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FOLEY & LARDNER LLP

50-State Survey of Telehealth Insurance Laws

Third Edition

Includes a Comparison of Laws Before and After the Public Health Emergency

APRIL 2024

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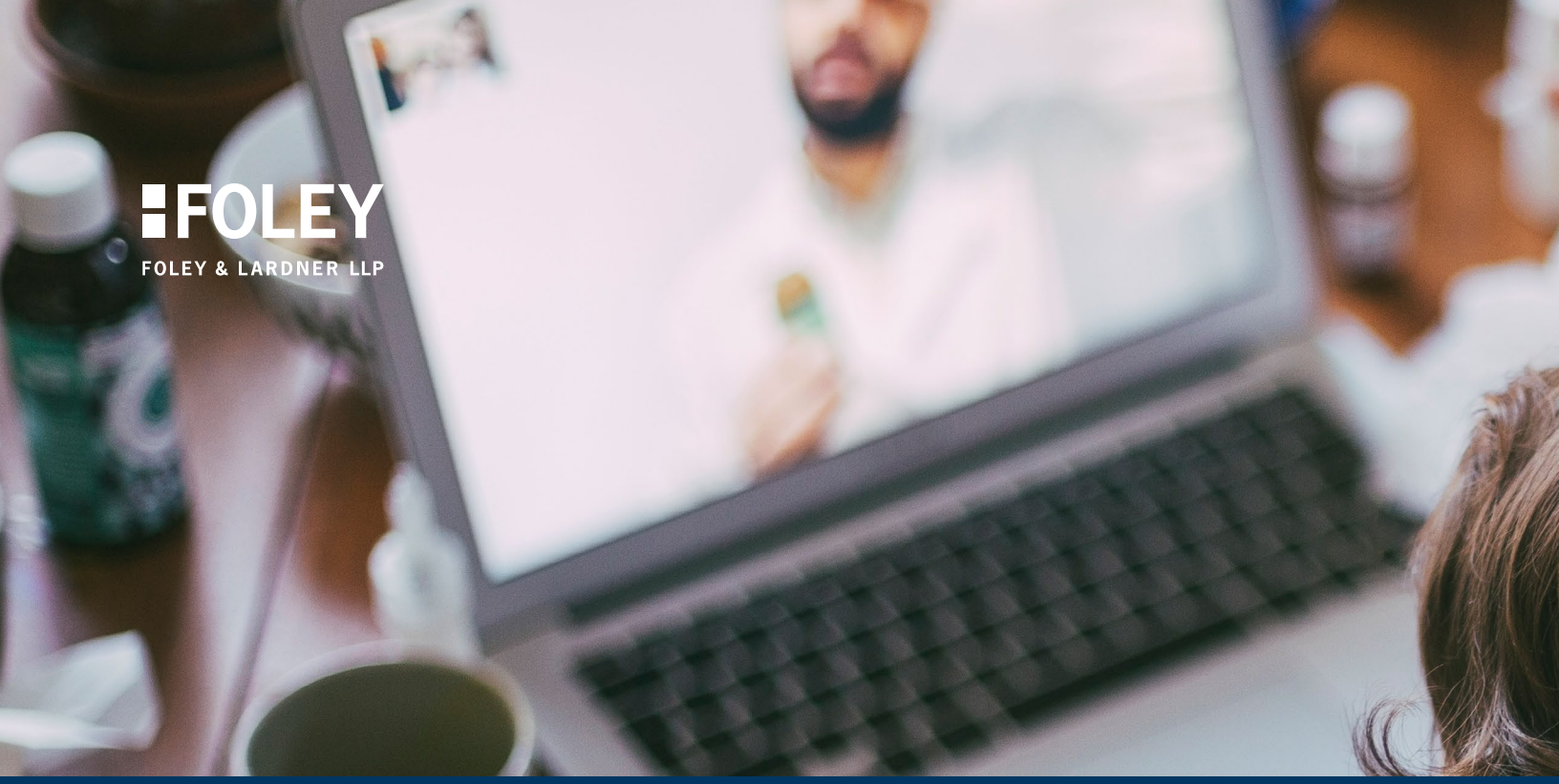

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ABOUT FOLEY & LARDNER'S TELEMEDICINE AND DIGITAL HEALTH INDUSTRY TEAM

Foley's Telemedicine and Digital Health Industry Team has been referred to as "***the premier firm for telehealth counsel***," "***a market leader in telemedicine issues***" and "***the Dream Team***." Using a team-based approach of deep subject matter experts, we help established and emerging companies build innovative virtual care programs, create scalable and sustainable digital health companies, and reach patients in new markets around the block and around the world. We are committed to helping clients fulfill their goals of harnessing new technology to meet patient needs anywhere, delivering care without borders or geographic limitations. Our lawyers help create fully fledged telemedicine offerings, delivering end-to-end legal services by coupling precise strategic guidance with "***a stunningly high level of care and responsiveness***" to maintain that sense of urgency necessary to launch new initiatives and remain competitive in the marketplace.

The depth and breadth of our experience, the qualifications of our attorneys, our unparalleled insight and knowledge of the telemedicine and digital health industry, and our work with some of the best and brightest names in healthcare allows us to deliver unique value. Our approach to working with clients is collaborative, deliberate, and actionable. One firm; all your digital health needs.

*All quotes were provided by clients and lawyers from peer law firms and published by *Chambers USA*: America's Leading Business Lawyers.

About This Report

Telemedicine and digital health technology continues to gain broad adoption among patients and healthcare professionals alike, with more organizations implementing and expanding robust virtual care services either as standalone programs or as a supplement to traditional in-person offerings. When Foley & Lardner's first nationwide telemedicine and digital health survey was published in 2014, our findings revealed that one of the most significant barriers to telehealth adoption was limited or uncertain coverage and reimbursement. A decade later, significant progress has been made — both legislative and technological — to advance the widespread use of virtual care services across the United States.

In 2020, the COVID-19 pandemic prompted state and federal policymakers to temporarily waive legal restrictions and materially expand coverage and reimbursement for virtual care services at a scale previously unseen. By temporarily eliminating restrictions and opening up coverage, the Public Health Emergency (PHE) offered telehealth providers the freedom to experiment and a chance to challenge previously-held presumptions about the efficacy and value of virtual care. After the PHE concluded in May 2023, studies began to emerge evaluating how these waivers affected patient care, access, quality, and medical spend. The findings indicated that waiving the telehealth laws during the PHE did not result in widespread quality of care failures nor increase fraud & abuse. Instead, the PHE years proved to the general public what a dedicated group of committed "tele-vangelists" believed for years: telehealth is a key tool to reach the coveted Triple Aim and can do so without being feared as a budget buster on medical spend. Accordingly, while the waivers were initially temporary and slated to end when the PHE expired, many states (and the Medicare program) made these waivers permanent, codifying them into law.

Foley & Lardner's 50-State Survey of Telehealth Insurance Laws provides a detailed report on each State's telehealth commercial insurance coverage and payment/reimbursement laws. This comprehensive survey contains pinpoint citations to the governing statutes and regulations on telehealth commercial health insurance laws, as well as the full text of those laws and regulations as a reference tool. The report does not include Medicaid or Medicaid managed care laws, which also vary on a state-by-state basis, and can be found primarily in state Medicaid program handbooks and regulations. The report is useful to healthcare providers (both traditional and emerging), lawmakers, entrepreneurs, telemedicine companies, and other industry stakeholders as a guide of telehealth insurance laws and regulations across all 50 states and the District of Columbia. This is the Third Edition of Foley's report, with the First Edition published in 2019 and the Second Edition published in 2021.

This report is for informational and educational purposes only and is not intended as a comprehensive statement of the law on this topic. It is not legal advice and cannot be relied upon as legal advice. The tables contained herein are an interpretive summary only and apply the most general coverage provision and/or the predominant answer across the state. There may be variances across coverage laws, and laws and rules are constantly changing, so be certain to reference and read the statutes and regulations for precise legal requirements. If you have questions on telehealth law or billing, coding, and reimbursement rules, consult with your legal counsel, certified billing and coding professionals, and/or your local Medicare Administrative Contractor. Our research was last comprehensively conducted from February 2024 through April 2024, and the authorities could be amended at a later date. Please note some states have multiple telehealth coverage laws applicable to various policy, service, and/or provider types.

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Nathaniel (Nate) Lacktman is a partner and Chair of Foley & Lardner's national Telemedicine & Digital Health Industry Team. He serves on the Board of Directors of the American Telemedicine Association. Nate advises entrepreneurial health care providers and technology companies on business arrangements, compliance, and corporate matters, with particular attention to telehealth, digital health, and health innovation. Working with entrepreneurs, hospitals, providers, and start-ups to build telemedicine arrangements across the United States and internationally, his practice emphasizes strategic counseling, creative business modeling, and fresh approaches to realize clients' ambitious and innovative goals. He speaks and writes frequently on issues at the forefront of telehealth and is often quoted for his insight about legal and business developments in this area. He has written telehealth legislation, regulations, comment letters, and policy input to lawmakers, the Drug Enforcement Agency, the Congressional Research Service, state Medicaid Agencies, and state boards of medicine across numerous states. He is the 2019 recipient of the ATA's Champion Award, which recognizes an individual who has made significant contributions to advocate for public policy changes that open payment support and provide regulatory pathways for telemedicine and digital health.

* The authors would like to extend their gratitude to Jane Blaney, Esq., for her for research contributions to this Third Edition.

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Noteworthy Legal Changes: Before and After the Public Health Emergency

In the time since our 2019 report, the legal landscape for telehealth insurance coverage and reimbursement has significantly expanded. Comparing the laws before and after the PHE, our research identified the following notable changes:

1. More Prohibitions Against Exclusive Telehealth Platform Arrangements

After the PHE ended, a number of states changed their laws to prohibit health plans from mandating in-network providers use a specific telehealth software platform or app in order for the member to receive insurance coverage. Similar laws were enacted to prohibit exclusive contracting arrangements between health plans and telehealth platforms, vendors, or service providers (including those affiliated with or controlled by the health plan). These restrictions existed in some states before the PHE, but were notably expanded to more states as of 2024.

The changes should offer more opportunity for individual clinics and hospitals to use whatever software platform they prefer, which is good for competition and opportunities among software companies. By limiting exclusive contracting arrangements, the changes should help ensure patients can obtain covered telehealth services from their in-person doctor, rather than requiring the patient to obtain in-person services from one doctor and telehealth services from a different medical group. Whether or not the changes result in increased competition (and therefore increased quality and decreased costs), time will tell.

2. Permanent Audio-Only Coverage Enters the Scene

Before the PHE, health plans did not separately reimburse for telephone calls with patients. Although the American Medical Association had for years advocated to reimburse telephone calls (and even created telephone call CPT codes decades ago), Medicare and health plans considered such services to be covered but not separately payable under the notion that phone calls were part of the pre- or post-work of an otherwise covered service (typically an E/M visit). Phone calls were something clinicians did for patients, but could not receive additional reimbursement for that work. All that changed during the PHE when Medicare and most health plans temporarily offered separate reimbursement for audio-only services. The payment was immediately popular with clinicians and patients because it allowed people to obtain virtual care services even in areas with low speed internet access while simultaneously compensating clinicians for that medical visit.

Audio-only telehealth was so popular during the PHE that approximately 18 states passed laws to make such coverage permanent for health plans. These states now require coverage and/or separate reimbursement for audio-only services, predominantly for mental health (e.g., Georgia, Hawaii, Nebraska, Nevada) or where other telehealth modalities are not feasible due to lack of adequate broadband access or are otherwise impractical or not medically advisable (e.g., Georgia, Kentucky, Tennessee). That is a significant and material change from 2019.

Even with this newly-expanded coverage, reimbursement rates for audio-only services vary. Hawaii mandates coverage for audio-only mental health services, and sets the reimbursement rate at 80% of the rate for equivalent in-person services. Separate from payment, some states prohibit a clinician from establishing a new clinician-patient relationship via audio-only, and the initial exam must be via audio-video or in-person and audio-only cannot be used with new patient relationships.

18 states passed audio-only telehealth laws to make such coverage permanent for health plans

3. Mental and Behavioral Health Enjoys Expanded Telehealth Coverage and Payment Parity

It is no secret the United States is experiencing a supply-demand imbalance between the number of patients seeking medical care and the limited number of clinicians available to provide such care. This imbalance is particularly felt in the mental and behavioral health field. States have taken notice and action to help address this imbalance by guaranteeing expanded insurance coverage and payment of telehealth-based mental and behavioral health services.

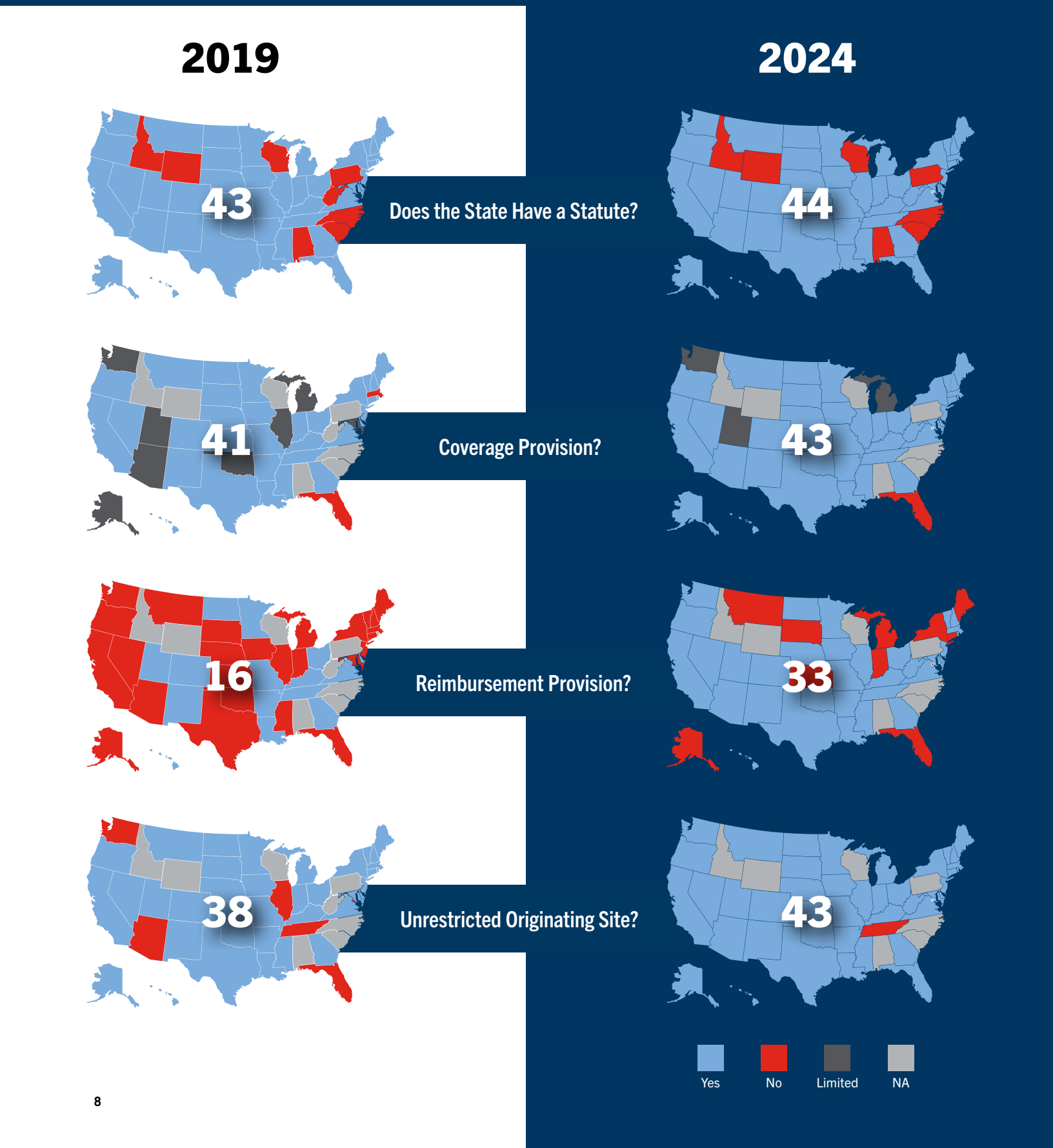
Following the PHE, approximately 11 states passed laws requiring coverage and payment parity for mental and behavioral health services delivered via telehealth. Much of this expansion came by recognizing audio-only modalities, but the expansion happened in other ways as well. For example, Iowa law now holds that a health plan cannot exclude out-of-state mental health providers from participating in the health plan so long as the mental health provider is licensed in Iowa and able to satisfy the same criteria as required for mental health providers physically located in the state. Iowa also added a payment parity provision, but only for mental health services.

2x **increase in states** that now have laws on payment parity or reimbursement rates in **2024**, compared to **16 states** in **2019**

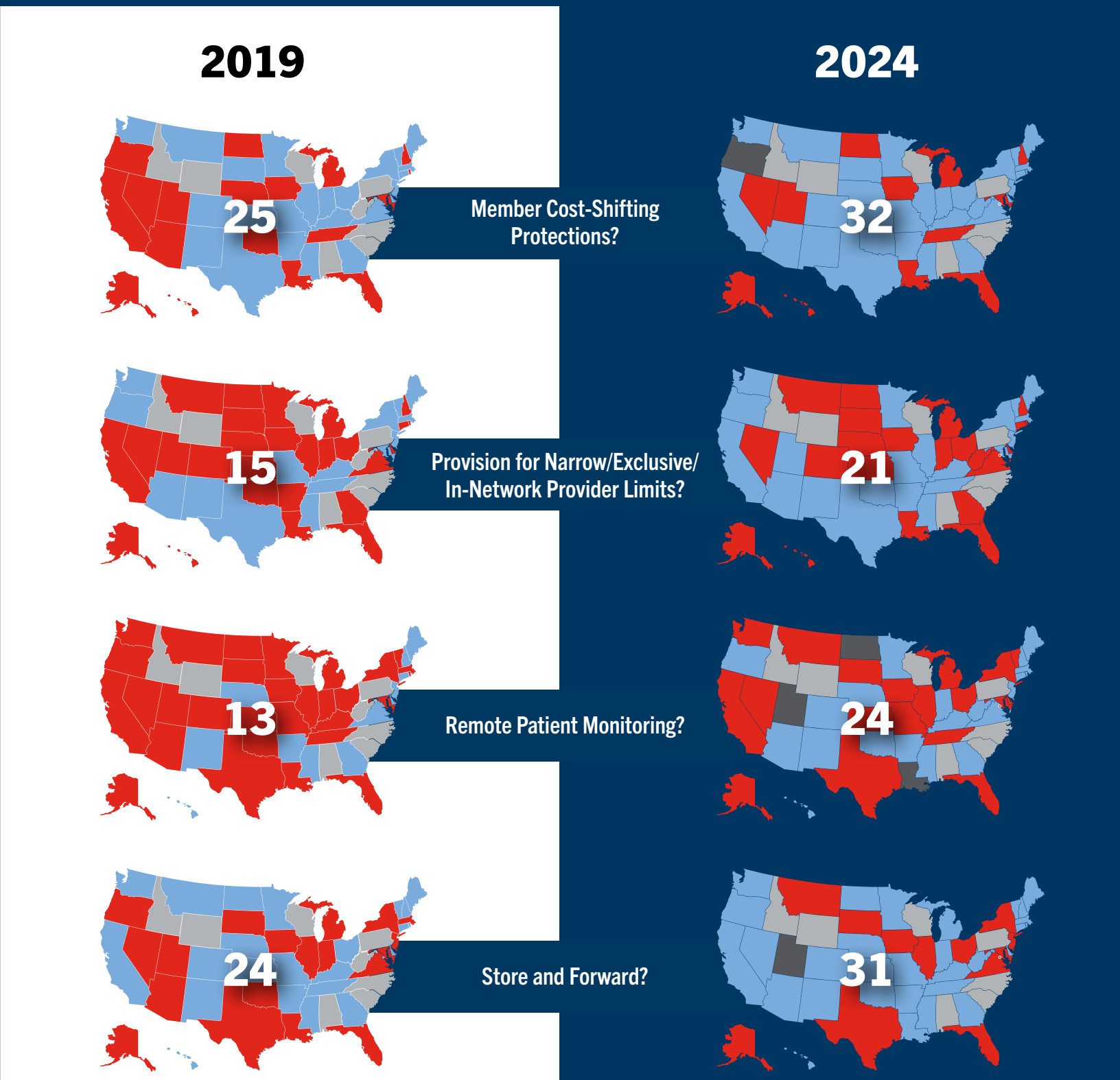
4. A Steady Increase in Payment Parity But Not As Widespread

As of 2024, 33 states now have laws on payment parity or reimbursement rates, up from 16 states in 2019. That twofold increase is significant, but a closer look at the actual statutory language reveals that the many of these laws do not constitute true payment parity. Some states enacted payment parity only for mental health services. Others expressly address reimbursement, but only require health plans to reimburse providers for telemedicine services "using the proper medical codes." Nebraska added a new reimbursement law, but it only requires payment parity if the telehealth provider also delivers in-person services at a physical location in Nebraska. Nevada's new reimbursement provision only applies when the patient is at a qualifying originating site or FQHC or rural area. Rhode Island's reimbursement provision limits payment parity to in-network primary care, registered dietitians/nutritionists, and behavioral health. And New York went the other way. After enacting telehealth payment parity during the PHE, New York's statute expired on April 1, 2024 and was not renewed.

State Telehealth Commercial Insurance Laws



Before and After the PHE



State Telehealth Commercial Insurance Laws

What Are Telehealth Commercial Coverage and Payment Parity Laws?

Currently, 43 states and DC have some sort of telehealth commercial insurance coverage law, with bills currently under development in several other states. These laws are sometimes referred to as "telehealth commercial payer statutes" or "telehealth parity laws." They are designed to promote patient access to care via telehealth in a multitude of scenarios, whether the patient is in a rural area without specialist care, or a busy metropolitan city without time to devote three hours to travel to an in-person check-up in a crowded waiting room. There are significant variances across the states, but two related but distinct concepts have emerged: telehealth coverage and telehealth payment parity.

Telehealth Commercial Coverage Laws

Telehealth coverage laws typically require health plans to cover services provided via telehealth to a member to the same extent the plan already covers the services for that member if the service was provided through an in-person visit. The laws do not mandate the health plan provide its members entirely new service lines or specialties, and the scope of services in the enrollee's member benefit package remains unchanged. Nor do these laws require a health plan to provide identical coverage to any and all members — the benefits (telehealth or otherwise) still track the covered benefits under each individual member's health benefit plan.

Assume, for example, Member A has a low-cost benefit plan with a narrow scope of 20 covered services. Member B has an expanded benefit plan with 50 covered services. A telehealth commercial coverage law would not require the health plan to cover 50 services for Member A. Member A would still enjoy coverage of only those 20 services in the benefit plan. The difference is that Member A can choose to receive those 20 services via telehealth rather than be compelled to drive to the doctor's waiting room for an in-person consult.

For a state to promote meaningful adoption of telehealth, much depends on the language of its statute. A narrowly drawn statute may provide coverage only for telehealth and define it as licensed physician services. In that event, the telehealth market will see growth primarily in physician consults and other physician-driven health care services. If, instead, a statute is drafted more broadly to include telehealth, virtual care, and/or remote patient monitoring, the state will see growth in those areas, including equipment manufacturing, software development, and other technologies associated with virtual

care services. This could also trigger growth in companies that create patient health apps or data-driven interfaces, all of which are part of the virtual care services enterprise.

When drafting a telehealth commercial insurance coverage law, an important decision point is whether to:

1. Cover telehealth-based services to the same extent that service is covered when provided in-person; or
2. Cover additional virtual care services, such as remote patient monitoring, even if the service is not applicable to the in-person setting.

Depending on the policy goals, different statutory language is appropriate because certain virtual care services (e.g., remote patient monitoring) do not exist in the in-person setting and will often not be a covered benefit. Some states, particularly those that have enacted telehealth coverage laws in the last few years, elected to expand telehealth coverage by also requiring health plans to cover remote patient monitoring. Remote patient monitoring includes a variety of patient oversight and communications devices, software, and processes to allow providers a greater ability to monitor patient care needs and immediately respond. States have taken this step because remote patient monitoring, by definition, is a virtual service and has no in-person equivalent that would likely already be found in a member's benefit package.

For example, if the legislature's intent is to cover a broad spectrum of virtual care services, but the bill's language reads "health plans must cover services provided via telehealth to the same extent those services are covered if provided in-person," that bill could create a coverage gap omitting remote patient monitoring because many health plans do not provide coverage for an in-person equivalent to remote patient monitoring. For this reason, some states (e.g., Mississippi) have enacted follow-up legislation to expressly expand the scope of covered virtual care services to include remote patient monitoring.

Telehealth coverage laws also frequently include language to protect patients from cost-shifting. This language disallows health plans from imposing higher or different deductibles, co-payments, or maximum benefit caps for services provided via telehealth. Any deductibles, co-payments and benefit caps apply equally and identically whether the patient receives the care in-person or via telehealth. This prevents the patient from being saddled with higher co-payments to access care via telehealth.

Telehealth Payment Parity Laws

A subset of states with telehealth coverage laws also include language regarding reimbursement rates for telehealth services. These laws are sometimes referred to as telehealth payment parity laws. Telehealth payment parity is different from coverage. A telehealth payment parity law requires the health plan to pay the network provider for a service delivered via telehealth at the same or equivalent reimbursement rate the health plan pays that provider when the same service is delivered in-person.

Payment parity laws were created in response to health plans paying for telehealth services at only a fraction of the rate the health plan pays for the identical service when delivered in-person. This can occur when a state enacts a broad telehealth coverage law, but fails to include any language regarding the reimbursement or payment of telehealth services.

Without payment parity, a health plan could unilaterally decide to pay network providers for telehealth services at 50% of the reimbursement rate that health plan pays the provider for an identical in-person service. This is not a theoretical risk, and actually occurred when New York implemented its broad telehealth coverage law in 2016, which did not include any language regarding payment/reimbursement rates. If the health plan's payment rate is too low, it can create a disincentive for providers to offer telehealth services, undermining the very policy purposes the coverage law was intended to achieve. When this happens, in-network providers have no recourse other than to 1) offer telehealth services at a loss or 2) simply no longer offer telehealth as an option. And because the telehealth service is covered under the patient's benefit plan, the provider cannot give the patient the option to pay out-of-pocket, as doing so could be a breach of contract under the provider's participation agreement with the health plan.

Here is how payment parity works. Assume, for example, Doctor A's participation agreement with a health plan reimburses that doctor $50 for a level 3 E/M service. Under a telehealth payment parity law, the health plan must reimburse Doctor A $50 whether he provides that level 3 E/M service in-person or via telehealth. This is because the agreed-upon reimbursement rate under the participation agreement between Doctor A and the health plan is to pay $50 for a level 3 E/M service to a covered member. Or if the agreed-upon contract rate for a level 2 E/M service is $30 when delivered in-person service, the rate would be $30 when delivered via telehealth.

Moreover, just like coverage laws, a payment parity law only affects the reimbursement rates negotiated under the participation agreement on a contract-by-contract basis. It would never require a health plan to pay all its network providers the exact same reimbursement rate. Interpreting

those laws in that way directly conflicts with how commercial health plan contracting works. For example, assume Doctor A negotiated a $50 reimbursement rate for a level 3 E/M service under his/her participation agreement with Health Plan X. And Doctor B negotiated a $45 reimbursement rate for a level 3 E/M service under his/her participation agreement with Health Plan X. A telehealth payment parity law would not require Health Plan X to reimburse Doctor B at $50. Rather, Doctor B would be paid the negotiated $45 because (unlike Medicare) commercial reimbursement rates are the result of private contract negotiations between the health plan and the provider. And if Doctor C was telehealth-only and offered no in-person services, Doctor C and Health Plan X could negotiate whatever reimbursement rates they desired because there would be no in-person rate between the parties.

Ideally, payment parity laws should not prevent the parties from negotiating for different reimbursement rates for telehealth vs in-person services, so long as such negotiations are truly voluntary by the provider and not forced upon them. Well-drafted payment parity laws can level the field for providers to enter into meaningful negotiations with health plans as to how telehealth services are covered and paid. Model payment parity laws should not eliminate opportunities for cost savings, and should allow health plans and providers to contract for alternative payment models and compensation methodologies for telehealth services, so long as those negotiations are voluntary. Nor are payment parity laws intended to prohibit health plans and providers from the freedom to develop and enter into at-risk, capitated or shared savings contracts, all of which are conducive to the benefits offered by telehealth. Keep in mind, payment parity laws do not change the health plan's existing utilization review processes. The doctor's services (whether in-person or via telehealth) must still be of high quality, appropriately documented, delivered in accordance with state medical practice standards, and medically necessary in order to be paid.

The payment parity provisions in California and Georgia statutes represent a compromise by statutorily setting payment parity as the baseline while expressly allowing providers and plans to voluntarily negotiate alternate payment rates and depart from the baseline. We include similar terms in our model legislative language (included later in this report).

The heat maps that follow provide a summary of the following:

1. Does the State Have a Telehealth Commercial Payer Statute?

Whether or not the state has a law addressing commercial health plan coverage of telehealth services.

2. Does the Law Have a Coverage Provision?

Does the state's law expressly discuss coverage parity, meaning the law requires a commercial insurer to cover a health care service delivered via telehealth if the insurer would cover the same service if it were provided during an in-person consultation? (Variances exist among the laws and not every state has strong coverage parity, so please be sure to read the actual statutory language.)

3. Does the Law Have a Reimbursement Provision?

Does the state law expressly include language addressing payment and reimbursement rates for telehealth services? For some states, this means the commercial insurer must pay the provider for a health care service delivered via telehealth at the same reimbursement rate the insurer would pay that same provider for the same service if it were delivered in-person. For other states, the reimbursement language sets a ceiling, floor, or gives instruction on how the parties must negotiate rates for telehealth services. (Variances exist among the laws and not every state has strong payment parity, so please be sure to read the actual statutory language.)

4. Unrestricted Originating Site?

Does the state impose restrictions on the patient's originating site? Some states still require the patient to be located in a particular clinical setting at the time of the telehealth consultation.

5. Member Cost-Shifting Protections?

Does the state have a cost-shifting protection, meaning does the state law prohibit a commercial insurer from charging a patient a deductible, coinsurance, and/or copayment for a telehealth consultation that exceeds what the insurer would charge for the same service if it were provided during an in-person consultation?

6. Provision for Narrow/Exclusive/In-Network Provider Limits?

Does the state telehealth law have language addressing whether or not a health plan may limit coverage and/or reimbursement for telehealth services to only those providers that are within the plan's narrow telehealth network, exclusive network contracting, or payment provisions for in-network vs out-of-network providers? (Variances exist among the laws, so please be sure to read the actual statutory language.)

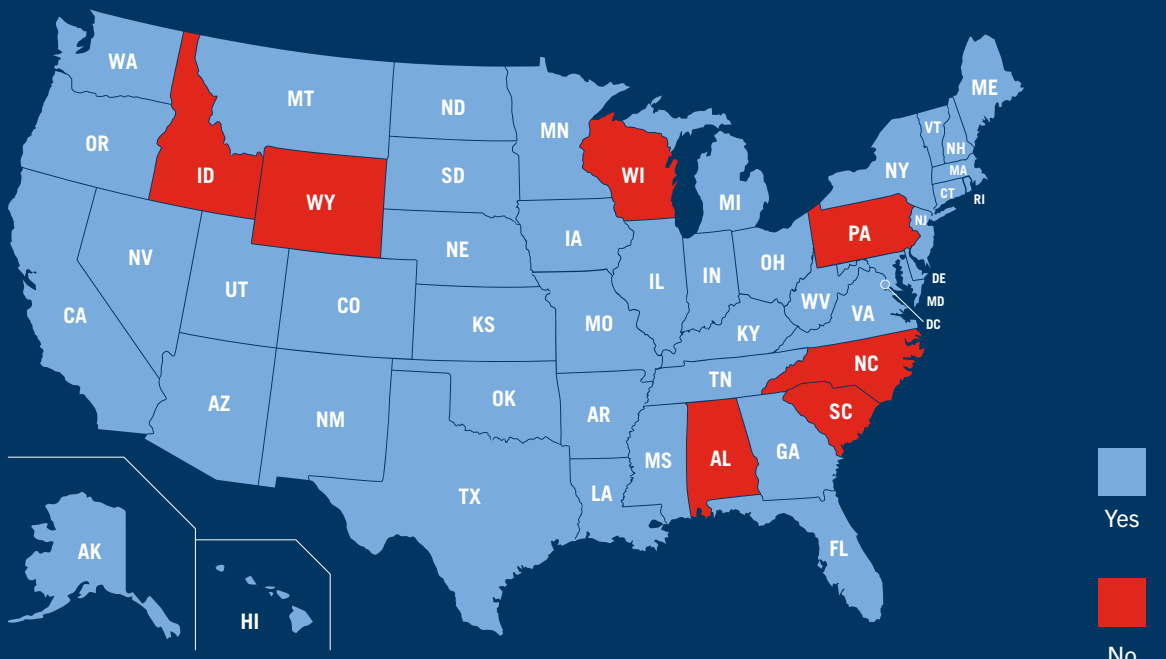
7. Remote Patient Monitoring (RPM)?

Does the state require coverage of RPM services?

8. Store and Forward (S&F) Telehealth? Does the state require coverage of store and forward/asynchronous telehealth services?

Does the State Have a Telehealth Commercial Payer Statute?

Whether or not the state has a law addressing commercial health plan coverage of telehealth services.



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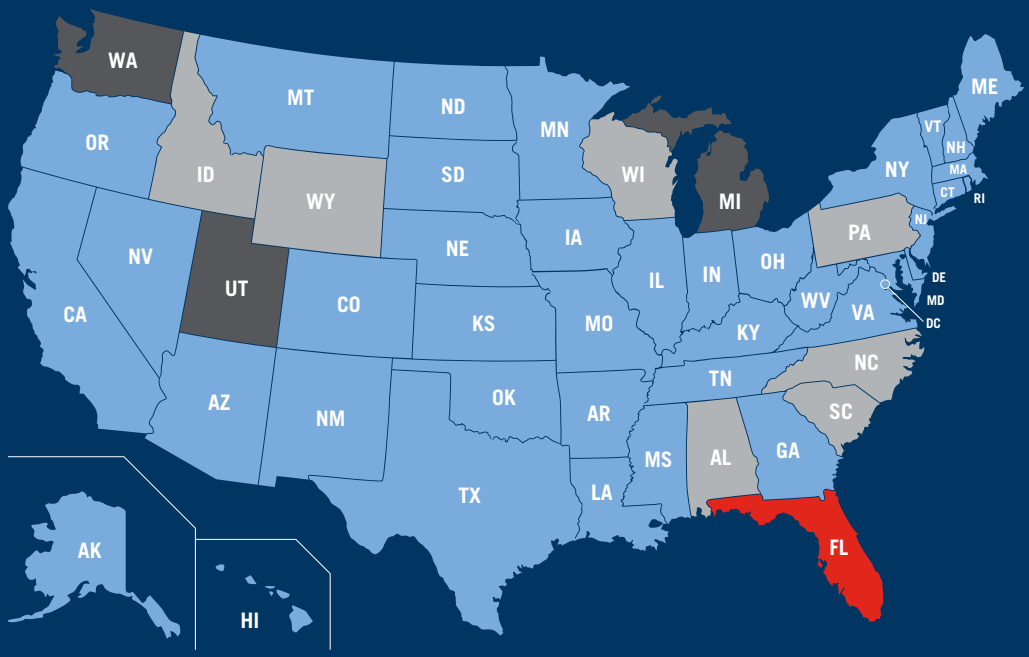

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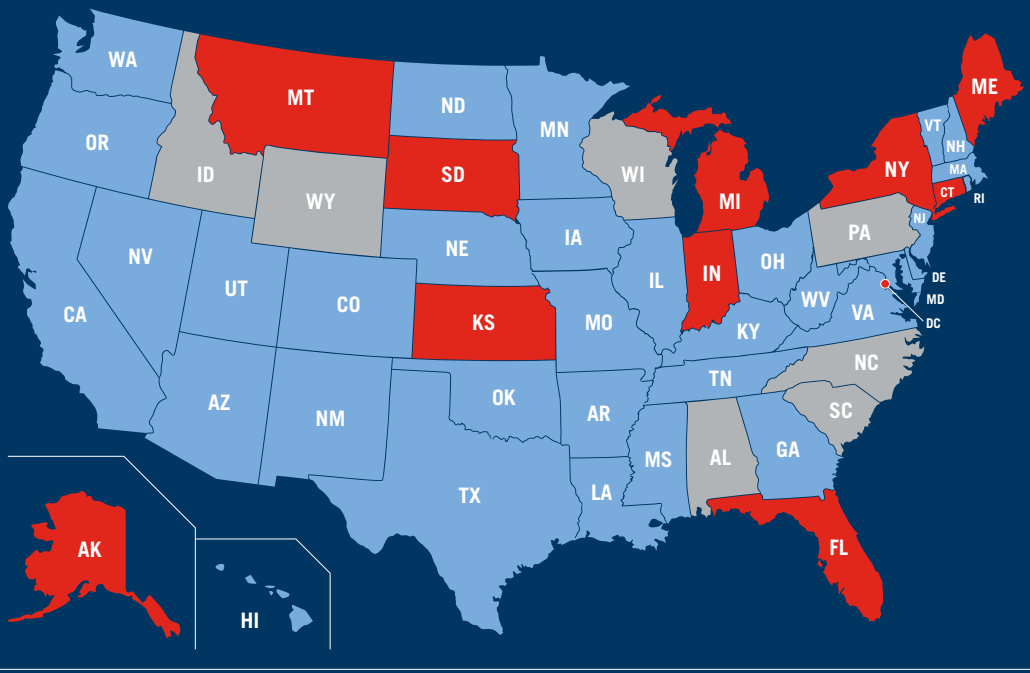
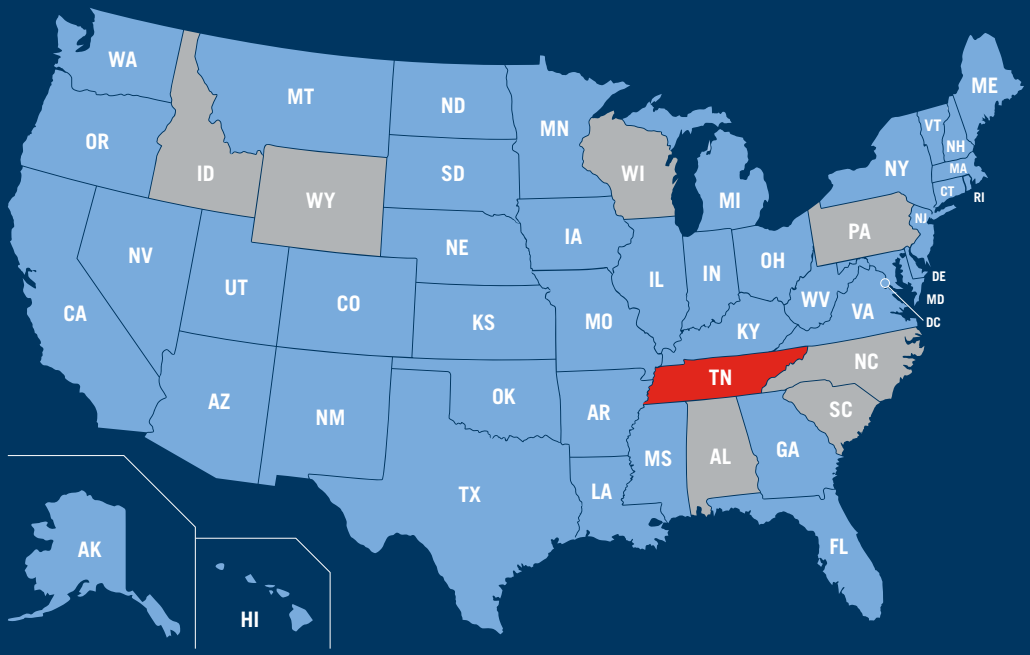


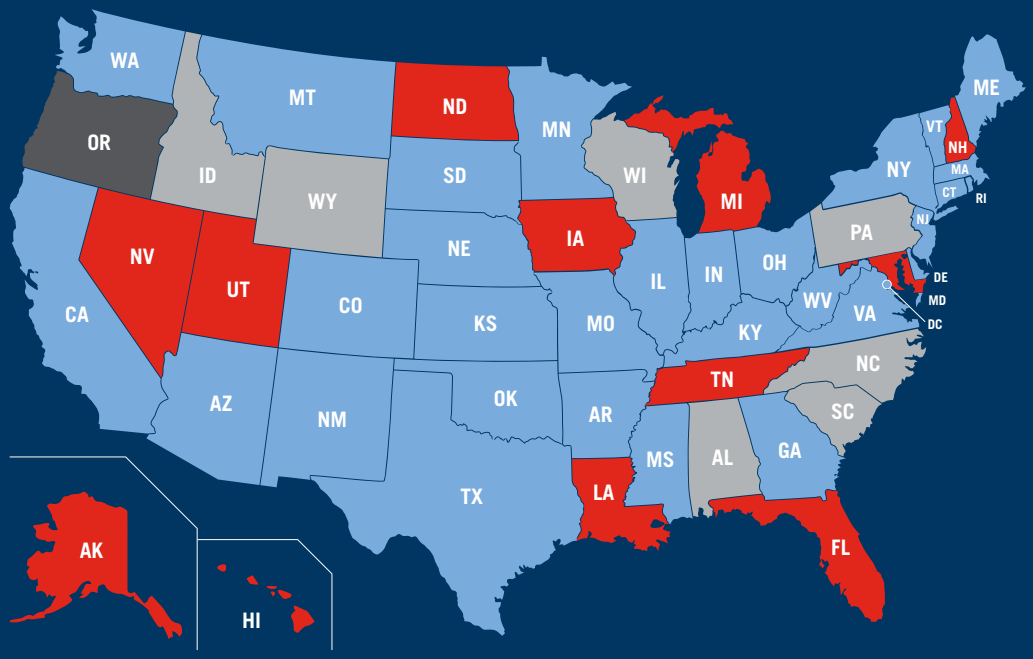
Unrestricted Originating Site?

Does the state impose restrictions on the patient's originating site? Some states still require the patient to be located in a particular clinical setting at the time of the telehealth consultation. If the patient is permitted to be at home, we considered this a state with an unrestricted originating site.



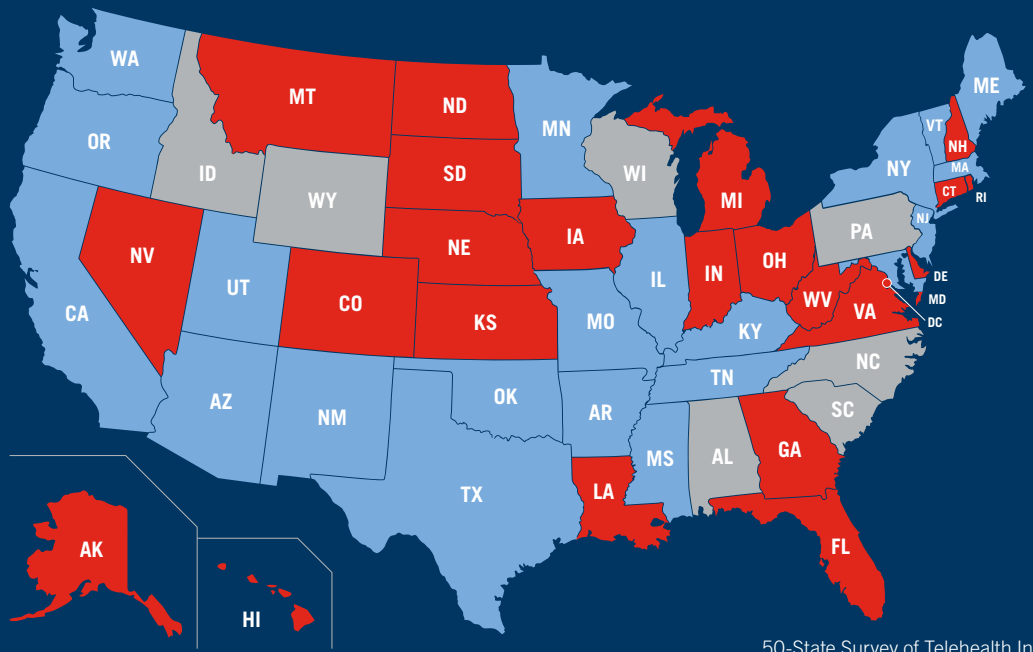
Member Cost-Shifting Protections?

Does the state have a cost-shifting protection, meaning does the state law prohibit a commercial insurer from charging a patient a deductible, coinsurance, and/or copayment for a telehealth consultation that exceeds what the insurer would charge for the same service if it were provided during an in-person consultation?



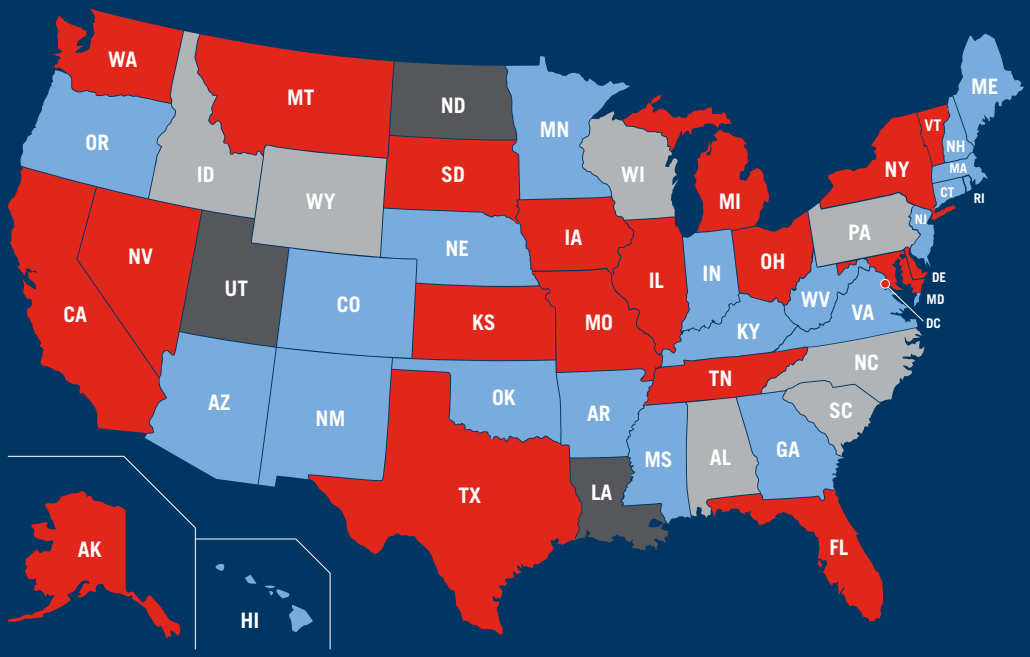
Provision for Narrow/Exclusive/In-Network Provider Limits?

Does the state telehealth law have language addressing whether or not a health plan may limit coverage and/or reimbursement for telehealth services to only those providers that are within the plan's narrow telehealth network, exclusive network contracting, or payment provisions for in-network vs out-of-network providers? (Variances exist among the laws, so please be sure to read the actual statutory language.)



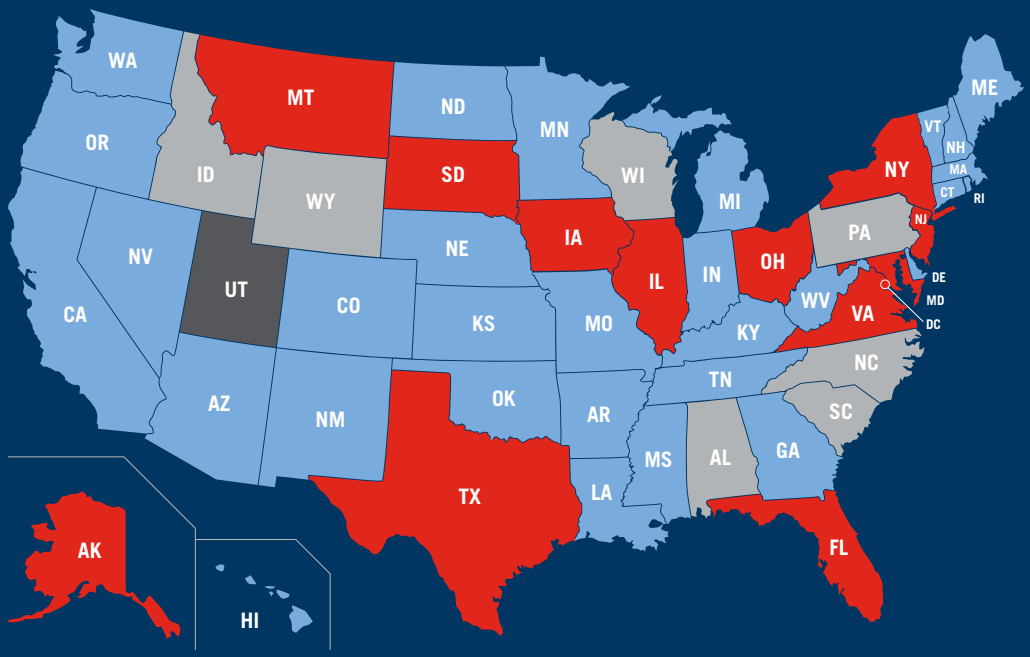
Remote Patient Monitoring?

Does the state require coverage of RPM services?



Store-and-Forward Telehealth?

Does the state require coverage of store and forward/asynchronous telehealth services?



State Telehealth Commercial Payer Statutes[1]

The following charts and tables are an interpretive summary for informational and educational purposes only; it is not legal advice. State telehealth laws and rules are constantly changing, and must be analyzed and applied to a specific clinical application. Please be sure to reference the specific state statutes and regulations for precise legal requirements, or contact your legal counsel for guidance.

✓ YES ✗ NO LTD LIMITED

	Does the State Have a Statute?	Coverage Provision?	Reimburse-ment Provision?	Unrestricted Originating Site?	Member Cost-Shifting Protections?	Provision for Narrow/ Exclusive/ In-Network Provider Limits?	Remote Patient Monitor-ing?	Store and Forward?	Authorities
AL	✗	N/A	N/A	N/A	N/A	N/A	N/A	N/A	None
AK	✓	✓	✗	✓	✗	✗	✗	✗	Alaska Stat. §§ 21.42.422, 47.05.270(e)
AZ	✓	✓	✓	✓	✓	✓	✓	✓	Ariz. Rev. Stat. §§§§ 20-841.09, 20-1406.05, 20-1057.13, 20-1376.05
AR	✓	✓	✓	✓	✓	✓	✓	✓	Ark. Code §§ 23-79-1601, 23-79-1602
CA	✓	✓	✓	✓	✓	✓	✗	✓	Cal. Health & Safety Code §§ 1374.13, 1374.14; Cal. Ins. Code §§ 10123.85, 10123.855; Cal. Bus. & Prof. Code § 2290.5
CO	✓	✓	✓	✓	✓	✗	✓	✓	Colo. Rev. Stat. § 10-16-123
CT	✓	✓	✗	✓	✓	✗	✓	✓	Conn. Gen. Stat. §§§§ 38a-499a, 38a- 526a, 19a-906, 19a-906a
DE	✓	✓	✓	✓	✓	✗	✗	✓	18 Del. Code §§ 3370, 3571R; 18 Del. Admin. Code 1409-2.0, -3.0, -4.0
DC	✓	✓	✗	✓	✓	✗	✗	✗	D.C. Code §§ 31-3861, 31-3862
FL	✓	✗	✗	✓	✗	✗	✗	✗	Fla. Stat. §§§ 627.42396, 641.31(45), 456.47(1)
GA	✓	✓	✓	✓	✓	✗	✓	✓	Ga. Code § 33-24-56.4

	Does the State Have a Statute?	Coverage Provision?	Reimburse-ment Provision?	Unrestricted Originating Site?	Member Cost-Shifting Protections?	Provision for Narrow/ Exclusive/ In-Network Provider Limits?	Remote Patient Monitor-ing?	Store and Forward?	Authorities
HI	✓	✓	✓	✓	✗	✗	✓	✓	Haw. Rev. Stat. §§§ 431:10A-116.3; 432D-23.5; 453.1.3(h), 432:1-601.5
ID	✗	N/A	N/A	N/A	N/A	N/A	N/A	N/A	None
IL	✓	✓	✓	✓	✓	✓	✗	✗	215 Ill. Comp. Stat. 5/356z.22
IN	✓	✓	✗	✓	✓	✗	✓	✓	Ind. Code § 27-8-34 et seq., 27-13- 7-22
IA	✓	✓	✓	✓	✗	✗	✗	✗	Iowa Code §§ 514C.34, 514C.35
KS	✓	✓	✗	✓	✓	✗	✗	✓	Kan. Stat. §§ 40-2,211; 40-2,213
KY	✓	✓	✓	✓	✓	✓	✓	✓	Ky. Rev. Stat. §§§ 211.332. 304.17A-138, 304.17A-005
LA	✓	✓	✓	✓	✗	✗	LTD	✓	La. Stat. §§§ 22:1821, La. Stat. § 22:1841-4445, 40:1223.3; 46 La. Admin. Code Pt XLV, 7503; 37 La. Admin. Code Pt XIII, 17947.
ME	✓	✓	✗	✓	✓	✓	✓	✓	Me. Rev. Stat. tit. 24-A, § 4316; ME Insurance Bulletin No. 459
MD	✓	✓	✓	✓	✗	✓	✗	✗	Md. Code, Ins. § 15-139
MA	✓	✓	✓	✓	✓	✓	✓	✓	M.G.L.A. 175 § 47MM , 176A § 38 , 176B § 25 , 176G § 33 , 176I § 13 , 32A § 30
MI	✓	LTD	✗	✓	✗	✗	✗	✓	Mich. Comp. Laws §§ 500.3476, 550.1401k
MN	✓	✓	✓	✓	✓	✓	✓	✓	Minn. Stat. § 62A.673
MS	✓	✓	✓	✓	✓	✓	✓	✓	Miss. Code §§ 83-9-351, 83-9-353
MO	✓	✓	✓	✓	✓	✓	✗	✓	Mo. Stat. § 376.1900
MT	✓	✓	✗	✓	✓	✗	✗	✗	Mont. Code § 33-22-138

	Does the State Have a Statute?	Coverage Provision?	Reimburse-ment Provision?	Unrestricted Originating Site?	Member Cost-Shifting Protections?	Provision for Narrow/ Exclusive/ In-Network Provider Limits?	Remote Patient Monitor-ing?	Store and Forward?	Authorities
NE	✓	✓	✓	✓	✓	✗	✓	✓	Neb. Rev. Stat. §§ 44-7,107; 44-312
NV	✓	✓	✓	✓	✗	✗	✗	✓	Nev. Rev. Stat. § 689A.0463; Nev. Rev. Stat. § 689B.0369; Nev. Rev. Stat. § 689C.195; Nev. Rev. Stat. § 616C.730; Nev. Rev. Stat. § 695A.265; Nev. Rev. Stat. § 695B.1904; Nev. Rev. Stat. § 695C.1708; Nev. Rev. Stat. § 695D.216; Nev. Rev. Stat. § 695G.162; Nev. Rev. Stat. § 629.515.
NH	✓	✓	✓	✓	✗	✗	✓	✓	N.H. Rev. Stat. §§ 415-J:2, 415-J:3, 420-J:8-e
NJ	✓	✓	✓	✓	✓	✓	✓	✗	N.J. Stat. §§ 26:2S-29, 52:14-17.29w, 52:14-17.46.6h, 45:1-61
NM	✓	✓	✓	✓	✓	✓	✓	✓	N.M Stat. § 13-7-14; N.M. Stat. § 59A-46-50.3; N.M. Stat. § 59A-22-49.3; N.M. Stat. § 59A-23-7.12; N.M. Stat. § 59A-47-45.3
NY	✓	✓	✗	✓	✓	✓	✗	✗	N.Y. Ins. Law § 3217-h; N.Y. Ins. Law § 4306-g; N.Y. Pub. Health Law § 4406-g
NC	✗	N/A	N/A	N/A	N/A	N/A	N/A	N/A	None
ND	✓	✓	✓	✓	✗	✗	LTD	✓	N.D. Cent. Code § 26.1-36-09.15
OH	✓	✓	✓	✓	✓	✗	✗	✗	Ohio Rev. Code § 3902.30; Ohio Rev. Code § 4743.09
OK	✓	✓	✓	✓	✓	✓	✓	✓	36 Okla. St. §§ 6802, 6803
OR	✓	✓	✓	✓	LTD	✓	✓	✓	Or. Rev. Stat. §§§§ 743A.012, 743A.058, 743A.168, 743A.185
PA	✗	N/A	N/A	N/A	N/A	N/A	N/A	N/A	None
RI	✓	✓	✓	✓	✓	✗	✓	✓	R.I. Gen. Laws §§ 27-81-3, 27-81-4
SC	✗	N/A	N/A	N/A	N/A	N/A	N/A	N/A	None
SD	✓	✓	✗	✓	✓	✗	✗	✗	S.D. Codified Laws §§ 58-17-167, -168, -169, -170
TN	✓	✓	✓	✗	✗	✓	✗	✓	Tenn. Code §§ 56-7-1002, -1003, -1011, -1012
TX	✓	✓	✓	✓	✓	✓	✗	✗	Tex. Ins. Code §§ 1455.001– 1455.004, 1455.006; Tex. Occ. Code § 111.001

	Does the State Have a Statute?	Coverage Provision?	Reimburse-ment Provision?	Unrestricted Originating Site?	Member Cost-Shifting Protections?	Provision for Narrow/ Exclusive/ In-Network Provider Limits?	Remote Patient Monitor-ing?	Store and Forward?	Authorities
UT	✓	LTD	✓	✓	✗	✓	LTD	LTD	Utah Code §§ 31A-22-649.5, 31A-22- 649, 26B-4-704
VT	✓	✓	✓	✓	✓	✓	✗	✓	8 Vt. Stat. § 4100k, § 4100l
VA	✓	✓	✓	✓	✓	✗	✓	✗	Va. Code § 38.2-3418.16
WA	✓	LTD	✓	✓	✓	✓	✗	✓	Wash. Rev. Code §§ 48.43.735, 41.05.700, 71.24.335
WV	✓	✓	✓	✓	✓	✗	✓	✓	W. Va. Code §§ 33-57-1, 5-16-7b
WI	✗	N/A	N/A	N/A	N/A	N/A	N/A	N/A	None
WY	✗	N/A	N/A	N/A	N/A	N/A	N/A	N/A	None

[1] Our research was last comprehensively conducted from February 2024 through April 2024, and the authorities could be amended at a later date. State laws and rules are constantly changing, so be certain to reference and read the statutes and regulations for precise legal requirements. Please note some states have multiple telehealth coverage laws applicable to various policy, service, and/or provider types. Our interpretive tables apply the most general coverage provision and/or the predominant answer across the state, but there may be variances across coverage laws in the state so please be certain to refer to the precise legal requirements.

Telehealth Commercial Insurance Coverage Model Statutory Language to Consider

Same Coverage: "A health insurance contract that is delivered, issued for delivery, or renewed in this state shall provide coverage for health care services delivered via telehealth to the same extent the services would be covered if delivered via an in-person encounter."

Same Reimbursement (payment parity but allowing for contract negotiations): "For purposes of reimbursement and payment, a health insurer shall compensate the health care provider for services delivered via telehealth on the same basis and at the same payment rate the health insurer would apply to the services if the services had been delivered via an in-person encounter by the health care provider. Nothing in this section is intended to limit the ability of a health insurer and a health care provider to voluntarily negotiate alternate payment rates for health care services delivered via telehealth. Nothing in this section is intended to require reimbursement for services delivered via telehealth to be unbundled from other capitated or bundled, risk-based payments."

Equitable Reimbursement (but not payment parity): "For purposes of reimbursement and payment, a health insurer shall compensate the healthcare provider for services delivered via telehealth at a fair payment rate that also takes into consideration the ongoing investment necessary to ensure these telehealth platforms are continuously maintained, seamlessly updated, and services can continue to expand as needed."

Same Restrictions: "A health insurer shall not impose any unique conditions for coverage of health care services delivered via telehealth. A health insurer shall not impose any originating site restrictions, nor distinguish between patients in rural or urban locations, nor impose any geographic or distance-based restrictions, when providing coverage for health care services delivered via telehealth. A health plan shall not restrict the type of telehealth technology that a healthcare provider may use to deliver services.

Same Utilization Review: "Decisions denying coverage of services provided via telehealth shall be subject to the same utilization review procedures as decisions denying coverage of services provided via an in-person encounter."

Same Provider Network: "A health insurer may not limit coverage of telehealth services only to those health care providers who are members of the health insurance plan's telehealth narrow network."

Same Patient Financial Responsibility: "A health insurer may charge a deductible, co-payment, or coinsurance for a health care service provided via telehealth so long as it does not exceed the deductible, co-payment, or co-insurance applicable to an in-person encounter."

Same Benefits: "A health insurer may not impose any annual or lifetime dollar maximum on coverage for telehealth services other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy, or impose upon any person receiving benefits pursuant to this section any copayment, coinsurance, or deductible amounts, or any policy year, calendar year, lifetime, or other durational benefit limitation or maximum for benefits or services, that is not equally imposed upon all terms and services covered under the policy, contract, or plan."

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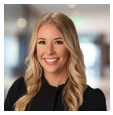

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