Illinois Department of Insurance

JB PRITZKER
Governor

ROBERT H. MURIEL
Director

M E M O R A N D U M

TO: **All Health Insurance Issuers**

FROM: **Robert H. Muriel, Director of Insurance**

DATE: **March 25, 2020**

RE: **Company Bulletin 2020-04 Requirements for Telehealth Services Under Executive Order 2020-09**

On March 19, 2020, Governor JB Pritzker issued Executive Order 2020-09 (the "EO") to temporarily expand the availability and enhance the affordability of telehealth services under commercial health insurance coverage in Illinois. The EO also temporarily allows any non-public facing remote communication products to be used by providers and patients, regardless of the patient's insurance status or provider's contractual arrangements. The provisions of the EO only apply for so long as Illinois remains subject to the Governor's proclamation of disaster, which may be issued and renewed in 30-day intervals. If the Governor does not renew the proclamation, the EO will lapse without further notice at the end of the corresponding 30-day interval.

Overview of the Telehealth Coverage Requirements

While a disaster proclamation remains in effect, the EO requires a health insurance issuer "to cover the costs of all Telehealth Services rendered by in-network providers to deliver any clinically appropriate, medically necessary covered services and treatments to insureds, enrollees, and members under each policy, contract, or certificate of health insurance coverage." Under this EO, telehealth services are not expressed as a separate covered benefit or set of benefits, but rather a delivery method for covered health care services. To the extent that a covered service or treatment may be delivered in a clinically appropriate manner via telehealth instead of in-person, the policy must cover it when medically necessary for the insured.

The EO allows issuers to set "reasonable requirements and parameters for Telehealth Services...to the extent consistent with this [EO] or any company bulletin subsequently issued by the Department of Insurance. An issuer's requirements and parameters may not be more restrictive or less favorable toward providers, insureds, enrollees, or members than those contained in the emergency rulemaking undertaken by the Department of Healthcare and Family Services at 89 Ill. Adm. Code 140.403(e)." As such, the emergency rulemaking referenced in the EO (the "Medicaid emergency rule") generally will provide the most detail about the requirements and parameters that issuers may use, but if any of those elements would prevent the issuer from complying with the directives of the EO or the Department's company bulletin, the Medicaid emergency rule will yield to that extent. This company bulletin shall not

be construed to exhaustively identify the circumstances when the Medicaid emergency rule would have to yield to the EO. The Department of Healthcare and Family Services published a Provider Notice on March 20, 2020 entitled “Re: Telehealth Services Expansion Prompted by COVID-19". This Provider Notice explains the provisions that were drafted for the Medicaid emergency rule. Until such time as the Medicaid emergency rule is published in the Illinois Register, the Provider Notice shall stand in place of the rule regarding the requirements and parameters that issuers are permitted to set for telehealth services, including with respect to provider documentation and reimbursement. The Provider Notice may be found at: https://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn200320b.aspx

For health insurance coverage that requires or incentivizes insureds to use one or more networks of providers to obtain covered health care services, this requirement applies with respect to all providers in every provider network that the insured may use under their coverage, including tiered networks. While the EO is in effect, a provider duly authorized to practice in Illinois that has a provider agreement with the issuer shall not be required to join an issuer’s telehealth-specific network in order for their telehealth services to be covered under the policy unless the issuer’s requirements for membership in the network are no more restrictive or less favorable than in the Medicaid emergency rule, subject to any overriding, contrary provisions in the EO itself. We assume that issuers have already verified the licensure of their in-network providers, and as such, there would be no practical need to take additional time to re-verify their licensure with the appropriate authorities in order to have their telehealth services covered while this EO remains in effect. If a duly authorized provider is “in-network" at any tier under the insured’s terms of coverage, and if they perform covered services that can be clinically appropriate to deliver via telehealth, then those telehealth services must be covered when medically necessary for the insured.

For indemnity policies that do not utilize provider networks, the EO states, “Any policy, contract, or certificate of health insurance coverage that does not distinguish between in-network and out-of-network providers shall be subject to this [EO] as though all providers were in-network.” Accordingly, issuers of such policies must reimburse the insured for telehealth services for covered benefits delivered by any provider duly authorized to practice when they are clinically appropriate and medically necessary. For claims processing purposes, issuers may require documentation of the telehealth encounter that is no more stringent than what is required in the Medicaid emergency rule for that particular encounter. To calculate the amount of reimbursement to the insured for the provider’s charges, the usual, customary, and reasonable (“UCR”) charge that the policy has established for the covered benefit would apply to the telehealth service as it would for the service delivered in person.

With respect to the EO’s prohibition on cost-sharing for in-network services, if the insured has a policy that uses a provider network, then the issuer and the provider must ensure that the insured is not held responsible for any of the cost of a covered telehealth service delivered by an in-network provider. For example, if an insured under a PPO plan otherwise would pay an in-network provider’s bill in full for an in-person service and then be fully reimbursed by the issuer, the same process would apply to a telehealth service. On the other hand, if the in-network provider of an in-person service normally would direct bill the issuer for the covered amount and would separately bill the insured for a copay or coinsurance, then an in-network provider of a telehealth service could either bill the whole amount to the issuer or follow the usual split billing process above, and in the latter case the issuer would reimburse the insured for the cost-sharing. Disputes about whether the provider charged the appropriate total amount for the service under the terms of the provider agreement would have to be resolved between the issuer and the provider. The corollary for indemnity policies that do not use a provider network is that the provider who delivered the telehealth services would bill the insured, and the insured would pay the bill and be reimbursed by the issuer up to the UCR amount. Importantly, however, when an indemnity policy does not use a provider network, there is no contractual hold harmless clause, and Section 356z.3a of the Illinois Insurance Code does not apply. As a result, if the provider of a telehealth service

bills the insured for more than the UCR amount of an in-person service under a non-network indemnity policy, then insured will have to bear the portion of the cost that exceeds the policy's UCR.

While the EO is in effect, prior authorization requirements are not allowed for telehealth services related to COVID-19 when delivered by in-network providers. In the corollary for an indemnity policy with no network, if the policy normally would have prior authorization requirements, the EO would not allow them to apply with respect to any telehealth services related to COVID-19 that are delivered by any provider duly authorized to practice in Illinois.

Without regard for whether telehealth services are delivered in-network, out-of-network, or under a policy that does not use networks, a policy's utilization review requirements for telehealth must not be unnecessary, duplicative, or unwarranted, and treatment limitations must be no more stringent for a telehealth service than they are for the same health care service delivered in-person. However, to the extent that a policy imposes different requirements or limitations for in-network versus out-of-network services that are delivered in person, the EO does not prohibit the policy from subjecting telehealth services to the same differentiation, except with respect to prior authorization for telehealth services related to COVID-19 as described above.

Limited Application to Excepted Benefit Policies

The EO generally applies to "health insurance coverage" as defined in Section 5 of the Illinois Health Insurance Portability and Accountability Act ("Act"). That definition does not distinguish between comprehensive health benefits and excepted benefits. Under Section 45 of the Act, excepted benefits for group policies are exempt from the Act's substantive requirements under specified circumstances. This reflects the relationship between the definitions and the substantive requirements for health insurance coverage in general and excepted benefits in particular under federal law, upon which the Act was substantially modeled. *See, e.g.*, 42 U.S.C. 300gg-21(b)-(c); 45 C.F.R. 146.145(b) and 148.220. In the same vein, the EO contains a clause generally exempting excepted benefit policies as defined by the federal regulations, which apply to both individual and group policies. However, the EO does not extend that exemption to policies for limited scope dental benefits, limited scope vision benefits, long-term care benefits, specified disease or illness, and accident-only policies.

The Department recognizes that some of the types of excepted benefit policies subject to the EO often are not designed to pay benefits based on the nature of the health care service delivered. For example, specified disease policies tend to pay benefits on an occurrence basis, whereby a lump sum is paid to the insured based on their diagnosis with a disease specified in the policy, regardless of what services are used to treat the disease or how much they ultimately cost. Accident-only policies often work in a similar manner. To the extent that payments to insureds or providers under such policies are not made based on whether a service is covered but merely on the occurrence of a health condition, the EO generally does not apply. The order requires issuers to pay costs of services that are already covered when they happen to be delivered via telehealth by a certain range of providers, but it does not require issuers to add qualitatively new benefits to their policies. However, the Department is aware of some policies that have been classified as specified disease and accident-only that do distinguish between covered and non-covered services in determining whether and how much they will pay for covered conditions and injuries. In those unusual instances, the EO would apply to the extent that the covered services can be performed via telehealth in a clinically appropriate manner, in the same way as the order applies to comprehensive health insurance coverage.

Additionally, long-term care policies may pay a fixed daily or monthly rate to an insured to cover expenses for personal care, home modification, and other services not falling within the definition of "telehealth services." Such services do not trigger the requirements of the EO. Long-term care policies

also are designed primarily around providing benefits to persons who are critically ill and need care and assistance in person, so under normal circumstances telehealth services are unlikely to be implicated. Still, some long-term care policies pay benefits on an expense-incurred basis for covered services. To the extent that a subset of covered services may end up being performed using non-public facing remote communication products – for example, services provided by appropriately licensed speech-language pathologists – the use of such remote communication products should not be a basis to deny or reduce benefits. Generally, the Department does not anticipate concerns to arise about this issue, but we mention it for the avoidance of doubt. Outside of that narrow context, and subject to the next paragraph, we do not believe that the EO affects long-term care policies in practice.

Finally, it would not be consistent with the intent of the EO for an issuer to deny or reduce benefits to an insured because the insured used clinically appropriate, medically necessary telehealth services in the course of satisfying any policy's benefit trigger. An insured may be relying upon one of these policies to help them absorb the cost of the health care services that the insured must use to obtain the diagnosis needed to trigger the benefit. The fact that telehealth services were used in the course of arriving at the diagnosis should not invalidate a claim for benefits as long as those particular services were clinically appropriate to deliver via telehealth. Obviously, a lab test requires the collection of a physical specimen from the insured, and certain examinations require the provider to physically manipulate the insured's body or otherwise administer physical stimuli to detect illness or injury. But a preliminary or follow-up exam might not always require in-person contact between the provider and the insured. Generally, we do not anticipate any concerns to arise about this issue for specified disease, accident-only, or long-term care policies, but we mention it for the avoidance of doubt.

Incorporation of the Medicaid Emergency Rule

While a disaster proclamation remains in effect in Illinois, the EO will temporarily affect the reimbursement rates for telehealth services under commercial health insurance coverage through its incorporation of the Medicaid emergency rule. The rule requires in-network providers to be paid the same rate for telehealth services as for services that they deliver by traditional, in-person methods. For indemnity policies that do not distinguish between in-network and out-of-network providers, the UCR for a covered in-person service shall stand in for an in-network reimbursement rate for that service.

One noteworthy area where the EO supersedes some provisions of the Medicaid emergency rule is with respect to "distant sites." An issuer may not strictly limit the providers eligible to deliver telehealth services to the list of "distant sites" in the Medicaid emergency rule where the EO allows additional providers to deliver telehealth services. Under the terms of the order, where applicable insurance laws require a policy to cover a benefit for services delivered by health care professionals with certain licensures, the EO requires that those laws supersede the Medicaid emergency rule. For example, Section 356z.14 of the Illinois Insurance Code requires comprehensive forms of health insurance coverage to cover various services related to treatment for autism spectrum disorders, including applied behavior analysis delivered by a "certified, registered, or licensed health care professional with expertise in treating effects of autism spectrum disorders when the care is determined to be medically necessary and ordered by a physician licensed to practice medicine in all its branches." 215 ILCS 5/356z.14(i). Board Certified Behavioral Analysts and Registered Behavioral Technicians are among those health care professionals. Even if those certifications do not fall within the scope of the Medicaid emergency rule, the EO still requires their services to be covered when delivered via telehealth. However, the EO does not require services to be covered for telehealth if the policy would not cover them when delivered in person, so policies that are not already subject to Section 356z.14 would not be newly required to cover applied behavioral analysis via telehealth by any provider.

Additionally, any specifications and restrictions for billing codes in the Medicaid emergency rule are not to be construed as limiting the services that an issuer must cover for commercial health insurance coverage. If a policy covers a health care service, and if it is clinically appropriate and medically necessary to deliver via telehealth to an insured, then the issuer must cover its delivery via telehealth. Questions about the appropriate choice of billing codes should be resolved between the issuer and the provider.

Finally, the Medicaid emergency rule's requirement that a patient have an established relationship with a provider for a virtual check-in or e-visit cannot be applied to commercial health insurance coverage under this Executive Order. Section 356z.22(b)(1)(A) of the Illinois Insurance Code prohibits requiring that "in-person contact occur between a health care provider and a patient…" 215 ILCS 5/356z.22(b)(1)(A). The only way that a patient could have an established relationship without in-person contact would be through a prior telehealth encounter. Yet, an essential purpose of the Executive Order is to temporarily but significantly expand the scope of providers and health care services to be covered for telehealth. A given provider might not have offered telehealth services before the COVID-19 outbreak, or they might never have provided any services to a particular insured because they specialize in an area of practice for which the insured only recently developed a health need. It would defeat the purpose of the Executive Order to require an established relationship for a virtual check-in or e-visit, so those requirements are not permitted. Otherwise, the parameters for a virtual check-in or e-visit may be applied, subject to modifications of the billing code parameters on a case-by-case basis if they do not fit the needs of a particular telehealth encounter as determined by the issuer and the provider.

No Direct Effect on Providers Authorized to Deliver Care to Illinois Insureds

The EO does not change which healthcare providers under any licensure are allowed to deliver care to Illinois insureds or to Illinois residents generally, even for telehealth services. The EO provides that an Illinois insured shall be covered for clinically appropriate, medically necessary telehealth services for a covered benefit that are delivered by any healthcare provider who is licensed, certified, registered, or otherwise authorized to practice in Illinois. For coverage under a policy that uses a provider network, this only applies to those professionals who are in-network. For non-network indemnity policies, it applies to any duly authorized provider.

However, the term "authorized" is intentionally broad. Whenever a healthcare provider would not be deemed to violate Illinois law by practicing in Illinois even if they are not specifically licensed, certified, or registered by the State, such providers are "authorized" and fall within the scope of the EO's coverage requirements. If the Governor or a State agency with relevant authority has taken action, or in the future takes action, to widen the scope of providers authorized to practice in Illinois during this COVID-19 outbreak, providers newly authorized under those actions would at that time be deemed to fall within the scope of this EO while in effect. On March 23, 2020, the Illinois Department of Financial and Professional Regulation announced measures to temporarily expand the scope of providers permitted to practice in Illinois, including certain practitioners licensed out-of-state. Please consult the Illinois Department of Financial and Professional Regulation's website for further details: https://www.idfpr.com/COVID-19.asp

Even if a provider newly becomes authorized to practice in Illinois under such emergency measures, any providers not already part of an issuer's network still would need to contract with the issuer or the administrator of the issuer's network in order to be deemed an "in-network provider" for purposes of the EO. They would not need to contract with an issuer for their services to be reimbursable under a non-network indemnity policy.

An Evolving Situation

The Department recognizes that expectations about what services are clinically appropriate to deliver via telehealth may evolve or be temporarily relaxed to some degree over the course of the COVID-19 outbreak. We encourage issuers and providers to keep up to date with relevant guidance from public health officials, as well as nationally recognized professional societies for medicine, mental health, or treatment of substance abuse, so as to maximize the availability of effective and prudent care via telehealth services. We encourage issuers and providers to continue sharing information with one another, with the Department, and with the people whom we all serve, to help us coordinate our efforts and make one another as effective as possible in responding to these difficult circumstances.

Questions about this bulletin should be directed to DOI.InfoDesk@illinois.gov