLO. REV. STAT. § 10-16-123(1) (West 2015). Colorado enacted a new telemedicine statute in 2015 to improve the existing parity law and remove the rural restrictions, but it will not go into effect until January 1, 2017. *Id.*

70. *Id.* at § 10-16-123(2).

71. *See* Smolensky, *supra* note 44, at 378.

These geographical limitations mirror the limitations present in the telemedicine policy of Medicare. State laws regarding medical subjects often follow the federal government's lead in requiring telemedicine reimbursement.[72] Coverage under Medicare is limited to originating sites located within either a Rural Professional Shortage Area, non-Metropolitan Statistical Area, or a site that is a part of a federal telemedicine demonstration project.[73] The geographical limitations of state private payer parity have limited expansion of telemedicine's use similarly to how Medicare's limit on telemedicine has failed to expand telemedicine's use.[74]

Another common restriction present in private payer parity statutes is a limit on the applicable technology. Michigan,[75] Oregon,[76] and Vermont[77] all have restrictions on the types of technology that qualify for reimbursement. The Michigan statute requires that "[t]o be considered telemedicine under this [statute], the health care professional must be able to examine the patient via a real-time, interactive audio or video, or both, telecommunications system."[78] Likewise, the other two states provide that covered services are only considered telemedicine if delivered through real-time or live interactive audio and video.[79]

The only way private insurers are required to reimburse telemedicine services in these states is if the patient and provider are

---

72. Eleanor D. Kinney, Symposium, *Behind the Veil Where the Action Is: Private Policy Making and American Health Care*, 51 ADMIN. L. REV. 145, 176 (1999) (opining that private insurers often follow the lead of Medicare in making reimbursement decisions, possibly due to the massive amount of federal funding allocated to health services research); Smolensky, *supra* note 44, at 383; *see also* George Lauer, *Medicare Telemedicine Bill Could Change Landscape*, iHEALTHBEAT (May 8, 2009), http://www.ihealthbeat.org/features/2009/medicare-telemedicine-bill-could-change-landscape.aspx ("A generally accepted maxim in health care: Where Medicare goes, the rest of the country follows.").

73. 42 C.F.R. § 410.78(b)(4) (2014).

74. *See* Smolensky, *supra* note 44, at 383.

75. MICH. COMP. LAWS ANN. § 500.3476(2) (2014).

76. OR. REV. STAT. § 743A.058(2) (2013).

77. VT. STAT. ANN. tit. 8, § 4100k(g)(4) (2012).

78. MICH. COMP. LAWS ANN. § 500.3476(2).

79. *See* VT. STAT. ANN. tit. 8, § 4100k(g)(4) ("'Telemedicine' means the delivery of health care services such as diagnosis, consultation, or treatment through the use of live interactive audio and video . . . ."); OR. REV. STAT. § 743A.058(2).

able to interact in real-time.[80] The decision to restrict coverage to interactive audio-video telemedicine is another that mirrors the choices of Medicare.[81] One commentator, Kirsten Rabe Smolensky, a former professor of law and healthcare attorney,[82] opines that Medicare does not reimburse for store-and-forward technology because the government either feared overuse or possibly had difficulty establishing appropriate procedures, but she also notes that Medicare has the power to reimburse for technology other than interactive audio-visual telemedicine.[83]

The restrictions on applicable technology eliminate the common forms of telemedicine delivery, store-and-forward and remote monitoring, and limit coverage to the least common method.[84] Interactive audio-visual telemedicine is the most similar to an in-person visit, but it is not as popular among providers as the other two forms because it requires expensive technology that the health care provider may not already possess.[85] The "cost/benefit ratio is likely to be far higher for store-and-forward services than for two-way video telemedicine, and the quality of care in certain areas of medicine would be just as high without interactive consultations."[86] By limiting reimbursement to the least common and least popular form of telemedicine delivery, this restriction practically defeats the goal of private payer parity statutes.

Along with geographical and technological restrictions, some states have other limitations on private insurance reimbursement. For example, Hawaii requires that "a health care provider-

---

80. *See, e.g.*, MICH. COMP. LAWS § 500.3476(2).

81. *See* 42 C.F.R. § 410.78(a)(3) (2014); *see also* Smolensky, *supra* note 44, at 378 (noting that Medicare does not generally reimburse for store and forward technology, which has been shown to be cost effective, and questions why Medicare would favor complex interactive video-consults).

82. Kirsten Rabe Smolensky is a graduate of the University Of Chicago School Of Law and a former healthcare attorney, Bigelow Fellow at the University of Chicago School of Law, and Associate Professor at the University Of Arizona James E. Rogers College Of Law. She is currently a generalist appraiser in Antiques & Residential Contents, Fine Art and instructor for the International Society of Appraisers in the Nashville, Tennessee area.

83. Smolensky, *supra* note 44, at 412−13.

84. *See supra* Section II.A.

85. *See, e.g.*, MEDICARE UPDATE, *supra* note 16, at 1; *Remote Monitoring SIG*, *supra* note 19.

86. Jakobsen, *supra* note 12, at 175.

patient relationship exists between the patient and one of the health care providers" before reimbursement for a telemedicine consultation.[87] Similarly, Louisiana requires that a licensed physician be present at one end of the telemedicine consultation for there to be any reimbursement at all.[88] Kentucky only requires private insurance coverage if "the consultation is provided through the [telemedicine] network established under [Kentucky law]."[89] Private payer parity statutes are meant to mandate comparable coverage for telemedicine services as for in-person services, but the above restrictions "seem to make the rule requiring telemedicine reimbursement by private insurers a fallacy."[90]

In 2015, Arkansas enacted its first telemedicine reimbursement statute,[91] and it is a prime example of a restriction-riddled private payer parity statute. Arkansas's statute includes telemedicine reimbursement under private insurance for physician-provided services only, and it also includes technology restrictions and requires an in-person visit before a telemedicine encounter.[92] The statute provides that "[a] health benefit plan shall cover the services of a physician who is licensed by the Arkansas State Medical Board for healthcare services through telemedicine on the same basis as the health benefit plan provides coverage . . . by the physician in person."[93] This is almost identical to the restriction in Louisiana's statute which means that telemedicine services are not covered when provided by a registered nurse, physician's assistant, etc.[94] Further, the Arkansas definition of telemedicine limits coverage to services delivered through "real-time two-way electronic audio-visual communications . . . to provide or support healthcare

87. HAW. REV. STAT. § 431:10A-116.3(c) (LexisNexis 2014).

88. LA. STAT. ANN. § 22:1821(F)(1) (2013) ("[For] health care service . . . performed via . . . telemedicine, such a payment, benefit, or reimbursement under such policy or contract shall not be denied to a *licensed physician* conducting or participating in the transmission . . . ." (emphasis added)).

89. KY. REV. STAT. ANN. § 304.17A-138(1)(a) (2011).

90. Smolensky, *supra* note 44, at 382.

91. ARK. CODE. ANN. § 23-79-1602 (West 2015). The Arkansas telemedicine statute applies to all health benefit plans delivered, issued, reissued, or extended in Arkansas on or after January 1, 2016. *Id.*

92. *Id.*; *see* THOMAS & CAPISTRANT, *supra* note 1, at 28.

93. ARK. CODE. ANN. § 23-79-1602(c)(1).

94. *Compare id.*, *with* LA. REV. STAT. ANN. § 22:1821(F)(1) (2013).

delivery that facilitates the assessment, diagnosis, consultation, or treatment of a patient's health care . . . ."[95] This provision provides a technology limitation on the use of telemedicine services and only allows for telemedicine services that are provided using real-time audio-visual communications, which eliminates the use of two very popular methods of delivery: store-and-forward technology and in-home monitoring.[96]

Lastly, the Arkansas private payer parity statute requires an in-person visit before a telemedicine encounter.[97] The statute states that telemedicine services will be covered when the patient is at an originating site and the healthcare professional is at a distant site, but the originating site is defined as "[t]he offices of a healthcare professional or a licensed healthcare entity where the patient is located at the time services are provided by a healthcare professional through telemedicine."[98] There is a limited exception for patients with end-stage renal disease, much like the exception to Medicare coverage, but this is a serious limitation because it requires a patient to be present at the office of a qualified healthcare professional to receive covered telemedicine services and effectively requires an in-patient visit.[99] It is evident from the Arkansas statute that newer private payer parity laws are not necessarily better. Arkansas's telemedicine statute is filled with limitations on reimbursable telemedicine services which practically defeat its purpose. Overall, Arkansas's private payer parity statute for telemedicine is a prime example of all the limitations and restrictions that states should seek to avoid when drafting their own telemedicine laws.

3. Lack of Clarity or Intent

An important aspect of any law is that it be clear enough for a layperson to understand the scope and intent. Opacity and lack of clear intent are limitations on current private payer parity statutes that render many ineffective. Professors Victoria Nourse and Jane Schacter, Professors of Law at Georgetown and Stanford

95. ARK. CODE ANN. § 23-79-1601(5).
96. *Id.*
97. *Id.* § 23-79-1602.
98. *Id.* § 23-79-1601(4)(A).
99. *Id.* § 23-79-1601(4)(B).

respectively, argue that clarity is the "single most significant judicial drafting virtue."[100] Legislative language should be written to be as unambiguous as possible so that reader knows what telemedicine is, which services are covered or excluded, how much providers are reimbursed for, etc., but many state statutes fail this mark.

Lack of clarity does not mean that a private payer parity statute does not accomplish the goal of parity in telemedicine. Texas[101] and Oklahoma[102] were among the first states to enact private payer parity statutes, both in 1997.[103] Due to the passage of time, now the statutes are minimal and state only that telemedicine services cannot be excluded from coverage simply because there is not person-to-person contact.[104] Compare these statutes with the Washington, D.C. statute, which states that "[a] health insurer . . . may not deny coverage for a healthcare service on the basis that the service is provided through [telemedicine] if the same service would be covered when delivered in person."[105] Neither Texas, Oklahoma, nor Washington, D.C. explicitly state that telemedicine services should be reimbursed the same as in-person services; however, they all do require full parity, and Washington, D.C. at least insinuates that telemedicine and in-person services are comparable.[106]

Many other statutes fail to explicitly state that there should be full parity in coverage of telemedicine services.[107] For example, the Virginia statute states that "a health care plan . . . shall provide

---

100. Victoria F. Nourse & Jane S. Schacter, *The Politics of Legislative Drafting: A Congressional Case Study*, 77 N.Y.U. L. REV. 575, 594 (2002).

101. TEX. INS. CODE ANN. § 1455.004 (2009).

102. OKLA. STAT. tit. 36, § 6803 (2009).

103. THOMAS & CAPISTRANT, *supra* note 1, at 61, 68.

104. *See* OKLA. STAT. tit. 36, § 6803(A) ("For services that a health care practitioner determines to be appropriately provided by means of telemedicine, health care service plans . . . shall not require person-to-person contact between a health care practitioner and a patient."); TEX. INS. CODE ANN. § 1455.004(a) ("A health benefit plan may not exclude a telemedicine medical service or a telehealth service from coverage under the plan solely because the service is not provided through a face-to-face consultation.").

105. D.C. CODE § 31-3862(a) (West 2013).

106. *See id.;* OKLA. STAT. tit. 36, § 6803; TEX. INS. CODE ANN. § 1455.004.

107. *See, e.g.*, CAL. INS. CODE § 10123.85(c) (2013); VA. CODE ANN. § 38.2-3418.16(C) (West 2014).

coverage for the cost of such health care services provided through telemedicine services, as provided in this section" and "[a]n insurer . . . shall not exclude a service for coverage solely because the service is provided through telemedicine services and is not provided through face-to-face consultation."[108] The Virginia statute makes clear that the provider cannot exclude a service from coverage solely because it was provided through telemedicine, but it does not explicitly state that coverage must be comparable to that of a face-to-face consultation. Compare the language with the New Mexico statute that reads: "[c]overage for health care services provided through telemedicine shall be determined in a manner consistent with coverage for health care services provided through in-person consultation."[109] This statute clearly mandates that private insurers reimburse for telemedicine services in a comparable manner to reimbursement for face-to-face services.

Many state private payer parity laws lack clarity due to the lack of or confusing nature of the statutory intent. The intent or purpose of the statute guides anyone reading it to what the legislature intended when it drafted the law.[110] An issue arises when there is no enacted intent, or the enacted intent is at odds with the remainder of the statute. Consider the stated intent of three state private parity laws. A California statute reads: "[i]t is the intent of the Legislature to recognize the practice of [telemedicine] as a legitimate means by which an individual may receive health care services . . . ."[111] A Georgia statute reads: "[i]t is the intent of the General Assembly to *mitigate geographic discrimination* in the delivery of health care by recognizing the application of and payment for covered medical care provided by means of telemedicine."[112] Lastly, consider that Maine's statute contains no statement of intent within its scant two paragraphs of text.[113]

---

108. VA. CODE ANN. § 38.2-3418.16(A), (C).

109. N.M. STAT. ANN. § 59A-22-49.3(A) (West 2013).

110. *See* Carlos E. Gonzalez, *Reinterpreting Statutory Interpretation*, 74 N.C.L. Rev. 585, 604 (1996) ("[S]tatutory text is the surest device for correctly estimating the whole legislature's intent.").

111. CAL. INS. CODE § 10123.85(b).

112. GA. CODE ANN. § 33-24-56.4(c) (2013) (emphasis added).

113. *See* ME. REV. STAT. tit. 24-A, § 4316 (2012).

114. *See* Gonzalez, *supra* note 110, at 598 ("While individuals can have intents . . . collectives such as legislatures cannot. Thus, Judge Easterbrook

These two different statements of intent, and the lack thereof in Maine's statute, exemplify the vast differences among state statutes mandating private insurance coverage for telemedicine. It seems as though Georgia mandates full private payer parity, but the enacted intent appears to suggest that an argument can be made limiting reimbursement to only rural or geographically discriminated against areas. What is a provider in Georgia to do when the statute contends to offer full parity, but the stated intent of the statute might restrict coverage? Some argue that legislatures cannot have intents, but instead only outcomes in the form of enacted law.[114] If one resigns to this theory, then the intent should not control the true purpose of the statute; but then why have stated intent? As one can see, the statutory intent of a statute is difficult to grasp or use, and it adds to the opacity of private payer parity statutes.

3. Lack of Definitions

Hand in hand with lack of clarity are the varying definitions, or the lack thereof, in private payer parity statutes. Professor Jeanne Price,[115] in a lengthy article on statutory definitions, opines that "[statutory definitions] are important thresholds to our understanding of and the success of legislation . . . . [T]hey confer the authority and establish a structure that allows the statute's normative provisions to have effect . . . ."[116] She goes on to write that "[i]f definitions control future interpretations of the statute, they may also clarify current application of the statute and promote predictability."[117] Predictability and clarity are lacking in most state private payer parity statutes, and this is where definition sections

---

writes, '[b]ecause legislatures compromise many members, they do not have "intents" or "designs," hidden yet discoverable. Each member may or may not have a design. The body as a whole, however, has only outcomes. . . .'" (quoting Frank H. Easterbrook, *Statutes' Domains*, 50 U. CHI. L. REV. 533, 547–48 (1983)).

115. Professor Price is the Director of the Wiener-Rogers Law Library at the University of Nevada, Las Vegas William S. Boyd School of Law.

116. Jeanne F. Price, *Wagging, Not Barking: Statutory Definitions*, 60 CLEV. ST. L. REV. 999, 1002–03 (2013).

117. *Id.* at 1022.

become vital, especially in an area as complex as insurance reimbursement for telemedicine.

State private payer parity statutes vary wildly on the presence of definitions. For example, New Hampshire's law does not contain a definition for telemedicine, health care provider, or anything else.[118] In contrast, Tennessee's statute contains definitions for "health insurance entity," "healthcare services," "healthcare services provider," "qualified site," "store-and-forward telemedicine," "telehealth," and "telehealth provider."[119] Georgia's statute exemplifies the middle ground by including definitions for "health benefit policy," "insurer," and "telemedicine."[120] Yet, in other states, such as Vermont, the statute simply refers the reader to another statutory section to find the definitions.[121] One of the basic rules of legislative drafting is to place a definition where it is most easily found by the reader.[122] Therefore, in an area of the law as complex as telemedicine, it benefits the reader most to have the definitions in the statute, not referenced to another statute or area of the code.

In those statutes that have definitions sections, the definitions often vary from statute to statute. In Mississippi's statute, telemedicine is defined as: "[T]he delivery of health care services such as diagnosis, consultation, or treatment through the use of interactive audio, video, or other electronic media. Telemedicine must be 'real-time' consultation, and it does not include the use of audio-only telephone, e-mail, or facsimile."[123] Compare that definition to Tennessee's definition of telemedicine:

> [T]he use of real-time, interactive audio, video telecommunications or electronic technology, or store-and-forward telemedicine services by a healthcare

---

118. N.H. REV. STAT. ANN. § 415-J:3 (2014).

119. TENN. CODE ANN. § 56-7-1002(a)(1)–(7) (2014).

120. GA. CODE ANN. § 33-24-56.4(b)(1)–(3) (2014).

121. *See, e.g.*, VT. STAT. ANN. tit. 8, § 4100k(g)(1)–(2) (2014) ("'Health insurance plan' means any health insurance policy or health benefit plan offered by a health insurer, as defined in 18 V.S.A. § 9402 . . . .").

122. NAT'L ARCHIVES FED. REGISTER, *Drafting Legal Documents*, http://www.archives.gov/federal-register/write/legal-docs/definitions.html (last visited Dec. 30, 2015).

123. MISS. CODE ANN. § 83-9-351(1)(d) (2014).

> services provider to deliver healthcare services to a patient within the scope of practice of the healthcare services provider when: (i) such provider is at a qualified site other than the site where the patient is located; and (ii) the patient is at a qualified site or a school clinic staffed by a healthcare services provider and equipped to engage in the telecommunications described in this section . . . .[124]

Tennessee and Mississippi, two adjacent states, should not have such varied statutory language and definitions for telemedicine. The definition in Mississippi's statute appears to limit telemedicine to "real-time consultation," which means that store-and-forward technology is not covered.[125] Conversely, Tennessee's statute explicitly includes store-and-forward technology along with all other forms of telemedicine services.[126] Doctors who hold licenses in both states would likely find it very difficult to know what they would be reimbursed for when practicing across multiple jurisdictions.

4. General Lack of Uniformity

The existing state-by-state regulatory framework of telemedicine reimbursement is ill equipped to resolve the challenges of the health care industry on a national scale.[127] Patients and providers normally encounter a patchwork of arbitrary insurance requirements that do not allow them to take advantage of telemedicine.[128] As evidenced by the discussion above of other problems within private payer parity statutes, it is evident that these statutes lack broad uniformity.[129]

Some state statutes offer coverage for interactive audio-visual, store-and-forward, and remote monitoring, while others merely cover real-time, interactive audio-visual telemedicine tech-

---

124. TENN. CODE ANN. § 56-7-1002(a)(6) (2014).
125. MISS. CODE ANN. § 83-9-351(1)(d).
126. TENN. CODE ANN. § 56-7-1002(a)(6).
127. Gupta & Sao, *supra* note 51, at 405.
128. THOMAS & CAPISTRANT, *supra* note 1, at 1.
129. *See* discussion *supra* Sections III.A.–C.

nology.[130] One state may intend to reimburse private insurers for telemedicine services throughout the state, while another may only cover patients living in rural areas.[131] Likewise, one state statute consists of two paragraphs, and another statute is nearly two pages long.[132]

A study conducted by Michigan State University's Department of Telecommunications found that "the lack of a uniform telemedicine reimbursement system may cause society, and those in the health care industry, to view traditional delivery methods as superior to telemedicine."[133] States do not have to enact precisely the same law, but a more uniform approach to private insurance reimbursement is necessary if telemedicine is to achieve its goals of improving access and quality of care. Ultimately, provider participation suffers because non-uniformity of telemedicine reimbursement leads to lack of enforcement and general awareness.[134]

IV. MODEL LEGISLATION & SOLUTIONS

Only twenty-nine United States jurisdictions currently have private payer parity statutes in some form.[135] It is much more difficult for telemedicine to gain nationwide expansion if insurers are not required to reimburse providers for services offered through telemedicine. While it is certainly possible for the insurance industry to expand telemedicine on its own, it is unlikely without a catalyst such as legislative intervention. Even if every state adopts a private payer parity statute, considering the current state of these

---

130. *Compare* TENN. CODE ANN. § 56-7-1002, *with* OR. REV. STAT. § 743A.058 (2013).

131. *Compare* MISS. CODE ANN. § 83-9-351 (2014), *with* ARIZ. REV. STAT. ANN. § 20-841.09 (LexisNexis 2014).

132. *Compare* TEX. INS. CODE ANN. § 1455.004 (West 2013), *with* MD. CODE ANN., Ins. § 15-139 (West 2014).

133. Jaime Bennett, *Improving Quality of Care Through Telemedicine: The Need to Remove Reimbursement and Licensure Barriers*, 19 ANNALS HEALTH L. ADVANCE DIRECTIVE 203, 210 (2010) (citing Pamela Whitten & Laurie Buis, *Private Payer Reimbursement for Telemedicine Services in the United States*, 13 TELEMEDICINE AND E-HEALTH 1, 22 (2007), http://www.researchgate.net/publication/6496994_Private_Payer_Reimbursement_for_Telemedicine_Services_in_The_United_States).

134. *See* THOMAS & CAPISTRANT, *supra* note 1, at 4.

135. STATE POLICY TOOLKIT, *supra* note 3, at 3.

laws, they will remain as ineffective as if they were never enacted.[136] Model legislation can solve many of the problems inherent in current private payer parity laws because the model serves to identify and solves the issues.

The following proposed model legislation was created using language from and portions of the most effective private payer parity statutes currently enacted.[137] The statutes used were all enacted within the past three years and have all been shown, through empirical analysis, to be among the strongest private payer parity laws.[138] The model legislation is valuable because it is created using successful telemedicine statutes, meaning that it will be an effective guide for states attempting to create the best, most operative law.

This part presents proposed model legislation for uniform national adoption of telemedicine laws mandating private insurance coverage comparable to that of in-person services. States that have ineffective or limited private payer parity statutes can use this model to revise their laws. States that have yet to enact laws mandating private insurance coverage of telemedicine services may use this model in drafting one. Following the proposed model legislation, the next section will explain how this model can solve the problems facing private payer parity statutes.

A. Model Legislation

Title: Private Insurance Reimbursement Parity in Telemedicine Services

---

136. *See* Smolensky, *supra* note 44, at 383 ("[E]vidence [shows] that the statutes' exceptions make them ineffective tools for increasing telemedicine reimbursements . . . . If more states enact mandatory telemedicine reimbursement statutes, then any company wishing to be in the medical insurance business in that state will be required to reimburse for telemedicine . . . .").

137. *See* Thomas & Capistrant, *supra* note 1, at 50−51, 56, 67 (2014). This study, conducted by the American Telemedicine Association, provides an analysis of telemedicine policy in all fifty states. *Id.* at 1. Of the states used to create the model legislation, the major states enacted their laws from 2012−14 and each state has an "A" rating for private insurance parity. *Id.* at 45, 50−51, 56, 67. The analysis by the American Telemedicine Association identified Maryland, Mississippi, Missouri, New Mexico, and Tennessee as the strongest in terms of their private payer parity laws. *Id.* at 49–50, 56, 67.

138. *See id.*

Declaration of Intent: It is the intent of the legislature to recognize the practice of telemedicine as a legitimate means by which individuals may receive medical services from a provider without in-person contact;[139] and to recognize the application of telemedicine as a reimbursable service by which an individual shall receive quality medical services.[140]

Definitions:

a. "Telemedicine": as it relates to the delivery of health care services, telemedicine means the use of real-time, interactive audio, video telecommunications or electronic technology, or store-and-forward telemedicine services by a health care provider to deliver health care services to a patient within the scope of practice of the healthcare services provider at a site other than the site at which the patient is located.[141] Telemedicine does not include audio-only conversations, electronic mail messaging, or facsimile transmissions.[142]
b. "Store-and-forward telemedicine services": the use of asynchronous computer-based communications between a patient and a health care provider at a distant site for the purpose of diagnostic assistance in the care of a patient;[143] or electronic information, imaging and communication, that is transferred or recorded or otherwise stored for asynchronous use.[144]
c. "Health care provider": a duly licensed hospital or other licensed facility, physician, or other health care professional authorized to furnish health care services in the State within the scope of the professional's license.[145]

Applicability: This statute applies to insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense-incurred basis under health

---

139. *See, e.g.*, CAL. INS. CODE § 10123.85(b) (West 2014).
140. *See* HAW. REV. STAT. § 431:10A-116.3(a) (2014).
141. *See* TENN. CODE ANN. § 56-7-1002(6) (2014).
142. *See id.*
143. *See, e.g.*, MONT. CODE ANN. § 33-22-138(6)(c) (2014); TENN. CODE ANN. § 56-7-1002(5) (2014).
144. *See* N.M. STAT. ANN. § 59A-22-49.3(H)(5) (2014).
145. *See id.*

insurance policies or contracts that are issued or delivered in the State, including HMOs.[146]

Reimbursement & Deductible: Any entity subject to this statute:

a. Is required to not exclude from coverage a health care service solely because it was provided through telemedicine and is not provided through an in-person consultation between a healthcare provider and an insured patient.[147]
b. Is required to reimburse a health care provider—to the same extent that it reimburses the same service if provided through in-person consultation—for the diagnosis, consultation, and treatment of an insured patient for a health care service covered under a health insurance policy or contract that can be appropriately, effectively, and safely provided through telemedicine.[148]
c. May impose a deductible, copayment, or coinsurance amount on benefits for health care services provided through telemedicine so long as it does not exceed the deductible, copayment, or coinsurance applicable to an in-person consultation.[149]
d. Is required to reimburse providers who are out-of-network for telemedicine services under the same reimbursement policies applicable to other out-of-network health care services providers.[150]
e. May limit reimbursement to only those services that are medically necessary, subject to the terms and conditions of the covered person's policy.[151]
f. May not require a health care provider be physically present with a patient 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.[152]

---

146. *See* MD. CODE ANN., INS. § 15-139(b) (LexisNexis 2014).

147. *See id.* at (c)(2); MO. REV. STAT. § 376.1900(4) (2014); TENN. CODE ANN. § 56-7-1002(d)(3).

148. *See* MD. CODE ANN., INS. § 15-139(d) (LexisNexis 2014).

149. *See* MISS. CODE ANN. § 83-9-351(3) (2014).

150. *See* TENN. CODE ANN. § 56-7-1002(d)(4) (2014).

151. *See* MISS. CODE ANN. § 83-9-351(5) (2014).

152. *See* MO. REV. STAT. § 376.1900(9) (2014).

Utilization Review: Any entity subject to this statute may undertake utilization review to determine the appropriateness of any health care service whether the service is provided through an in-person consultation or through telemedicine if the appropriateness of the health care service is determined the same.[153]
Geographic Discrimination Prohibition: A health insurance policy or contract may not distinguish between patients in rural and urban locations in providing coverage under the policy or contract for health services delivered through telemedicine.[154]
Provisions Not Stipulated: Any provisions not stipulated by this statute is required to be governed by the terms and conditions of the health insurance policy and contract.[155]

B. Solutions for Private Reimbursement Statutes

It is important that states enact statutes that mandate private insurance parity in telemedicine reimbursement because it has been proven to be very effective in promoting the adoption of telemedicine.[156] A 2014 study using the Information Technology Supplement to the American Hospital Association's 2012 annual survey of acute hospitals supports the enactment of private payer parity laws.[157] Those conducting the study found that "state policies that required private payers to reimburse for [telemedicine] services to the same extent as face-to-face services made hospitals more likely to adopt [telemedicine]."[158] The researchers suggest that "states may want to consider implementing policies to promote private payer reimbursement of [telemedicine]."[159] The study concluded that state policies mandating private payer reimbursement are the most effective manner in which to promote telemedicine expansion.[160] The proposed model legislation serves at a starting point for states to begin drafting a private payer parity statute, and it can solve many of the problems inherent in current laws.

---

153. *See* MD. CODE ANN., INS. §15-139(e) (LexisNexis 2014); MO. REV. STAT. § 376.1900(7) (2014); N.M. STAT. ANN. § 59A-22-49.3(C) (2014).
154. *See* MD. CODE ANN., INS. § 15-139(f).
155. *See* TENN. CODE ANN. § 56-7-1002(g) (2014).
156. *See* Adler-Milstein, *supra* note 5, at 207.
157. *See id.*
158. *Id.* at 211.
159. *Id.* at 214.
160. *Id.* at 213.

Current laws mandating private insurance reimbursement for telemedicine suffer from artificial restrictions, lack of clarity, and non-uniformity.[161] This Note highlighted the major barriers to utilization of these statutes and the model legislation strives to fix these problems. For example, the model removes all restrictions for geographic area, providers, technology, or relationships, all of which are present in some state statutes.[162] The model legislation prevents clarity issues by stating a strong intent and providing clear definitions. Likewise, if widely adopted, the model will solve the issue of uniformity.

Uniformity is likely the biggest issue in the area of telemedicine.[163] Each state maintains the power to regulate activities affecting health under the Tenth Amendment to the United States Constitution.[164] Since each state has its own laws relating to health care, it is very difficult for doctors to practice in multiple jurisdictions, absent obtaining multiple licenses.[165] Consequently, uniformity in licensure is an important topic in the area of telemedicine because it is a barrier to expansion, much like reimbursement policies.[166] Current licensing practices force health care providers to fulfill requirements and protocols that differ for each state

---

161. *See* discussion *supra* Sections III.B.i.−iv.

162. *See, e.g.*, COLO. REV. STAT. § 10-16-123(1) (2014) (rural area restriction); LA. REV. STAT. ANN. § 22:1821(F)(1) (2013) (provider restriction); OR. REV. STAT. § 743A.058(1)(c) (2013) (technology restriction).

163. *See* Symposium, *supra* note 17, at 17.

164. *See* U.S. CONST. amend. X; *see also* Goldfarb v. Virginia State Bar, 421 U.S. 773, 792 (1975) (opining that states have a compelling interest in regulating the practice of medicine and other activities related to health, safety, and welfare of its citizens); Fish, Shiri A. Hickman & Humayun J. Chaudry, *State Licensure Regulations Evolve to Meet the Demands of Modern Medical Practice*, 10 ABA SCITECH LAW 18 (2014) (noting that the U.S. Supreme Court recognizes the states have a right to regulate health care); Zillis, *supra* note 10, at 201 (citing to the Tenth Amendment in support or state regulation of health care). *But see* Gupta & Sao, *supra* note 51, at 413−14 (arguing that states do not have a constitutional right to exclusive domain over health care regulation and that current state regulation is likely unconstitutional per the Dormant Commerce Clause).

165. *See* CNTR. FOR TELEMEDICINE LAW, OFFICE FOR THE ADVANCEMENT OF TELEHEALTH: TELEMEDICINE LICENSURE REPORT 1 (2003).

166. *See id.* at 2 ("[L]icensure is a major barrier to the development of telemedicine."); Fish, Hickman, & Chaudry, *supra* note 164, 18−19; Spradley, *supra* note 17, at 317.

board, and there are sixty-nine licensing jurisdictions in the United States.[167] There are myriad proposals to remedy the current state of medical licensure, but the consensus is that there must be a uniform approach among the states without relinquishing state control to the federal government.[168]

What does licensure have to do with the adoption of the proposed model legislation? Telemedicine, by nature, is a cross-jurisdictional practice; several scholars and medical professionals conclude that the establishment of a uniform set of standards and regulations is necessary to realize telemedicine's potential.[169] The ability to deliver health care across distances using telemedicine achieves the goals of greater quality and access to health care.[170] As medical licensure enjoys a movement towards uniformity, so should reimbursement policy, and the model legislation can help accomplish this goal.

States have the opportunity to blaze the path toward widespread telemedicine adoption through the implementation of private payer parity statutes. As mentioned previously, mandating private insurance coverage for telemedicine has proven to be the most effective means of expansion.[171] If laws differ greatly from state-to-state, however, physicians will be discouraged from fully effectuating their potential. Telemedicine can extend health care to traditionally underserved populations, provide access to specialists, allow for fewer site visits for chronic patients, decrease health care expenditures, and much more.[172]

With uniform state reimbursement laws, health care providers and insurers are able to know which telemedicine services

---

167. *See* Spradley, *supra* note 17, at 317.

168. *See id.* at 317–20 (providing examples of solutions to medical licensure as a telemedicine barrier); LICENSURE PORTABILITY, AM. TELEMED. ASS'N (Mar. 2007), https://web.archive.org/web/20100616143720/http:/www.americantelemed.org/files/public/policy/Licensure_Portability.pdf (providing position statement and recommendations proposed by the American Telemedicine Association).

169. *See* Gupta & Sao, *supra* note 51, at 387; s*ee also* Susan E. Volkert, *Telemedicine: Rx for the Future of Health Care*, 6 MICH. TELECOMM. & TECH. L. REV. 147, 158–59 (2000).

170. Gupta & Sao, *supra* note 51, at 442.

171. *See* Adler-Milstein, *supra* note 5, at 214.

172. Gupta & Sao, *supra* note 51, at 389–91.

they are able to provide and still receive reimbursement. For example, under the current state statutes, a patient in Tennessee wishing to consult via telemedicine with an orthopedist in Alabama would run the serious risk of not receiving coverage. Alabama lacks any kind of law that mandates coverage for telemedicine.[173] Financially the patient is better off driving to Alabama than consulting with a specialist through telemedicine if he is unlikely to receive reimbursement. Therein lies the problem with lack of uniformity and lack of widespread private payer parity statutes. While telemedicine may be the more efficient and cost-effective means of health care delivery, doubt about reimbursement will likely cause providers and patients to stick to traditional health care delivery.[174] Nationwide adoption of this model private payer parity legislation can spur telemedicine to the forefront of the health care scene, and ultimately, telemedicine will prove to be the savior for a failing health care system faced with constantly rising costs.[175]

V. CONCLUSION

Telemedicine has evolved from a futuristic fantasy into a promising, rapidly growing industry. The technological and monetary obstacles that once prevented the industry from expanding are no longer impediments. With access to modernized networks, providers have the ability to administer specialized and high-quality treatment to those who would not otherwise have access. Additionally, telemedicine falls clearly in line with today's culture of interconnectivity and autonomy. Before we can realize the full potential of telemedicine, several changes must take place within our legal system.

For telemedicine to flourish, a reimbursement solution must be established whereby providers and insurers know what services are covered. State legislatures and private insurers can lead the

---

173. THOMAS & CAPISTRANT, *supra* note 1, at 26 ("AL is bordered by LA, MS, and TN which enacted private insurance parity laws.").

174. *See* Bennett, *supra* note 133, at 210 ("Ultimately, the lack of a uniform telemedicine reimbursement system may cause society, and those in the healthcare industry, to view traditional delivery methods as superior to telemedicine as a delivery method.").

175. *See* Gupta & Sao, *supra* note 51, at 389.

way towards nationwide telemedicine adoption through state enactment of private payer parity statutes. Standardized adoption of mandated private insurance laws will eliminate artificial barriers between jurisdictions by providing knowledge and security in telemedicine reimbursement.

There are serious restrictions on the few enacted state private payer parity statutes for telemedicine. Only twenty-nine of fifty-one jurisdictions have adopted these laws, and many of those that have would benefit from thorough revision. The proposed model legislation seeks to remedy these limitations and provides a statute that can be uniformly and nationally adopted so as to facilitate the expansion of telemedicine. Until the state legislatures of our nation move to enact and revise statutes mandating private coverage for telemedicine services, it is unlikely that the federal government, or any other entity, will take the lead. There is ample data proving that telemedicine and private payer parity statutes are effective at lowering costs, expanding access, and promoting efficacy. Nationwide utilization of telemedicine is a reality and it may be the answer to our country's health care problem. Widespread state mandated private reimbursement can be the catalyst toward a more efficient and cost-effective system of telemedicine utilization.