

Assembly Bill No. 457

CHAPTER 439

An act to amend Section 650 of the Business and Professions Code, to amend Section 1374.14 of, and to add Section 1374.141 to, the Health and Safety Code, and to amend Section 10123.855 of, and to add Section 10123.856 to, the Insurance Code, relating to telehealth.

[Approved by Governor October 1, 2021. Filed with Secretary
of State October 1, 2021.]

LEGISLATIVE COUNSEL'S DIGEST

AB 457, Santiago. Protection of Patient Choice in Telehealth Provider Act.

(1) Existing law provides for the licensure and regulation of various healing arts professions and vocations by boards within the Department of Consumer Affairs. Under existing law, it is unlawful for healing arts licensees, except as specified, to offer, deliver, receive, or accept any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, in the form of money or otherwise, as compensation or inducement for referring patients, clients, or customers to any person, subject to certain exceptions.

This bill would provide that the payment or receipt of consideration for internet-based advertising, appointment booking, or any service that provides information and resources to prospective patients of licensees does not constitute a referral of a patient if the internet-based service provider does not recommend or endorse a specific licensee to a prospective patient.

(2) Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a contract issued, amended, or renewed on or after January 1, 2021, between a health care service plan or health insurer and a health care provider to require the plan or insurer to reimburse the provider for the diagnosis, consultation, or treatment of an enrollee, subscriber, insured, or policyholder appropriately delivered through telehealth services on the same basis and to the same extent as the same service through in-person diagnosis, consultation, or treatment.

This bill would delete that date restriction, thereby extending the telehealth reimbursement parity requirement for all contracts between a health care service plan or a health insurer and a health care provider. The bill would provide that these provisions are severable.

The bill would also enact the Protection of Patient Choice in Telehealth Provider Act, and would require a health care service plan and a health insurer to comply with specified notice and consent requirements if the plan or insurer offers a service via telehealth to an enrollee or an insured through a third-party corporate telehealth provider, as defined. For an enrollee or insured that receives specialty telehealth services for a mental or behavioral health condition, the bill would require that the enrollee or insured be given the option of continuing to receive that service with the contracting individual health professional, a contracting clinic, or a contracting health facility. The bill would exempt specified health care service plan contracts and Medi-Cal managed care plan contracts from those provisions. The bill would require the State Department of Health Care Services to consider the appropriateness of applying those requirements to the Medi-Cal program, as specified. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.

(3) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

The people of the State of California do enact as follows:

SECTION 1. This act shall be known and may be cited as the Protection of Patient Choice in Telehealth Provider Act.

Protection of Patient Choice in Telehealth Provider Act

SEC. 2. The Legislature finds and declares both of the following:

(a) The purpose of telehealth is to allow a patient to interact with the patient's physician or other health care provider when safety or convenience make in-person treatments difficult or impossible.

(b) Third-party telehealth corporations should coordinate with a patient's usual source of care and contribute to the longitudinal patient record in order to be part of a comprehensive, integrated health care system.

SEC. 3. Section 650 of the Business and Professions Code is amended to read:

650. (a) Except as provided in Chapter 2.3 (commencing with Section 1400) of Division 2 of the Health and Safety Code, the offer, delivery, receipt, or acceptance by any person licensed under this division or the Chiropractic Initiative Act of any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for referring patients, clients, or customers to any person, irrespective of any membership,

proprietary interest, or coownership in or with any person to whom these patients, clients, or customers are referred is unlawful.

(b) The payment or receipt of consideration for services other than the referral of patients that is based on a percentage of gross revenue or similar type of contractual arrangement shall not be unlawful if the consideration is commensurate with the value of the services furnished or with the fair rental value of any premises or equipment leased or provided by the recipient to the payer.

(c) The offer, delivery, receipt, or acceptance of any consideration between a federally qualified health center, as defined in Section 1396d(l)(2)(B) of Title 42 of the United States Code, and any individual or entity providing goods, items, services, donations, loans, or a combination thereof to the health center entity pursuant to a contract, lease, grant, loan, or other agreement, if that agreement contributes to the ability of the health center entity to maintain or increase the availability, or enhance the quality, of services provided to a medically underserved population served by the health center, shall be authorized only to the extent sanctioned or permitted by federal law.

(d) Except as provided in Chapter 2.3 (commencing with Section 1400) of Division 2 of the Health and Safety Code and in Sections 654.1 and 654.2 of this code, it shall not be unlawful for any person licensed under this division to refer a person to any laboratory, pharmacy, clinic, including entities exempt from licensure pursuant to Section 1206 of the Health and Safety Code, or health care facility solely because the licensee has a proprietary interest or coownership in the laboratory, pharmacy, clinic, or health care facility, provided, however, that the licensee's return on investment for that proprietary interest or coownership shall be based upon the amount of the capital investment or proportional ownership of the licensee which ownership interest is not based on the number or value of any patients referred. Any referral excepted under this section shall be unlawful if the prosecutor proves that there was no valid medical need for the referral.

(e) Except as provided in Chapter 2.3 (commencing with Section 1400) of Division 2 of the Health and Safety Code and in Sections 654.1 and 654.2 of this code, it shall not be unlawful to provide nonmonetary remuneration, in the form of hardware, software, or information technology and training services, as described in subsections (x) and (y) of Section 1001.952 of Title 42 of the Code of Federal Regulations, as amended October 4, 2007, as published in the Federal Register (72 Fed. Reg. 56632 and 56644), and as subsequently amended.

(f) "Health care facility" means a general acute care hospital, acute psychiatric hospital, skilled nursing facility, intermediate care facility, and any other health facility licensed by the State Department of Public Health under Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code.

(g) Notwithstanding this section or any other law, the payment or receipt of consideration for advertising, wherein a licensee offers or sells services

through a third-party advertiser, shall not constitute a referral of patients when the third-party advertiser does not itself recommend, endorse, or otherwise select a licensee. The fee paid to the third-party advertiser shall be commensurate with the service provided by the third-party advertiser. If the licensee determines, after consultation with the purchaser of the service, that the service provided by the licensee is inappropriate for the purchaser or if the purchaser elects not to receive the service for any reason and requests a refund, the purchaser shall receive a refund of the full purchase price as determined by the terms of the advertising service agreement between the third-party advertiser and the licensee. The licensee shall disclose in the advertisement that a consultation is required and that the purchaser will receive a refund if ineligible to receive the service. This subdivision shall not apply to basic health care services, as defined in subdivision (b) of Section 1345 of the Health and Safety Code, or essential health benefits, as defined in Section 1367.005 of the Health and Safety Code and Section 10112.27 of the Insurance Code. The entity that provides the advertising shall be able to demonstrate that the licensee consented in writing to the requirements of this subdivision. A third-party advertiser shall make available to prospective purchasers advertisements for services of all licensees then advertising through the third-party advertiser in the applicable geographic region. In any advertisement offering a discount price for a service, the licensee shall also disclose the regular, nondiscounted price for that service.

(h) To the extent consistent with federal law, regulations, or guidance, the payment or receipt of consideration for internet-based advertising, appointment booking, or any service that provides information and resources to prospective patients of licensees shall not constitute a referral of a patient if the internet-based service provider does not recommend or endorse a specific licensee to a prospective patient.

(i) A violation of this section is a public offense and is punishable upon a first conviction by imprisonment in a county jail for not more than one year, or by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code, or by a fine not exceeding fifty thousand dollars (\$50,000), or by both that imprisonment and fine. A second or subsequent conviction is punishable by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code, or by that imprisonment and a fine of fifty thousand dollars (\$50,000).

SEC. 4. Section 1374.14 of the Health and Safety Code is amended to read:

1374.14. (a) (1) A contract between a health care service plan and a health care provider for the provision of health care services to an enrollee or subscriber shall specify that the health care service plan shall reimburse the treating or consulting health care provider for the diagnosis, consultation, or treatment of an enrollee or subscriber appropriately delivered through telehealth services on the same basis and to the same extent that the health care service plan is responsible for reimbursement for the same service through in-person diagnosis, consultation, or treatment.

(2) This section does not limit the ability of a health care service plan and a health care provider to negotiate the rate of reimbursement for a health care service provided pursuant to a contract subject to this section. Services that are the same, as determined by the provider's description of the service on the claim, shall be reimbursed at the same rate whether provided in person or through telehealth. When negotiating a rate of reimbursement for telehealth services for which no in-person equivalent exists, a health care service plan and the provider shall ensure the rate is consistent with subdivision (h) of Section 1367.

(3) This section does not require telehealth reimbursement to be unbundled from other capitated or bundled, risk-based payments.

(b) (1) A health care service plan contract shall specify that the health care service plan shall provide coverage for health care services appropriately delivered through telehealth services on the same basis and to the same extent that the health care service plan is responsible for coverage for the same service through in-person diagnosis, consultation, or treatment. Coverage shall not be limited only to services delivered by select third-party corporate telehealth providers.

(2) This section does not alter the obligation of a health care service plan to ensure that enrollees have access to all covered services through an adequate network of contracted providers, as required under Sections 1367, 1367.03, and 1367.035, and the regulations promulgated thereunder.

(3) This section does not require a health care service plan to cover telehealth services provided by an out-of-network provider, unless coverage is required under other law.

(c) A health care service plan may offer a contract containing a copayment or coinsurance requirement for a health care service delivered through telehealth services, provided that the copayment or coinsurance does not exceed the copayment or coinsurance applicable if the same services were delivered through in-person diagnosis, consultation, or treatment. This subdivision does not require cost sharing for services provided through telehealth.

(d) Services provided through telehealth and covered pursuant to this chapter shall be subject to the same deductible and annual or lifetime dollar maximum as equivalent services that are not provided through telehealth.

(e) The definitions in subdivision (a) of Section 2290.5 of the Business and Professions Code apply to this section.

(f) This section shall not apply to Medi-Cal managed care plans that contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) of, Chapter 8 (commencing with Section 14200) of, or Chapter 8.75 (commencing with Section 14591) of, Part 3 of Division 9 of the Welfare and Institutions Code.

(g) The provisions of this section are severable. If any provision of this section or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

SEC. 5. Section 1374.141 is added to the Health and Safety Code, immediately following Section 1374.14, to read:

1374.141. (a) If a health care service plan offers a service via telehealth to an enrollee through a third-party corporate telehealth provider, all of the following conditions shall be met:

(1) The health care service plan shall disclose to the enrollee in any promotion or coordination of the service both of the following:

(A) The availability of receiving the service on an in-person basis or via telehealth, if available, from the enrollee's primary care provider, treating specialist, or from another contracting individual health professional, contracting clinic, or contracting health facility consistent with the service and existing timeliness and geographic access standards in Sections 1367 and 1367.03 and regulations promulgated thereunder.

(B) If the enrollee has coverage for out-of-network benefits, a reminder of the availability of receiving the service either via telehealth or on an in-person basis using the enrollee's out-of-network benefits, and the cost sharing obligation for out-of-network benefits compared to in-network benefits and balance billing protections for services received from contracted providers.

(2) After being notified pursuant to paragraph (1), the enrollee chooses to receive the service via telehealth through a third-party corporate telehealth provider.

(3) The enrollee consents to the service consistent with Section 2290.5 of the Business and Professions Code.

(4) If the enrollee is currently receiving specialty telehealth services for a mental or behavioral health condition, the enrollee is given the option of continuing to receive that service with the contracting individual health professional, a contracting clinic, or a contracting health facility.

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

(1) "Contracting individual health professional" means a physician and surgeon or other professional who is licensed by the state to deliver or furnish health care services, including mental and behavioral health services, and who is contracted with or employed by the enrollee's health care service plan as a network provider. A "contracting individual health professional" shall not include a dentist licensed pursuant to the Dental Practice Act (Chapter 4 (commencing with Section 1600) of Division 2 of the Business and Professions Code). Application of this definition is not precluded by a contracting individual health professional's affiliation with a group.

(2) "Contracting clinic" means a clinic, as defined in Section 1200, that is contracted with or owned by the enrollee's health care service plan and as a network provider.

(3) "Contracting health facility" means a health facility, as defined in Section 1250 and paragraph (1) of subdivision (f) of Section 1371.9, that is contracted with or operated by the enrollee's health care service plan and serves as a network provider.

(4) "Third-party corporate telehealth provider" means a corporation directly contracted with a health care service plan that provides health care

services exclusively through a telehealth technology platform and has no physical location at which a patient can receive services.

(c) If services are provided to an enrollee through a third-party corporate telehealth provider, a health care service plan shall comply with all of the following:

(1) Notify the enrollee of their right to access their medical records pursuant to, and consistent with, Chapter 1 (commencing with Section 123100) of Part 1 of Division 106.

(2) Notify the enrollee that the record of any services provided to the enrollee through a third-party corporate telehealth provider shall be shared with their primary care provider, unless the enrollee objects.

(3) Ensure that the records are entered into a patient record system shared with the enrollee's primary care provider or are otherwise provided to the enrollee's primary care provider, unless the enrollee objects, in a manner consistent with state and federal law.

(4) Notify the enrollee that all services received through the third-party corporate telehealth provider are available at in-network cost-sharing and out-of-pocket costs shall accrue to any applicable deductible or out-of-pocket maximum.

(d) A health care service plan shall include in its reports submitted to the department pursuant to Section 1367.035 and regulations adopted pursuant to that section, in a manner specified by the department, all of the following for each product type:

(1) By specialty, the total number of services delivered via telehealth by third-party corporate telehealth providers.

(2) The names of each third-party corporate telehealth provider contracted with the plan and, for each, the number of services provided by specialty.

(3) For each third-party corporate telehealth provider with which it contracts, the percentage of the third-party corporate telehealth provider's contracted providers available to the plan's enrollees that are also contracting individual health professionals.

(4) For each third-party corporate telehealth provider with which it contracts, the types of telehealth services utilized by enrollees, including frequency of use, gender, age, and any other information as determined by the department.

(5) For each enrollee that has accessed services for a third-party corporate telehealth provider, enrollee demographic data, including gender and age, and any other information as determined by the department.

(e) The director shall investigate and take enforcement action, as appropriate, against a health care service plan that fails to comply with these requirements and shall periodically evaluate contracts between health care service plans and third-party corporate telehealth providers to determine if any audit, evaluation, or enforcement actions should be undertaken by the department.

(f) If a health care service plan delegates responsibilities under this section to a contracted entity, including, but not limited to, a medical group or

independent practice association, the delegated entity shall comply with this section.

(g) This section shall not apply when an enrollee seeks services directly from a third-party corporate telehealth provider.

(h) This section shall not apply to a health care service plan contract or a Medi-Cal managed care plan contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code. The State Department of Health Care Services shall consider the appropriateness of applying the requirements of this section, in whole or in part, to the Medi-Cal program pursuant to the advisory group process described in paragraph (2) of subdivision (f) of Section 14124.12 of the Welfare and Institutions Code.

SEC. 6. Section 10123.855 of the Insurance Code is amended to read:

10123.855. (a) (1) A contract between a health insurer and a health care provider for an alternative rate of payment pursuant to Section 10133 shall specify that the health insurer shall reimburse the treating or consulting health care provider for the diagnosis, consultation, or treatment of an insured or policyholder appropriately delivered through telehealth services on the same basis and to the same extent that the health insurer is responsible for reimbursement for the same service through in-person diagnosis, consultation, or treatment.

(2) This section does not limit the ability of a health insurer and a health care provider to negotiate the rate of reimbursement for a health care service provided pursuant to a contract subject to this section. Services that are the same, as determined by the provider's description of the service on the claim, shall be reimbursed at the same rate whether provided in person or through telehealth. When negotiating a rate of reimbursement for telehealth services for which no in-person equivalent exists, a health insurer and the provider shall ensure the rate is consistent with subdivision (a) of Section 10123.137.

(b) (1) A policy of health insurance that provides benefits through contracts with providers at alternative rates of payment shall specify that the health insurer shall provide coverage for health care services appropriately delivered through telehealth services on the same basis and to the same extent that the health insurer is responsible for coverage for the same service through in-person diagnosis, consultation, or treatment. Coverage shall not be limited only to services delivered by select third-party corporate telehealth providers.

(2) This section does not alter the existing statutory or regulatory obligations of a health insurer to ensure that insureds have access to all covered services through an adequate network of contracted providers, as required by Sections 10133 and 10133.5 and the regulations promulgated thereunder.

(3) This section does not require a health insurer to deliver health care services through telehealth services.

(4) This section does not require a health insurer to cover telehealth services provided by an out-of-network provider, unless coverage is required under other provisions of law.

(c) A health insurer may offer a policy containing a copayment or coinsurance requirement for a health care service delivered through telehealth services, provided that the copayment or coinsurance does not exceed the copayment or coinsurance applicable if the same services were delivered through in-person diagnosis, consultation, or treatment. This subdivision does not require cost sharing for services provided through telehealth.

(d) Services provided through telehealth and covered pursuant to this chapter shall be subject to the same deductible and annual or lifetime dollar maximum as equivalent services that are not provided through telehealth.

(e) The definitions in subdivision (a) of Section 2290.5 of the Business and Professions Code apply to this section.

(f) The provisions of this section are severable. If any provision of this section or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

SEC. 7. Section 10123.856 is added to the Insurance Code, to read:

10123.856. (a) If a health insurer offers a service via telehealth to an insured through a third-party corporate telehealth provider, all of the following conditions shall be met:

(1) The health insurer shall disclose to the insured in any promotion or coordination of the service both of the following:

(A) The availability of receiving the service on an in-person basis or via telehealth, if available, from the insured's primary care provider, treating specialist, or from another contracting individual health professional, a contracting clinic, or a contracting health facility consistent with the service and existing timeliness and geographic access standards in Section 10133.5 and regulations promulgated thereunder.

(B) If the insured has coverage for out-of-network benefits, a reminder of the availability of receiving the service either via telehealth or on an in-person basis using the insured's out-of-network benefits, and the cost sharing obligation for out-of-network benefits compared to in-network benefits and balance billing protections for services received from contracted providers.

(2) After being notified pursuant to paragraph (1), the insured chooses to receive the service via telehealth through a third-party corporate telehealth provider.

(3) The insured consents to the service consistent with Section 2290.5 of the Business and Professions Code.

(4) If the insured is currently receiving specialty telehealth services for a mental or behavioral health condition, the insured is given the option of continuing to receive that service with the contracting individual health professional, a contracting clinic, or a contracting health facility.

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

(1) “Contracting individual health professional” means a physician and surgeon or other professional who is licensed by the state to deliver or furnish health care services, including mental or behavioral health services, and who is contracted with the insured’s health insurer. A “contracting individual health professional” shall not include a dentist licensed pursuant to the Dental Practice Act (Chapter 4 (commencing with Section 1600) of Division 2 of the Business and Professions Code). Application of this definition is not precluded by a contracting individual health professional’s affiliation with a group.

(2) “Contracting clinic” means a clinic, as defined in Section 1200 of the Health and Safety Code, that is contracted with the insured’s health insurer.

(3) “Contracting health facility” mean a health facility, as defined in Section 1250 of the Health and Safety Code, that is contracted with the insured’s health insurer.

(4) “Third-party corporate telehealth provider” means a corporation directly contracted with a health insurer that provides health care services exclusively through a telehealth technology platform and has no physical location at which a patient can receive services.

(c) If services are provided to an insured through a third-party corporate telehealth provider, a health insurer shall comply with all of the following:

(1) Notify the insured of the insured’s right to access the insured’s medical records pursuant to, and consistent with, Chapter 1 (commencing with Section 123100) of Part 1 of Division 106 of the Health and Safety Code.

(2) Notify the insured that the record of any services provided to the insured through a third-party corporate telehealth provider shall be shared with the insured’s primary care provider, unless the insured objects.

(3) Ensure that the records are entered into a patient record system shared with the insured’s primary care provider or are otherwise provided to the insured’s primary care provider, unless the insured objects, in a manner consistent with state and federal law.

(4) Notify the insured that all services received through the third-party corporate telehealth provider are considered to be in network available at in-network cost-sharing and out-of-pocket costs shall accrue to any applicable deductible or out-of-pocket maximum.

(d) A health insurer shall include in its reports submitted to the department pursuant to Section 10133.5 and regulations adopted pursuant to that section, in a manner specified by the commissioner, all of the following for each product type:

(1) By specialty, the total number of services delivered via telehealth provided by third-party corporate telehealth providers.

(2) The names of each third-party corporate telehealth provider contracted with the insurer and, for each, the number of services provided by specialty.

(3) For each third-party corporate telehealth provider with which it contracts, the percentage of the third-party corporate telehealth provider’s contracted providers available to the insurer’s insured that are also contracting individual health professionals.

(4) For each third-party corporate telehealth provider with which it contracts, the types of telehealth services utilized by insureds, including frequency of use, gender, age, and any other information as determined by the department.

(5) For each enrollee that has accessed services for a third-party corporate telehealth provider, enrollee demographic data, including gender and age, and any other information as determined by the department.

(e) The commissioner shall investigate and take enforcement action, as appropriate, against a health insurer that fails to comply with these requirements and shall periodically evaluate contracts between health insurers and third-party corporate telehealth providers to determine if any audit, evaluation, or enforcement actions should be undertaken by the commissioner.

(f) This section shall not apply when an insured seeks services directly from a third-party corporate telehealth provider.

SEC. 8. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.