

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 23 Telehealth
SPONSOR(S): Ways & Means Committee, Yarborough
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	11 Y, 2 N	Siples	McElroy
2) Ways & Means Committee	14 Y, 3 N, As CS	Aldridge	Langston
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Telehealth is the remote provision of health care services through the use of technology. HB 23 defines telehealth and authorizes its use in this state.

The bill authorizes Florida licensed health care professionals to use telehealth to deliver health care services within their respective scopes of practice. The bill also authorizes out-of-state health care professionals to use telehealth to deliver health care services to Florida patients if they register with the Department of Health (DOH) or the applicable board, meet certain eligibility requirements, and pay a fee. A registered telehealth provider may use telehealth, within the relevant scope of practice established by Florida law and rule, to provide health care services to Florida patients, but is prohibited from opening an office in Florida and from providing in-person health care services to patients located in Florida.

The bill also establishes standards of practice for services provided using telehealth, including patient examination, record-keeping, and prohibition on prescribing controlled substances for chronic malignant pain.

For tax years beginning on or after January 1, 2020, the bill creates a tax credit for health insurers and health maintenance organizations (HMOs) that cover services provided by telehealth. A tax credit, in the amount of one tenth of one percent of total insurance premiums received on certain accident or health insurance policies issued or delivered in Florida in the previous calendar year, may be applied against the incurred corporate income tax or insurance premium tax.

The bill has a significant, negative fiscal impact on DOH and appropriates \$261,389 in recurring and \$15,020 in nonrecurring funds and authorizes four FTEs to implement the bill's provisions.

The Revenue Estimating Conference estimates the bill to have a negative impact on General Revenue of \$31.4 million beginning in FY 2020-21 growing to \$35.4 million annually by FY 2023-24. The bill does not affect local government revenues.

The bill provides an effective date of July 1, 2019, except the provisions relating to the tax credit which become effective upon the act becoming a law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Health Care Professional Shortage

The U.S. has a current health care provider shortage.¹ For example, as of September 30, 2018, the U.S. Department of Health and Human Services has designated 6,890 Primary Care Health Professional Shortage Areas (HPSAs) (requiring 14,136 additional primary care physicians to eliminate the shortage), 5,732 Dental HPSAs (requiring 10,425 additional dentists to eliminate the shortage), and 5,035 Mental Health HPSAs (requiring 6,628 additional psychiatrists to eliminate the shortage).

This shortage is predicted to continue into the foreseeable future and will likely worsen with the aging and growth of the U.S. population² and the expanded access to health care under the Affordable Care Act.³ Aging populations create a disproportionately higher health care demand due to seniors having a higher per capita consumption of health care services than younger populations.⁴ Additionally, as more individuals qualify for health care benefits, there will necessarily be a greater demand for more health care professionals to provide these services. There are several other factors which will likely increase the demand for a larger health care workforce. These include:⁵

- Shortage of health care professionals being educated, trained and licensed;
- Lack of specialists and health facilities in rural areas;
- Adverse events, injuries and illness at hospitals and physician's offices; and
- Need to improve community and population health.

Florida is not immune to the national problem and is experiencing a health care provider shortage itself. This is evidenced by the fact that for just primary care, dental care and mental health there are 677 federally designated Health Professional Shortage Areas (HPSA) within the state.⁶ It would take 1,577 primary care, 1,242 dental care, and 404 mental health practitioners to eliminate these shortage areas.⁷

Physician Workforce Data

The Association of American Medical Colleges Center for Workforce Studies estimates that the U.S. will face a physician shortage of between 42,600 and 121,300 across all specialties by 2030.⁸ The

¹ U.S. Department of Health and Human Services, Health Resources and Services Administration, *Designated Health Professional Shortage Area Statistics, Fourth Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary*, (Sept. 30, 2018), available at https://ersrs.hrsa.gov/ReportServer?/HGDW_Reports/BCD_HPSA/BCD_HPSA_SCR50_Qtr_Smry_HTML&rc:Toolbar=false (last visited December 7, 2018).

² There will be an increase in the U.S. population, estimated to grow from just under 319 million in 2014 to approximately 359.4 million in 2030, eventually reaching 417 million in 2060. See U.S. Census Bureau, *Projections of the Size and Composition of the U.S. Population: 2014 to 2060* (March 2015), available at <https://www.census.gov/content/dam/Census/library/publications/2015/demo/p25-1143.pdf> (last visited December 7, 2018).

³ Association of American Medical Colleges, *The Complexities of Physician Supply and Demand: Projections from 2016 to 2030, 2018 2018 Update*, (March 2018), available at https://aamc-black.global.ssl.fastly.net/production/media/filer_public/85/d7/85d7b689-f417-4ef0-97fb-ecc129836829/aamc_2018_workforce_projections_update_april_11_2018.pdf (last visited December 7, 2018).

⁴ *Id.*

⁵ Matthew A. Hein, *Telemedicine: An Important Force in the Transformation of Healthcare*, (June 25, 2009), available at https://2016.trade.gov/td/health/telemedicine_2009.pdf (last visited on December 7, 2018).

⁶ *Supra* note 1.

⁷ *Id.*

⁸ *Supra* note 3.

projected shortfall for primary care physicians ranges from 14,800 to 49,300 physicians and for non-primary care specialties ranges from 33,800 and 72,700 by 2030.⁹

In 2016, there were 271.6 physicians¹⁰ actively practicing per 100,000 population in the U.S., ranging from a high of 443.5 in Massachusetts to a low of 186.1 in Mississippi. The states with the highest number of physicians per 100,000 population are concentrated in the northeastern states.¹¹ Regarding primary care physicians, there were 91.7 per 100,000 population.¹²

Florida had 236.1 physicians actively providing direct patient care per 100,000 population in 2016. Although Florida is the third most populous state in the nation,¹³ it ranks as having the 21st highest physician to population ratio.¹⁴ In 2016, Florida had a ratio of 80.0 primary care physicians providing direct patient care per 100,000 population, ranking Florida 28th compared to other states.¹⁵

Numerous solutions have been proposed to combat the health care professional shortage. These proposals seek to address both the current and future shortages. Proposals include the creation of new scholarships and residency programs for emerging health care providers.¹⁶ These proposals address the shortage in the future by creating new health care professionals and supporting professional development of the workforce. Other proposals to address the shortage include broadening the scope of practice for certain health care professionals¹⁷ and more efficient utilization of our existing workforce through the expanded use of telehealth.¹⁸

Telehealth

There is no universally accepted definition of telehealth. In broad terms, telehealth is:

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, research and evaluation, and for the continuing education of health care providers, all in the interests of advancing the health of individuals and their communities.¹⁹

More specific definitions vary by state and occasionally by profession.²⁰ There are, however, common elements among the varied definitions of telehealth. Telehealth generally consists of synchronous

⁹ *Id.*

¹⁰ These totals include allopathic and osteopathic doctors.

¹¹ Association of American Medical Colleges, *2017 State Physician Workforce Data Book*, November 2017, pg. 4, available at: <https://www.aamc.org/data/workforce/reports/484392/2017-state-physician-workforce-data-report.html> (last visited on December 7, 2018). The book must be downloaded to view its contents.

¹² *Id.*

¹³ As of July 1, 2017, the U.S. Census Bureau estimated Florida to have 20,984,400 residents, behind California (39,536,653) and Texas (28,304,596). U.S. Census Bureau, *Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2017: 2017 Population Estimates*, available at:

https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=PEP_2014_PEPANNRES&prodType=table (last visited on December 10, 2018).

¹⁴ *Supra* note 11, at pp. 8-9.

¹⁵ *Supra* note 11, at pp. 13-14.

¹⁶ U.S. Department of Health and Human Services, *Strategic Plan: Strategic Goal 1: Reform, Strengthen, and Modernize the Nation's Healthcare System*, available at <https://www.hhs.gov/about/strategic-plan/strategic-goal-1/index.html> (last visited December 10, 2018).

¹⁷ *Id.*

¹⁸ *Id.*

¹⁹ World Health Organization, *Telemedicine: Opportunities and Developments in Member States, Global Observatory for Ehealth Series- Volume 2*, Section 1.2, page 9 (2010), available at http://www.who.int/goe/publications/goe_telemedicine_2010.pdf (last visited December 10, 2018).

²⁰ Center for Connected Health Policy, The National Telehealth Policy Resource Center, *State Telehealth Laws and Reimbursement Policies: A Comprehensive Scan of the 50 States and the District of Columbia*, (Oct. 2018), available at https://www.cchpca.org/sites/default/files/2018-10/CCHP_50_State_Report_Fall_2018.pdf (last visited on December 10, 2018).

and/or asynchronous transmittal of information.²¹ Synchronous refers to the live²² transmission of information between patient and provider during the same time period.²³ Asynchronous telehealth is the transfer of data over a period of time, and typically in separate time frames.²⁴ This is commonly referred to as “store and forward.” Definitions of telehealth also commonly contain restrictions related to the location where telehealth may be used. For example, the use of the “hub and spoke” model is a common location restriction. A hub site is the location from which specialty or consultative services originate, i.e., the provider.²⁵ A spoke site is a remote site where the patient is presented during the telehealth encounter.²⁶ Under this model, health services may be provided through telehealth only if the patient is located at a designated spoke site and the provider is located at a designated hub site.

Telehealth includes telemedicine and telemonitoring. Telemedicine is focused on the delivery of traditional clinical services, like diagnosis and treatment. Telemonitoring is the process of using audio, video, and other telecommunications and electronic information processing technologies to monitor the health status of a patient from a distance.²⁷ Telehealth more broadly includes non-clinical services, such as patient and professional health-related education and health administration.²⁸

Telehealth is not a type of health care service but rather is a mechanism for delivery of health care services. Health care professionals use telehealth as a platform to provide traditional health care services in a non-traditional manner. These services include, among others, preventative medicine and the treatment of chronic conditions.²⁹

Telehealth, in its modern form,³⁰ started in the 1960s in large part driven by the military and space technology sectors.³¹ Specifically, telehealth was used to remotely monitor physiological measurements of certain military and space program personnel. As this technology became more readily available to the civilian market, telehealth began to be used for linking physicians with patients in remote, rural areas. As advancements were made in telecommunication technology, the use of telehealth became more widespread to include not only rural areas but also urban communities. Due to recent technology advancements and general accessibility, the use of telehealth has spread rapidly and is now becoming integrated into the ongoing operations of hospitals and healthcare systems around the country.³² In fact, there are currently an estimated 200 telehealth networks, with 3,500 service sites in the U.S.³³

²¹ The majority of telehealth definitions allow for both synchronous and asynchronous transmittal of information. Some definitions however omit asynchronous from the definition of telehealth.

²² This is also referred to as “real time” or “interactive” telehealth.

²³ American Telemedicine Association, *Telemedicine Glossary*, available at <http://thesource.americantelemed.org/resources/telemedicine-glossary> (last visited December 10, 2018). The use of live video to evaluate and diagnosis a patient would be considered synchronous telehealth.

²⁴ *Id.* A common example of synchronous telehealth is the transfer of x-rays or MRI images from one health care provider to another health care provider for review in the future.

²⁵ *Id.*

²⁶ *Id.*

²⁷ *Id.*

²⁸ Office of the National Coordinator for Health Information Technology, *What is Telehealth? How is Telehealth Different from Telemedicine?*, available at <https://www.healthit.gov/faq/what-telehealth-how-telehealth-different-telemedicine> (last visited December 10, 2018).

²⁹ U.S. Department of Health and Human Services, *Report to Congress: E-Health and Telemedicine*, (August 2016), available at <https://aspe.hhs.gov/system/files/pdf/206751/TelemedicineE-HealthReport.pdf> (last visited December 10, 2018).

³⁰ Historically, telehealth can be traced back to the mid to late 19th century with one of the first published accounts occurring in the early 20th century when electrocardiograph data were transmitted over telephone wires. See *supra* note 19 at p. 9.

³¹ *Id.*

³² American Telemedicine Association, *About Telemedicine*, available at <http://www.americantelemed.org/about/about-telemedicine> (last visited December 10, 2018).

³³ American Telemedicine Association, *Telemedicine Frequently Asked Questions*, available at <http://www.americantelemed.org/main/about/telehealth-faqs->, (last visited December 10, 2018).

Telehealth is used to address several problems in the current health care system. Inadequate access to care is one of the primary obstacles to obtaining quality health care.³⁴ This occurs in both rural areas and urban communities.³⁵ Telehealth reduces the impact of this issue by providing a mechanism to deliver quality health care, irrespective of the location of a patient or a health care professional. Cost is another barrier to obtaining quality health care.³⁶ This includes the cost of travel to and from the health care facility, as well as related loss of wages from work absences. Costs are reduced through telehealth by decreasing the time and distance required to travel to the health care professional. Two more issues addressed through telehealth are the reutilization of health care services and hospital readmission. These often occur due to a lack of proper follow-up care by the patient³⁷ or a chronic condition.³⁸ These issues however can potentially be avoided through the use of telehealth and telemonitoring.

Telehealth and Federal Law

Several federal laws and regulations apply to the delivery of health care services through telehealth.

Prescribing Via the Internet

Federal law specifically prohibits prescribing controlled substances via the Internet without an in-person evaluation. The federal regulation under 21 CFR §829 states:

No controlled substance that is a prescription drug as determined under the Federal Food, Drug, and Cosmetic Act may be delivered, distributed, or dispensed by means of the Internet without a valid prescription.

A valid prescription is further defined under the same regulation as one issued by a practitioner who has conducted at least one in-person medical evaluation of the patient. The in-person medical evaluation requires that the patient be in the physical presence of the provider without regard to the presence or conduct of other professionals.³⁹ However, the Ryan Haight Online Pharmacy Consumer Protection Act,⁴⁰ signed into law in October 2008, created an exception for the in-person medical evaluation for telehealth practitioners. The practitioner is still subject to the requirement that all controlled substance prescriptions be issued for a legitimate purpose by a practitioner acting in the usual course of professional practice.

Medicare Coverage

Specific telehealth⁴¹ services delivered at designated sites are covered under Medicare.⁴² The Federal Centers for Medicare and Medicaid Services' (CMS') regulations require both a distant site and a separate originating site (hub and spoke model) under their definition of telehealth. Asynchronous

³⁴ American Telemedicine Association, *Telemedicine Benefits*, available at <http://www.americantelemed.org/main/about/about-telemedicine/telemedicine-benefits> (last visited December 10, 2018).

³⁵ *Id.*

³⁶ *Id.*

³⁷ Post-surgical examination subsequent to a patient's release from a hospital is a prime example. Specifically, infection can occur without proper follow-up and ultimately leads to a readmission to the hospital.

³⁸ For example, diabetes is a chronic condition which can benefit by treatment through telehealth.

³⁹ 21 CFR §829(e)(2).

⁴⁰ Ryan Haight Online Consumer Protection Act of 2008, Public Law 110-425 (H.R. 6353).

⁴¹ Medicare covers a broader set of services using the term telehealth. Medicare defines telehealth as the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance.

⁴² Centers for Medicare and Medicaid Services, *Information on Medicare Telehealth*, (Nov. 15, 2018), available at <https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Information-on-Medicare-Telehealth-Report.pdf> (last visited December 10, 2018).

(store and forward) activities are only reimbursed under Medicare in federal demonstration projects.⁴³ To qualify for Medicare reimbursement, the originating site must be:⁴⁴

- Located in a federally defined rural county;
- Located in a health professional shortage area that is outside a Metropolitan Statistical Area (MSA)⁴⁵ or in a rural census tract; or
- Identified as a participant in a federal telemedicine demonstration project as of December 21, 2000.

In addition, an originating site must be one of the following location types as further defined in federal law and regulation:⁴⁶

- The office of a physician or practitioner;
- A critical access hospital;
- A rural health clinic;
- A federally qualified health center;
- A hospital;
- A hospital-based or critical access hospital-based renal dialysis center (including satellites);
- A skilled nursing facility; or
- A community mental health center.

In 2016, CMS began using its waiver authority to test innovative payment and service delivery models that broaden the use of telehealth beyond what is currently allowed.⁴⁷ Under the models being tested, the originating site type and the geographic requirements may be waived so that patients may receive telehealth services in any location, including the patient's home or in a non-rural setting.⁴⁸ Under some projects, the requirement to provide services via synchronous technologies is waived and certain services such as teledermatology and teleophthalmology may be provided using asynchronous store and forward technology.⁴⁹

Veterans Affairs

In May 2018, the U.S. Department of Veterans Affairs (VA) adopted a regulation that allows its practitioners to provide services to its patients via telehealth irrespective of the state or the location within a state where the healthcare practitioner or patient is physically located at the time the service is provided.⁵⁰ Such services are limited to the health care practitioner's scope of practice and may only be performed in the scope of his or her VA employment.⁵¹

Protection of Personal Health Information

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects personal health information. Privacy rules were initially issued in 2000 by the U.S. Department of Health and Human

⁴³ Only two states have a federal demonstration project that meets these qualifications, Hawaii and Alaska.

⁴⁴ *Supra* note 42 at pp. 1-2. See also 42 U.S.C. sec. 1395(m)(4)(C)(i).

⁴⁵ A metropolitan statistical area (MSA) is a core area containing a substantial population nucleus, as well as adjacent communities that have a high degree of economic and social integration with that core. Each MSA has at least one urbanized area with a population of at least 50,000. See U.S. Census Bureau, *Metropolitan and Micropolitan*, available at <https://www.census.gov/programs-surveys/metro-micro/about.html> (last visited on December 10, 2018).

⁴⁶ See 42 U.S.C. sec. 1395(m)(4)(C)(ii).

⁴⁷ *Supra* note 42 at pp. 22-26.

⁴⁸ *Id.*

⁴⁹ *Id.*

⁵⁰ See 38 C.F.R. s. 17.417.

⁵¹ *Id.*

Services and later modified in 2002.⁵² These rules address the use and disclosure of an individual's personal health information as well as create standards for information security. Only certain entities are subject to HIPAA's provisions. These "covered entities" include:⁵³:

- Health plans;
- Health care providers;
- Health care clearinghouses; and
- Business associates of any of the above.

Covered entities are obligated to meet HIPAA's requirements to ensure privacy and confidentiality personal health information, regardless of the method in which the medical service is delivered.

In 2009, the Health Information Technology for Economic and Clinical Health (HITECH) Act was enacted as part of American Recovery and Reinvestment Act (ARRA).⁵⁴ The HITECH Act promoted the adoption and meaningful use of health information technology infrastructure and provided financial incentives to help healthcare providers offset the initial costs of electronic health records.⁵⁵ HITECH was intended to strengthen existing HIPAA security and privacy rules.⁵⁶ It expanded HIPAA to entities not previously covered; specifically, "business associates" now includes Regional Health Information Organizations, and Health Information Exchanges.⁵⁷ Similarly, it made changes to the privacy rule to better protect personal health information held, transferred, or used by covered entities.⁵⁸

Under the provisions of HIPAA and the HITECH Act, a health care provider or other covered entity participating in the electronic exchange of personal health information are subject to HIPAA and HITECH. These federal laws apply to covered entities in Florida, regardless of whether there is an express reference to them in Florida law.

Telehealth Barriers

There are several barriers which impede the use of telehealth. These barriers include:⁵⁹

- Lack of a standard definition for telehealth;
- Lack of standard regulations for the practice of telehealth;
- Licensure requirements which prohibit cross-state practice; and
- Restrictions on the location where telehealth services may be provided.

Standardized Definition

Lack of a standard definition⁶⁰ presents a barrier to the use of telehealth. As previously noted, there is no universally accepted definition. A health care professional is left to speculate as to whether the service he or she is providing constitutes telehealth. This can have far-reaching consequences which range from a denial of reimbursement for the services provided to an inquiry as to whether the services provided equate to the unlicensed practice of medicine. Florida law does not define telehealth.

⁵² U.S. Department of Health and Human Services, *The HIPAA Privacy Rule*, available at

<http://www.hhs.gov/ocr/privacy/hipaa/administrative/privacyrule/> (last visited on December 10, 2018).

⁵³ U.S. Department of Health and Human Services, *For Covered Entities and Business Associates*, available at <http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/> (last visited on December 10, 2018).

⁵⁴ U.S. Department of Health & Human Services, *HITECH Act Enforcement Interim Final Rule*, available at

<http://www.hhs.gov/hipaa/for-professionals/special-topics/HITECH-act-enforcement-interim-final-rule/index.html> (last visited December 10, 2018).

⁵⁵ *Id.*

⁵⁶ *Id.*

⁵⁷ *Id.*

⁵⁸ *Id.*

⁵⁹ *Supra* note 20.

⁶⁰ *Id.* No two states define telehealth exactly alike, although some similarities in language exist between certain states.

Standardized Regulations

The absence of a uniform regulatory structure governing the use of telehealth presents another barrier to its use. Currently, six states⁶¹ do not have any statutory structure for the delivery of health care services through telehealth.⁶² This absence places the burden upon individual professionals to determine what is appropriate, and invites health professional licensing boards to fill the regulatory gap. This can lead to inconsistent regulation of telehealth amongst the varying health care professions and impede the use of telehealth.

For example, a common telehealth regulation is the requirement that a health care professional conduct an in-person examination of the patient prior to providing services via telehealth.⁶³ Many times an exception is expressly contained within the regulation which allows the in-person requirement to be met through telehealth.⁶⁴ This exception, however, can vary by profession in the absence of a uniform regulation. For example, an audiologist may be authorized to conduct the initial evaluation through telehealth while a physical therapist is required to perform an in-person physical examination prior to providing services through telehealth. There may not be any reasonable justification for this disparate treatment.

Licensure

Licensure requirements present one of the greatest barriers to the use of telehealth. Some states prohibit a health care professional from using telehealth to provide health care services unless the professional is licensed in the state where the patient is located.⁶⁵ Nine states require out-of-state licensed health care professionals to acquire a special telehealth license or certificate to provide health care services through telehealth to patients in those states.⁶⁶

In the absence of an exception or a state regulation authorizing otherwise, it appears that a health care professional must be licensed in the state where the patient is located to provide health care services through telehealth. Requiring health care professionals to obtain multiple state licenses to provide health care services through telehealth may be burdensome and may inhibit the use of telehealth across state borders.

⁶¹ Florida currently has no statutory framework for regulating health care services provided via telehealth. However, the Board of Medicine has promulgated rules establishing standards for telemedicine practice (see below).

⁶² Even amongst states with telehealth statutory regulations, no two states regulate telehealth in exactly the same manner. *Supra* note 20.

⁶³ *Id.*

⁶⁴ *Id.*

⁶⁵ *Id.* This includes Florida.

⁶⁶ These states are Alabama, Louisiana, Maine, Minnesota, New Mexico, Ohio, Oregon, Tennessee (osteopathic physicians only), and Texas. *Supra* note 20. Additionally, there are 24 states who have adopted the Interstate Medical Licensure Compact which allows for expedited licensure for licensed physicians whose state is a member of the compact (see Interstate Medical Licensure Compact, *The IMLC*, available at <https://imlcc.org/> (last visited December 11, 2018)); 31 states, including Florida, have adopted the Nurse Licensure Compact which authorizes a single multistate license to practice in any state that is a member of the compact (see Interstate Commission of Nurse Licensure Compact Administrators, *NLC Member States*, available at <https://www.ncsbn.org/listofmemberstatesanddates111618.pdf> (last visited December 11, 2018)); three states have adopted the Advanced Practice Registered Nurse Compact which authorizes a single multistate license to practice in any state that is a member of the compact (see National Council of State Boards of Nursing, *APRN Compact*, available at <https://www.ncsbn.org/aprn-compact.htm> (last visited December 11, 2018)), 21 states have enacted the Physical Therapy Compact which allows for expedited licensure for licensed physical therapists and physical therapist aides whose state is a member of the compact (see Physical Therapy Compact Commission, *Physical Therapy Compact Map*, available at <http://ptcompact.org/ptc-states> (last visited December 11, 2018)), and seven states have adopted the Interjurisdictional Compact which facilitates the practice of psychology using telecommunications technologies and/or temporary in-person, face to face practice, (see Psychological Interjurisdictional Compact, *Legislative Update*, available at <https://www.asppb.net/mpage/legislative> (last visited December 11, 2018)).

Location Restrictions

Generally, states impose two types of location restrictions. The first is a geographical restriction which limits the use of telehealth to certain designated areas within a state. For example, only individuals in areas designated as a rural area or a medically underserved area may be authorized to receive health care services through telehealth.

The second restriction relates to limitations on the specific location where telehealth services may be provided. The most common example of this type of limitation is the hub and spoke model.⁶⁷ Under this model, “hub” refers to the location to where the health care professional must be located while “spoke” refers to the location where the patient must be located.

The two types of restrictions are not mutually exclusive and are commonly used in conjunction. This presents a significant obstacle to access to care by placing arbitrary restrictions on the use of telehealth which inhibits the effectiveness, as well as the use of telehealth to deliver health care services.

Telehealth in Florida

Florida does not have a statutory structure for the delivery of health care services through telehealth.⁶⁸ References to telehealth in the Florida Administrative Code relate to the Board of Medicine,⁶⁹ the Board of Osteopathic Medicine,⁷⁰ the Child Protection Team program,⁷¹ and the Florida Medicaid program.⁷² In 2016, the Legislature created an advisory council to explore issues related to telehealth and issue a report on its findings and recommendations.⁷³

Florida Board of Medicine

In 2014, the Florida Board of Medicine adopted a rule setting forth standards for telemedicine.⁷⁴ The rule defines telemedicine as the practice of medicine by a licensed Florida physician or physician assistant where patient care, treatment, or services are provided through the use of medical information exchanged from one site to another via electronic communications.⁷⁵ The definition could be interpreted to limit the use of telemedicine to physicians and physician assistants; however, the Board does not have the authority to regulate other professions. The rule provides that:⁷⁶

- The standard of care is the same as that required for services provided in person;
- A physician-patient relationship may be established through telemedicine;
- A physician or physician assistant is responsible for the quality and safety of the equipment and used to provide services through telemedicine; and
- The same patient confidentiality and record-keeping requirements applicable to in-person services are applicable to services provided through telemedicine.

⁶⁷ Florida’s Department of Health’s Children’s Medical Services Program (CMS) currently uses the hub and spoke model to provide services via telehealth to children enrolled in the program.

⁶⁸ The only references to telehealth in the Florida Statutes are in ss. 364.0135, 381.885, and 394.453, F.S. Section 364.0135, F.S., relates to broadband internet services and does not define or regulate telehealth in any manner. Section 381.885, F.S., relates to epinephrine auto-injectors and expressly states that consultation for the use of the auto-injector through electronic means does not constitute the practice of telemedicine. Section 394.453, F.S., provides legislative intent for the Florida Mental Health Act, in which the Legislature finds that the use of telemedicine for patient evaluation, case management, and ongoing care will improve management of patient care and reduce costs of transportation.

⁶⁹ Rule 64B8-9.0141, F.A.C.

⁷⁰ Rule 64B15-14.0081, F.A.C.

⁷¹ Rule 64C-8.003, F.A.C.

⁷² Rule 59G-1.057, F.A.C.

⁷³ Chapter 2016-240, Laws of Fla.

⁷⁴ Rule 64B8-9.0141, F.A.C. The Board of Medicine and the Board of Osteopathic Medicine rules for telemedicine are virtually identical.

⁷⁵ *Id.*

⁷⁶ *Supra* note 74.

The rule prohibits physicians and physician's assistants from providing treatment recommendations, including issuing a prescription, through telemedicine unless the following has occurred:⁷⁷

- A documented patient evaluation, including history and physical examination to establish the diagnosis for which any legend drug is prescribed;
- A discussion between the physician or the physician assistant and the patient regarding treatment options and the risks and benefits of treatment; and
- Contemporaneous medical records are maintained.

The rule prohibits prescribing controlled substances through telemedicine except for the treatment of psychiatric disorders.⁷⁸ However, the new rule does not preclude physicians from ordering controlled substances through the use of telemedicine for patients hospitalized in a facility licensed pursuant to 395, F.S.⁷⁹

Although the rule provides some regulation of telehealth in this state, it applies only to Florida-licensed physicians and physician assistants. The rule does not authorize out-of-state physicians or any other type of health care practitioner to provide services via telehealth.

Florida Medicaid Program

Under the Medicaid Medical Assistance (MMA) Program implemented in 2014, the vast majority of Medicaid recipients are covered through managed care. In 2018, the Agency for Health Care Administration (AHCA), the state agency responsible for administering the Medicaid program, re-procured the Medicaid managed care contracts.⁸⁰ In the new contracts, AHCA requires Medicaid managed care plans to reimburse for telemedicine and teledentistry services.⁸¹ Such services must be covered to the same extent the services would be covered through an in-person visit.⁸² AHCA also prohibits the Medicaid managed care plans from establishing more restrictive coverage requirements for services provided via telehealth.⁸³ Previously, Medicaid managed care plans were limited to using only two-way, real-time communication to provide services via telehealth. Beginning with the new contracts, telehealth may also be provided using store-and-forward and telemonitoring modalities.⁸⁴

Telehealth Advisory Council

In 2016, the Legislature created a 15-member Telehealth Advisory Council to make recommendations to increase the use and accessibility of services provided via telehealth, as well as any implementation or access barriers, to the Legislature and the Governor.⁸⁵ The recommendations are to be based on a report prepared by the Agency for Healthcare Administration (AHCA), along with the DOH, and the Office of Insurance Regulation (OIR) regarding telehealth utilization and coverage. The bill required the agencies to conduct a survey of health care practitioners, health care facilities, and insurers to collect the following information:

- The types of health care services provided via telehealth;
- The extent to which telehealth is used by health care practitioners and health care facilities nationally and in the state;

⁷⁷ *Id.*

⁷⁸ *Id.*

⁷⁹ *Id.*

⁸⁰ Beth Kidder, Agency for Health Care Administration, Presentation before the Health Quality Subcommittee, "Telemedicine and Florida Medicaid Managed Care," on February 13, 2019, available at

[https://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=3021&Session=2019&DocumentType=Meeting Packets&FileName=hqs 2-13-19.pdf](https://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=3021&Session=2019&DocumentType=Meeting%20Packets&FileName=hqs%202-13-19.pdf) (last visited March 3, 2019).

⁸¹ *Id.*

⁸² *Id.*

⁸³ *Id.*

⁸⁴ *Id.*

⁸⁵ Chapter 2016-240, Laws of Fla.

- The estimated costs and cost savings to health care entities, health care practitioners, and the state associated with the use of telehealth to provide health care services; and
- Which health care insurers, health maintenance organizations, and managed care organizations cover health care services provided to patients in this state via telehealth, whether the coverage is restricted or limited, and how such coverage compares to that insurer's coverage for services provided in person.

In December 2016, AHCA issued a report on the results of the surveys conducted that addressed accessibility and usage of telehealth services in this state, as well as research findings.⁸⁶ Of the 11,900 health care facilities surveyed by AHCA, 49 percent responded to the survey; all of the 54 health plans surveyed by OIR responded to the survey; and DOH received 26,579 responses to its survey.

Among health care facilities surveyed by AHCA, approximately 45% of hospitals responding to the survey offer telehealth services through their facilities.⁸⁷ The facilities indicated that the benefits of providing services using telehealth included patient convenience, better care coordination, better patient outcomes, and better access to specialists. Health care facilities use telehealth most often to diagnose and treat patients, provide emergency care, or to provide or obtain a second opinion. The health care facilities also identified the greatest barriers to services using telehealth. The ongoing challenges for offering telehealth include, among other things, lack of health insurance reimbursement for services provided using telehealth, lack of funding for telehealth equipment, and an inability to determine the return on investment.

Although a national survey of health care executives in 2016 reported 63 percent of health care practitioners provide some services via telehealth, the survey conducted by DOH found that only six percent of the responding health care practitioners in Florida use telehealth to provide health care services.⁸⁸ The health care practitioners indicated that the major factors in adopting the use of telehealth in their private practice include the lack of insurance reimbursement for services provided using telehealth, lack of funding for telehealth equipment, and inability to determine return on investment.⁸⁹

OIR found that 43 percent of Florida health insurers cover some form of telehealth services.⁹⁰ However, that coverage is usually very limited. Unlike the majority other states, Florida does not have any statutory requirements that coverage and reimbursement for telehealth services be covered the same as face-to-face services. The surveyed health plans indicated that the greatest barriers to covering and reimbursing for services provided using telehealth include government regulation,⁹¹ concerns with liability, costs of the still evolving technology, and a need to significantly change payment and reimbursement guidelines.

The Telehealth Advisory Council's final report contained the following recommendations:⁹²

- Establish a clear and consistent definition for telehealth, including the following elements:
 - Telehealth can be used for providing health care and public health services;
 - Telehealth includes both synchronous and asynchronous transmission modalities;
 - Health care practitioners treating Florida patients must be licensed in Florida or supervised by a Florida-licensed health care practitioner;
 - Health care practitioners must practice act within the scope of their practice;

⁸⁶ Agency for Health Care Administration, *Florida Report on Telehealth Utilization and Accessibility*, (December 2016), available at http://www.ahca.myflorida.com/SCHS/telehealth/docs/Telehealth_Report_Final.pdf (last visited on December 11, 2018).

⁸⁷ *Id.*

⁸⁸ *Id.*

⁸⁹ *Id.*

⁹⁰ *Id.*

⁹¹ *Id.* This includes issues of interstate practice since each state is responsible for licensing the health care practitioners that provide services in its state.

⁹² *Id.*

- Telehealth may occur between health care practitioners or a health care practitioner and a patient; and
- There must be no limitations on geographic location or place of service;
- Require Florida-licensed health insurance plans to provide coverage for health services provided via telehealth, if coverage is available for the same service if provided in-person;
- Require Florida-licensed health insurance plans to provide reimbursement parity⁹³ for covered services provided via telehealth;
- Amend the Medicaid fee-for-service rule for telehealth to include coverage of store-and-forward and remote patient monitoring in addition to the currently-reimbursed synchronous or live transmission modality;
- Authorize Medicaid managed care plans to incorporate telehealth for the purpose of meeting network adequacy;
- Enact laws to authorize participation in multistate health care practitioner licensure compacts, if the eligibility requirements for licensure are equal to or more stringent than existing Florida requirements; and
- Authorize the establishment of a patient-practitioner relationship through telehealth, including for the purposes of prescribing and care coordination.

Jurisdiction and Venue

A Florida court has jurisdiction over a resident health care practitioner due to his or her presence in the state. For a nonresident health care profession, a Florida patient must establish in court that:

- The health care practitioner subjected himself or herself to jurisdiction through Florida's long-arm statute; and
- The health care practitioner had sufficient minimum contacts with the state so that he or she could reasonably anticipate being haled into court in Florida.⁹⁴

Under the long-arm statute, any health care practitioner (irrespective of whether he or she is a resident of the state) who commits certain enumerated acts is subject to the jurisdiction of the courts of Florida.⁹⁵ Such acts include:

- Operating, conducting, engaging in, or carrying on a business or business venture in this state or having an office or agency in this state;
- Committing a tortious act within this state;
- Causing injury to persons or property within this state arising out of an act or omission by the defendant outside this state, if, at or about the time of the injury, the health care practitioner was engaged in solicitation or service activities in this state; and
- Breaching a contract in this state by failing to perform act required by the contract to be performed in this state.⁹⁶

“Venue” refers to the geographical area, that is the county or district, where a cause may be heard or tried.⁹⁷ For Florida residents, actions may be brought in the county where the defendant resides, where the cause of action accrued, or where the property in litigation is located.⁹⁸ An action against a nonresident may be brought in any county of the state.⁹⁹

⁹³ Reimbursement parity is the requirement that health plans pay health care practitioners and facilities for covered health care services at a rate that is equivalent to reimbursement rate for the same service if performed face-to-face.

⁹⁴ *Venetian Salami Co. v. Parthenais*, 554 So.2d 499, 501 (Fla. 1989).

⁹⁵ Section 48.193(1), F.S.

⁹⁶ *Id.*

⁹⁷ *Metnick & Levy, P.A. v. Seuling*, 123 So.3d 639 (Fla. 4th DCA 2013).

⁹⁸ Section 47.011, F.S.

⁹⁹ *Supra* note 97. This is subject to the doctrine of forum non conveniens.

Service of process on a person outside of the state may be made by any officer authorized to serve process in the state where the person is served.¹⁰⁰

National Practitioner Data Bank

The National Practitioner Data Bank (NPDB) is a federal databank that serves as a repository of information related to the professional competence and conduct of health care practitioners in the U.S.¹⁰¹ Due to the perceived increase in medical malpractice litigation, Congress created the NPDB to improve the quality of medical care and restrict the ability of an incompetent physician or dentist to move from state to state without the disclosure or discovery of the physician's or dentist's previous damaging or incompetent performance.¹⁰²

The information collected in the NPDB includes:¹⁰³

- Medical malpractice payments;
- Adverse licensure actions;
- Adverse clinical privileges actions related to professional competence or conduct;
- Adverse actions taken by the Drug Enforcement Administration against a practitioners controlled substance registration;
- Exclusions from participation in Medicare, Medicaid, and other federal health care programs;
- Negative actions or findings by peer review and private accreditation organizations;
- Actions taken by certain state agencies, such as law enforcement, Medicaid Fraud Control Units, or state agencies administering state health care programs; and
- Health-care related criminal convictions and civil judgments.

Certain entities are required to submit the above-referenced actions to the NDPB. These include medical malpractice payers, hospitals and other health care entities, state licensing agencies, health plans, peer review and private accreditation organizations, federal government agencies, federal and state law enforcement agencies, state Medicaid Fraud Control Units, and state agencies administering state health care programs.¹⁰⁴

The information in the NPDB is not available to the general public and is limited to certain entities. The information released may vary by the entity performing the query, including state practitioner regulatory agencies and boards.¹⁰⁵

Although, the database initially only contained information related to physicians and dentists, it now includes many other types of health care practitioners.¹⁰⁶

For physicians, DOH must consult the NPDB at the time of initial licensure and each licensure renewal for disciplinary history and medical malpractice claim history.¹⁰⁷

Insurance Premium Tax and Credits

Florida's insurance premium tax was established in 1895 as an annual tax of 1% of gross receipts of insurance premiums (except for life insurance) on each insurance company doing business within the

¹⁰⁰ Section 48.194, F.S.

¹⁰¹ U.S. Department of Health and Human Services, National Practitioner Data Bank, *About Us*, available at <https://www.npdb.hrsa.gov/topNavigation/aboutUs.jsp> (last visited December 10, 2018).

¹⁰² U.S. Department of Health and Human Services, *NPDB Guidebook*, (Oct. 2018), available at <https://www.npdb.hrsa.gov/resources/NPDBGuidebook.pdf> (last visited on December 10, 2018).

¹⁰³ *Id* at pp. C-7 – C-8.

¹⁰⁴ *Id* at p. E-1.

¹⁰⁵ *Id* at pp. D-1 – D-13.

¹⁰⁶ *Id*.

¹⁰⁷ Section 456.041(1)(b). DOH reviews the NPDB for medical doctors, osteopathic physicians, podiatrists, and chiropractic physicians. (E-mail with DOH dated December 11, 2018, on file with the Health Quality Subcommittee).

state.¹⁰⁸ Today, the insurance premium tax is set at 1.75% on insurance premiums written in Florida and paid by insurance companies to the Department of Revenue (DOR).¹⁰⁹ In addition to the insurance premium tax imposed under Chapter 624, F.S., municipalities and fire control districts are authorized to impose excise taxes on insurers that do business within their jurisdictions for the purpose of funding the pensions of police and firefighters. Police pensions are funded by 0.85 percent excise taxes on the premiums for casualty insurance on property within the jurisdiction;¹¹⁰ firefighters' pensions are funded by a 1.85 percent tax on property insurance premiums.¹¹¹ These taxes are fully offset by credits against the state insurance premium tax.¹¹²

In order to provide funds for emergency management, preparedness, and assistance, an annual surcharge of \$2 per policy is imposed on every homeowners, mobile home owners, tenant homeowners, and condominium unit owners policy, and an annual \$4 surcharge is imposed on every commercial fire, commercial multiple peril, and business owner's property insurance policy, issued or renewed on or after May 1, 1993.¹¹³ The surcharge is paid by the policyholder to the insurer. Also, every domestic, foreign, and alien insurer authorized to engage in the business of fire insurance in the State of Florida is subject to a State Fire Marshal regulatory assessment equal to one percent of the gross amount of premiums collected on policies of fire insurance issued and insuring property in the State of Florida.¹¹⁴ A State Fire Marshal surcharge is collected from each holder of a policy of fire, allied lines, or multiperil insurance insuring commercial property located in this state.¹¹⁵ The surcharge is imposed at a rate of 0.1 percent on the gross direct premium written on commercial property located in this state.¹¹⁶

It is estimated that DOR will collect \$777.2 million in insurance premium tax and related surcharges in FY 2018-2019.¹¹⁷ This revenue is distributed to general revenue and various trust funds.¹¹⁸

Receipts			Distributions [†]			
Fiscal Year	Collections	Annual Change	General Revenue	Insurance Regulatory Trust Fund	Police & Firefighters Premium Tax Trust Fund	Emergency Management Preparedness & Assistance Trust Fund
2018-19 [*]	\$777,200,000	-0.08%	\$537,100,000	\$38,800,000	\$187,500,000	\$15,000,000
2017-18 [*]	\$777,800,000	8.16%	\$544,000,000	\$37,500,000	\$179,900,000	\$14,800,000
2016-17	\$719,147,973	2.16%	\$497,000,000	\$36,500,000	\$172,300,000	\$15,000,000
2015-16	\$703,914,531	2.18%	\$471,500,000	\$37,500,000	\$175,900,000	\$14,500,000
2014-15	\$688,898,528	-3.23%	\$466,500,000	\$36,700,000	\$169,700,000	\$13,900,000
2013-14	\$711,866,203	1.43%	\$470,500,000	\$39,700,000	\$173,100,000	\$13,600,000
2012-13	\$701,799,289	-0.21%	\$477,000,000	\$38,300,000	\$165,900,000	\$13,600,000

* Estimate
[†] Distributions do not equal collections due to beginning and ending cash balances and refunds.

Section 624.5091, F.S., requires out of state insurance to pay retaliatory taxes to the state.¹¹⁹ These retaliatory taxes are levied in almost every state¹²⁰ and help ensure a level playing field by preventing

¹⁰⁸ Chapter 4322, Laws of Fla., codified as Title VI, ch. 1, s. 464, F.S.

¹⁰⁹ Section 624.509, F.S. Different tax rates apply to wet marine and transportation insurance, self-insurance, and annuity premiums.)

¹¹⁰ Section 185.08, F.S.

¹¹¹ Section 175.101, F.S.

¹¹² Section 624.509(4), F.S.

¹¹³ Section 252.372, F.S.

¹¹⁴ Section 624.515(1), F.S.

¹¹⁵ Section 624.515(2), F.S.

¹¹⁶ *Id.*

¹¹⁷ Florida Revenue Estimating Conference, *2018 Florida Tax Handbook*, p. 112, available at <http://edr.state.fl.us/content/revenues/reports/tax-handbook/taxhandbook2018.pdf> (last visited February 9, 2019).

¹¹⁸ *Id.*

companies from choosing to locate in one state in order to lower their insurance premium taxes.¹²¹ Insurance companies are permitted to receive an employees' salary credit and corporate income tax credit against insurance premium taxes.^{122,123}

Corporate Income Tax and Credit

Florida imposes a 5.5% tax on the taxable income of all corporations doing business in the state.¹²⁴ The determination of taxable income for Florida tax purposes begins with the taxable income used for federal income tax purposes.¹²⁵ This means that a corporation paying taxes in Florida generally receives the same benefits from deductions allowed in determining its federal taxable income. With federal taxable income as a starting point, Florida law then requires a variety of additions and subtractions to reflect Florida-specific policies to determine Florida taxable income. The Florida corporate income tax uses a three-factor apportionment formula consisting of property, payroll, and sales (which is double-weighted) to measure the portion of a multistate corporation's business activities attributable to Florida.¹²⁶ Income that is apportioned to Florida using this formula is then subject to the Florida income tax.

Corporate income taxes paid by any insurer are credited against the liability for insurance premium tax for the annual period in which such tax payments are made.¹²⁷ The total of the credit granted for corporate income taxes¹²⁸ and the Florida employees salary credit may not exceed 65 percent of the insurance premium tax due after deducting taxes paid by the insurer for certain pension funds and assessments.¹²⁹

In FY 2018-19, the corporate income tax credit is estimated to reduce insurance premium tax revenue by \$259.1 million.¹³⁰

Effect of Proposed Changes

Currently, there is no statutory definition for telehealth. HB 23 broadly defines telehealth as the use of synchronous or asynchronous telecommunications technology by a telehealth provider to provide health care services. It does not include audio-only telephone calls, e-mail messages, or facsimile transmission.

Telehealth Providers

The bill authorizes any Florida-licensed health care practitioner or registered out-of-state-health care providers to provide health care-related services using telehealth. The bill provides that a non-physician telehealth provider using telehealth and acting within the applicable scope of practice, as established under Florida law, may not be interpreted as practicing medicine without a license.

Florida-licensed telehealth providers must be one of the following health care practitioners:¹³¹

¹¹⁹ Section 624.5091, F.S.

¹²⁰ *Supra* note 117, at 115.

¹²¹ Office of Program Policy Analysis and Government Accountability, *The Corporate Income Tax Credit Scholarship Program Saves the State Dollars*, Report No. 08-68, December 2008, available at <http://www.oppaga.state.fl.us/reports/pdf/0868rpt.pdf> (last visited February 25, 2019).

¹²² Section 624.509(4), F.S.

¹²³ Section 624.509(5), F.S.

¹²⁴ Section 220.11, F.S.

¹²⁵ Sections 220.12 and 220.13, F.S.

¹²⁶ s. 220.15, F.S.

¹²⁷ Florida Senate Committee on Finance and Tax, *An Overview of Florida's Insurance Premium Tax*, October 2006, available at http://archive.flsenate.gov/data/Publications/2007/Senate/reports/interim_reports/pdf/2007-122ftlong.pdf (last visited on February 25, 2019).

¹²⁸ Section 624.509(4), F.S.

¹²⁹ *Id.*

¹³⁰ *Supra* note 117, at 115.

- Behavioral Analyst
- Acupuncturist;
- Allopathic physician;
- Osteopathic physician;
- Chiropractor;
- Podiatrist;
- Optometrist;
- Nurse;
- Pharmacist;
- Dentist;
- Dental hygienist;
- Midwife;
- Speech therapist
- Occupational therapist;
- Radiology technician;
- Electrologist;
- Orthotist;
- Pedorthist;
- Prosthetist;
- Medical physicist;
- Emergency Medical Technician;
- Paramedic;
- Massage therapist;
- Optician;
- Hearing aid specialist;
- Clinical laboratory personnel;
- Respiratory therapist;
- Physical therapist;
- Psychologist;
- Psychotherapist;
- Dietician/Nutritionist;
- Athletic trainer;
- Clinical social worker;
- Marriage and family therapist; or
- Mental health counselor.

Out-of-State Telehealth Providers

Out-of-state telehealth providers must register biennially with DOH or the applicable board to provide telehealth services, within the relevant scope of practice established by Florida law and rule, to patients in this state. To register or renew registration as an out-of-state telehealth provider, the health care professional must:

- Hold an active unencumbered license, consistent with the definition of “telehealth provider” listed above, in a U.S. state or jurisdiction and against whom no disciplinary action has been taken during the five years before submission of the application;¹³²
- Never have had a license revoked in any U.S. state or jurisdiction;
- Designate a registered agent in this state for the service of process; and
- Prominently display a link to the DOH website, described below, which provides public information on registered telehealth providers.

The bill prohibits an out-of-state telehealth provider from opening an office in Florida and from providing in-person health care services to patients located in Florida.

The bill requires out-of-state telehealth providers to notify the applicable board or DOH of restrictions placed on the health care professional’s license to practice or disciplinary actions taken against the health care practitioner within 5 days after such occurrence.

The bill authorizes a board, or DOH if there is no board, to revoke an out-of-state telehealth provider’s registration if the registrant:

- Fails to notify DOH of any adverse actions taken against his or her license within 5 days after such adverse action;
- Has restrictions placed on or disciplinary action taken against his or her license in any state or jurisdiction; or
- Violates any of the requirements for the registration of out-of-state telehealth providers.

The bill requires DOH to publish on its website the name of each registered out-of-state telehealth provider. It must also include the following background information, to the extent applicable, for each registrant:

¹³¹ These are professionals licensed under s. 393.17; part III, ch. 401; ch. 457; ch. 458; ch. 459; ch. 460; ch. 461; ch. 463; ch. 464; ch. 465; ch. 466; ch. 467; part I, part III, part IV, part V, part X, part XIII, and part XIV, ch. 468; ch. 478; ch. 480; part II and part III, ch. 483; ch. 484; ch. 486; ch. 490; or ch. 491.

¹³² The bill requires DOH to consult the National Practitioner Data Bank to verify whether adverse information is available for the registrant.

- Health care occupation;
- Completed health care training and education, including completion dates and any certificates or degrees obtained;
- Out-of-state health care license with license number;
- Florida telehealth provider registration number;
- Specialty;
- Board certification;
- 5 year disciplinary history, including sanctions and board actions;
- Medical malpractice insurance provider and policy limits, including whether the policy covers claims which arise in this state; and
- The name and address of the registered agent designated for the service of process in this state.

The bill provides exceptions to the registration requirement for emergencies or for consultations between health care practitioners.

The bill requires a registered telehealth provider, who is a pharmacist, to use a pharmacy holding a Florida permit, a nonresident pharmacy registered in Florida, or a nonresident pharmacy or outsourcing facility holding a nonresident sterile compounding permit to dispense medicinal drugs to Florida patients.

The bill provides an appropriation of \$261,389 in recurring funds and \$15,020 in nonrecurring funds, as well as 4 new full time positions to DOH to offset the workload increase anticipated from the telehealth provider registration requirement.

Telehealth Standards of Practice

The bill establishes that the standard of care for telehealth providers is the same as the standard of care for health care practitioners or health care providers providing in-person health care services to patients in this state. This ensures that a patient receives the same standard of care irrespective of the modality used by the health care professional to deliver the services.

Under the bill a telehealth provider is not required to research a patient's medical history or conduct a physical examination of the patient before providing telehealth services to the patient if the telehealth provider is capable of conducting a patient evaluation in a manner consistent with the applicable standard of care sufficient to diagnose and treat the patient when using telehealth. The bill also allows the evaluation to be performed using telehealth.

The bill provides that a patient receiving telehealth services may be in any location at the time that the telehealth services are rendered and that a telehealth provider may be in any location when providing telehealth services to a patient.

The bill prohibits a telehealth provider from prescribing a controlled substance to prescribe a controlled substance to treat chronic nonmalignant pain, unless ordered for inpatient treatment at a facility licensed under ch. 395, F.S., prescribed for a patient receiving hospice services as defined under s. 400.601, F.S., or prescribed for a resident of a nursing home facility as defined under s. 400.021(12), F.S. Otherwise, a health care practitioner who is authorized to prescribe controlled substances may use telehealth to prescribe controlled substance.

The bill requires that a telehealth provider document the telehealth services rendered in the patient's medical records according to the same standard as that required for in-person services. The bill requires that such medical records be kept confidential consistent with ss. 395.3025(4) and 456.057, F.S. Section 456.057, F.S., relates to all licensed health care professionals while s. 395.3025(4), F.S., relates to all health care facilities licensed under ch. 395 (hospitals, ambulatory surgical centers, and

mobile surgical centers). Thus, the same confidentiality requirements placed upon health care facilities and health care practitioners for medical records generated as part of in-person treatment apply to any medical records generated as part of treatment rendered through telehealth.

Venue

The bill establishes, for jurisdictional purposes, that any act that constitutes the delivery of health care services shall be deemed to occur at the place where the patient is physically located at the time the act is performed. This will assist a patient in establishing jurisdiction and venue in Florida in the event he or she pursues a legal action against the telehealth provider.

The bill authorizes DOH or an applicable board to adopt rules to administer the requirements related to telehealth set forth in the bill.

Telehealth Tax Credit

For tax years beginning on or after January 1, 2020, the bill creates a telehealth tax credit for any health insurer or health maintenance organization (HMO) that cover services provided by telehealth. The tax credit may be taken against any corporate income tax or insurance premium tax liability incurred by a health insurer or HMO. The tax credit does not affect the emergency management surcharge, the fire marshal regulatory assessment and surcharge or the municipal police and firefighter pension excise taxes. The tax credit is one tenth of one percent of the total insurance premiums received on accident or health insurance policy or plans issued in Florida that provide medical, major medical, or similar comprehensive coverage. The Office of Insurance Regulation (OIR) must confirm the coverage to the Department of Revenue (DOR). The bill authorizes an unused tax credit or portion thereof to be carried forward for a period not to exceed five years.

The bill authorizes DOR, in addition to its existing audit and investigation authority, additional authority to perform financial and technical audits and investigations to verify eligibility for the telehealth tax credit. Such audits and investigations may include examining the accounts, books, and records of the health insurer or HMO. The bill also directs OIR to provide technical assistance upon request by DOR on any audits or investigations it performs. If DOR discovers that a health insurer or health maintenance organization received a telehealth tax credit for which it was not entitled, DOR is authorized to pursue recovery of the funds in accordance to the law.

The bill authorizes a health insurer or HMO to transfer a telehealth tax credit in whole or in part to another taxpayer by written agreement. To perfect the transfer, the transferor must provide a written statement to DOR that states:

- The transferor's intent to transfer the tax credit to the transferee;
- The date the transfer is effective;
- The transferee's name, address, and federal taxpayer identification number;
- The tax period; and
- The amount the tax credit to be transferred.

Upon receipt of the transfer statement, DOR will issue a certificate reflecting the transferred credit amount, a copy of which must be attached to each tax return for which the transferee seeks to apply the credit.

An insurer that claims the telehealth tax credit is not required to pay any additional retaliatory tax, as a result of claiming such a credit.

DOR and OIR are authorized to adopt rules to administer the telehealth tax credit, including rules regarding implementation and administration of the tax credit and forms needed to claim the telehealth tax credit.

The bill provides an effective date of July 1, 2019, except the provisions relating to the tax credit, which become effective upon the act becoming a law.

B. SECTION DIRECTORY:

Section 1: Creates s. 220.197, F.S., relating to the telehealth tax credit.

Section 2: Amends s. 624.509, F.S., relating to the premium tax; rate and computation.

Section 3: Creates s. 456.47, F.S.; relating to the use of telehealth to provide services.

Section 4: Provides an appropriation.

Section 5: Provides an effective date of July 1, 2019, except as otherwise expressly provided in the bill.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

The Revenue Estimating Conference estimates the bill to have a negative impact on General Revenue of \$31.4 million beginning in FY 2020-21 growing to \$35.4 million annually by FY 2023-24.

2. Expenditures:

The bill requires out-of-state health care professionals to register with DOH prior to providing any health care services through telehealth to individuals located in Florida. The State of Texas offers a comparable telehealth license to physicians and physician's assistants out of state. There are currently 422 active telehealth licensed physicians in the state of Texas and a total 79,220 active-licensed physicians. Applying the ratio found in Texas of telehealth physicians compared to the total in-state physicians of 0.53% to the current active in-state physicians in the state of Florida, 59,302, an anticipated 314 physicians will seek telehealth licensure in Florida. Applying the same rate to the 895,467 additional health care practitioners identified in the bill, an anticipated 5,060 will register as out-of-state telehealth providers in Florida. The Florida Medical Quality Assurance Division currently employs 570 positions to regulate 954,769 active in-state licenses.¹³³

The bill provides an appropriation of \$261,389 recurring and \$15,020 nonrecurring from the Medical Quality Assurance Trust Fund and four full-time equivalent positions and \$145,870 in salary rate.

DOH and the affected regulatory boards within DOH, may incur nominal costs associated with rulemaking, which can be absorbed within existing resources.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

¹³³ Department of Health, Division of Medical Quality Assurance, *Annual Report and Long Range Plan for Fiscal Year 2017-2018*, available at <http://www.floridahealth.gov/licensing-and-regulation/reports-and-publications/documents/annual-report-1718.pdf> (last visited December 13, 2018).

For individuals located in areas where certain types of practitioners are scarce or who have mobility issues, this may provide additional or timelier access to needed services.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. This bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill provides DOH and the applicable boards sufficient rulemaking authority to implement it.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 18, 2019, the Ways & Means Committee adopted an amendment that corrected a typographical error in the bill and reported the bill favorably as amended. The bill creates an insurance premium tax credit available under specified circumstances equal to 0.001 percent of total insurance premiums received on accident and health insurance policies or plans delivered or issued in this state in the previous calendar year that provide medical, major medical, or similar comprehensive coverage. The intent is for the credit to be equal to one-tenth of one percent of total insurance premiums received. The amendment correctly expresses this as “0.1 percent of total insurance premiums received ...”

The analysis is drafted to the bill as passed by the Ways & Means Committee.