

September 25, 2026

Assemblywoman Pamela Hunter
LOB 646
Albany, NY 12248

Sent via email to: Christa Rapoport (CRapoport@ncoil.org) and Will Melofchik (wmelofchik@ncoil.org)

RE: NCOIL Telemedicine Authorization and Reimbursement Act (TARA)

Dear Assemblywoman Hunter,

The Blue Cross Blue Shield Association (BCBSA) commends the National Council of Insurance Legislators (NCOIL) for its commitment to expanding access to telemedicine and for its continued work to modernize the *Telemedicine Authorization and Reimbursement Act* (TARA). We offer the attached recommendations that reflect our commitment to ensuring patients have access to high-quality virtual care while preserving the tools health plans need to promote clinically appropriate use.

BCBSA is a national federation of independent, community-based and locally operated Blue Cross and Blue Shield companies (Plans) that collectively provide health care coverage for one in three Americans. BCBS Plans contract with 97% of hospitals and 83% of doctors across the country and serve those who are covered through Medicare, Medicaid, an employer, or purchase coverage on their own.

BCBSA supports the proposed amendments as of June 16, 2026, and we suggest a handful of modifications to strengthen them. We welcome the removal of the pandemic-specific findings, which reflect telemedicine as a permanent part of how care is delivered rather than an emergency response. We also support the prohibition on excluding coverage simply because a service is delivered virtually, where that service is clinically appropriate for telemedicine, and the requirement that telemedicine complement rather than replace an adequate in-person network. The recommendations that follow build on that foundation.

Our recommendations center on three themes:

- **First, coverage should track clinical appropriateness.** Not all services produce equivalent outcomes when delivered virtually, so coverage requirements should apply to services that are appropriately provided through telemedicine and consistent with the plan's benefit design, rather than as a blanket mandate. Plans should also keep the ability to apply clinically appropriate safeguards, such as periodic in-person follow-up, where the standard of care or patient safety warrants it. These changes reinforce the value of telemedicine by encouraging its use in the settings best tailored to delivering high-quality care for patients.

- **Second, plans need flexibility on payment and cost-sharing.** Telemedicine works best when plans can design benefits that make virtual care more affordable for members. We recommend extending payment rate flexibility to all providers, including those who also provide services at a brick-and-mortar location. Further, we support allowing telemedicine cost-sharing to be negotiated differently than the comparable in-person service for any provider, as long as it still counts toward the same deductible and out-of-pocket maximum. This approach reflects the differences in provider costs associated with in-person versus virtual care in a way that encourages use while protecting the affordability of care for patients.
- **Third, clearer definitions can sharpen the effectiveness of the model.** Replacing the undefined term "emergent" with the state's existing emergency services standard would allow for effective management of non-emergent care. In addition, reframing the vendor requirement to exclude exclusive single-vendor arrangements – while still allowing for preferred vendor arrangements – is a reasonable approach to support cost efficiency and member experience while also incentivizing vendors to maximize quality and affordability.

Thank you for your leadership on this important issue. BCBSA welcomes the opportunity to support further collaboration as the model act advances. If you have any questions, please feel free to contact Randi Chapman, Senior Manager, State Affairs, at Randi.Chapman@bcbsa.com.

Sincerely,



Clay S. McClure Senior Director, State Affairs
Blue Cross Blue Shield Association

Attachment:

BCBSA redline comments on the NCOIL Telemedicine Authorization and Reimbursement Act

616 Fifth Avenue, Unit 106
Belmar, NJ 07719
732-201-4133
CHIEF EXECUTIVE OFFICER: Will Melofchik



PRESIDENT: Sen. Paul Utke, MN
VICE PRESIDENT: Rep. Edmond Jordan, LA
TREASURER: Rep. Jim Dunnigan, UT
SECRETARY: Rep. Brenda Carter, MI

IMMEDIATE PAST PRESIDENT:
Asw. Pamela Hunter, NY

National Council of Insurance Legislators (NCOIL)

Telemedicine Authorization and Reimbursement Act (TARA)

**Sponsored by Asw. Pam Hunter (NY)*

**Adopted by the NCOIL Health Insurance & Long Term Care Issues Committee on November 18, 2021 and the NCOIL Executive Committee on November 20, 2021. Re-adopted by the Health Insurance & Long Term Care Issues Committee on April 17, 2026 and the Executive Committee on April 19, 2026 until the 2026 Summer Meeting while proposed amendments are developed.*

**Draft as of June 16, 2026. To be discussed by the NCOIL Health Insurance & Long Term Care Issues Committee on July 17, 2026. Proposed Amendments sponsored by Asw. Pam Hunter (NY).*

Table of Contents

Section 1. Title
Section 2. Purpose
Section 3. Definitions
Section 4. Coverage of Telemedicine Services
~~Section 5. Limited Telemedicine License~~
Section ~~5~~6. Network Adequacy and Limitation
Section ~~6~~7. Rules
Section ~~7~~8. Effective Date
Section ~~8~~9. Severability

Section 1. Title.

This act shall be known as and may be cited as the Telemedicine Authorization and Reimbursement Act.

Section 2. Purpose

The Legislature hereby finds and declares that:

(A) The advancements and continued development of medical and communications technology have had a profound impact on the practice of medicine and offer opportunities for improving the delivery and accessibility of health care, particularly in the area of telemedicine.

(B) Geography, weather, availability of specialists, transportation, and other factors can create barriers to accessing appropriate health care, including behavioral health care, and one way to provide, ensure, or enhance access to care given these barriers is through the appropriate use of technology to allow health care consumers access to qualified health care providers.

(C) There is a need in this state to embrace efforts that will encourage health insurers and health care providers to support the use of telemedicine and that will also encourage all state agencies to evaluate and amend their policies and rules to remove any regulatory barriers prohibiting the use of telemedicine services.

~~(D) The need to access health care services is compounded by the challenges associated with COVID-19, as consumers are experiencing the negative effects the pandemic has on physical, mental, and emotional health that will extend into future years.~~

~~(DE) Access to telemedicine is vital to ensuring the continuity of physical, mental, and behavioral health care for consumers during the COVID-19 pandemic and responding to any future outbreaks of the virus.~~

Section 3. Definitions

(A) “Telemedicine” means the delivery of clinical health care services by means of real time audio only telephonic conversation, two-way electronic audio visual communications, including the application of secure video conferencing or store and forward technology to provide or support healthcare delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self management of a patient’s health care while such patient is at an originating site and the health care provider is at a distant site; consistent with applicable federal law and regulations; unless the term is otherwise defined by law with respect to the provision in which it is used.

(B) “Telehealth” means delivering health care services by means of information and communications technologies consisting of telephones, remote patient monitoring devices or other electronic means which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient’s health care while such patient is at the originating site and the health care provider is at the distant site; consistent with applicable federal law and regulations; unless the term is otherwise defined by law with respect to the provision in which it is used.

(C) “Store and forward” transfer means the transmission of a patient’s medical information from an originating site to the provider at the distant site without the patient being present.

(D) “Distant site” means a site at which a health care provider is located while providing health care services by means of telemedicine or telehealth; unless the term is otherwise defined with respect to the provision in which it is used.

(E) “Originating site” means a site at which a patient is located at the time health care services are provided to him or her by means of telemedicine or telehealth, unless the term is otherwise

defined with respect to the provision in which it is used; provided, however, notwithstanding any other provision of law, insurers and providers may agree to alternative siting arrangements deemed appropriate by the parties.

Section 4. Coverage of Telemedicine Services

(A) Each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for the cost of such health care services appropriately provided through telemedicine services and consistent with the plan's benefit design, as provided in this section.

(B) An insurer, corporation, or health maintenance organization shall not exclude a service for coverage solely because the service is provided through telemedicine services and is not provided through in-person consultation or contact between a health care provider and a patient for services appropriately provided through telemedicine services.

(C) An insurer, corporation, or health maintenance organization shall not require a covered person to have a previously established patient-provider relationship with a specific provider in order for the covered person to receive health care services provided through telemedicine services; however, the establishment of a patient-provider relationship shall not occur via an audio-only telephonic conversation. Nothing in this subsection shall prevent an insurer, corporation, or health maintenance organization from applying clinically appropriate safeguards, including an in-person evaluation or periodic in-person follow-up, where warranted by the applicable standard of care or patient safety.

(D) An insurer, corporation, or health maintenance organization shall reimburse the treating provider or the consulting provider for the diagnosis, consultation, or treatment of the insured delivered through telemedicine services on the same basis that the insurer, corporation, or health maintenance organization is responsible for coverage for the provision of the same service through in-person consultation or contact. provided that the insurer, corporation, or health maintenance organization and the provider may negotiate a different rate for services delivered through telemedicine, where such provider also provides services at a brick and mortar location; but where the provider provides healthcare services only via telemedicine (or within a telemedicine only network), the provider may accept lower rates, as negotiated. Insurers, corporations or health maintenance organizations may not mandate patients utilize telemedicine only providers.

(E) An insurer, corporation, or health maintenance organization may offer a health plan containing a deductible, copayment, or coinsurance requirement for a health care service provided through telemedicine services; however, such deductible, copayment, or coinsurance shall be combined with counted toward the deductible, copayment, or coinsurance applicable to the same services provided through in-person diagnosis, consultation, or treatment.

(F) No insurer, corporation, or health maintenance organization shall impose any annual or lifetime dollar maximum on coverage for telemedicine 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,

Commented [BCBSA1]: We recommend narrowing subsection (A) so that coverage applies to services appropriately provided through telemedicine, consistent with the plan's benefit design, rather than as a blanket mandate. As drafted, subsection (A) requires coverage of telemedicine services broadly, which leaves plans limited flexibility to determine which services are appropriately and effectively delivered virtually. Federal policy already reflects this approach. In the Medicare Advantage program, CMS permits the plan, not the agency, to identify which services are clinically appropriate to furnish through electronic exchange (42 CFR 422.135). Tying coverage to clinical appropriateness preserves the non-discrimination principle in subsection (B) while ensuring coverage tracks whether a service is appropriately and effectively delivered through telemedicine. Not all services produce equivalent clinical outcomes when delivered virtually, and coverage tied to clinical appropriateness protects patients from care being pushed into a modality that does not serve them well, while still guaranteeing access wherever telemedicine is a sound substitute for in-person care.

Commented [BCBSA2]: We recommend preserving the prohibition on blanket prior-relationship requirements while allowing plans to apply clinically appropriate safeguards. This preserves broad telemedicine access while allowing guardrails where the clinical context warrants them. For example, initial tele-prescribing of Medication Assisted Treatment (MAT) for opioid use disorder without an in-person visit should be permitted, with periodic in-person follow-up required where consistent with the applicable standard of care and an exception process available for extenuating circumstances.

Commented [BCBSA3]: We recommend extending negotiated-rate flexibility to all providers, not only telemedicine-only ones. The provision allows plans to negotiate a rate that reflects a virtual delivery model with telemedicine-only providers, but requires equal reimbursement when the same virtual service is furnished by a provider who also maintains a physical practice. The result is that the rate for an identical virtual visit depends on the provider's practice structure rather than on the service delivered, giving dual-practice providers a potential payment advantage for the exact same care. Extending this flexibility to all providers keeps payment tied to the service and supports more affordable virtual care for members.

Commented [BCBSA4]: We recommend that telemedicine cost-sharing be permitted to differ from the same in-person service, while still counting toward the same deductible and out-of-pocket maximum. As written, the requirement to combine telemedicine cost-sharing with the in-person amount can be read to lock telemedicine cost-sharing to the in-person amount, removing the ability to set it differently. Changing 'combined with' to 'counted toward' keeps the protection the provision appears aimed at, no separate or duplicative telemedicine deductible, while preserving the flexibility to make telehealth more affordable for members.

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.

(G) The requirements of this section shall apply to all insurance policies, contracts, and plans delivered, issued for delivery, reissued, or extended in [State] on and after January 1, 20__, or at any time thereafter when any term of the policy, contract, or plan is changed or any premium adjustment is made.

(H) This section shall not apply to short-term travel, accident-only, limited or specified disease, or individual conversion policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

(I) Nothing shall preclude the insurer, corporation, or health maintenance organization from undertaking utilization review to determine the appropriateness of telemedicine services, provided that such appropriateness is made in the same manner as those determinations are made for the treatment of any other illness, condition, or disorder covered by such policy, contract, or plan. [Any such utilization review shall not require prior authorization of emergent telemedicine services that meet the definition of emergency services under [State] law].

Section 5. Limited Telemedicine License

An applicant who has an unrestricted license in good standing in another state and maintains an unencumbered certification in a recognized specialty area; or is eligible for such certification and indicates a residence and a practice outside [State] but proposes to practice telemedicine only across state lines on patients within the physical boundaries of [State], shall be issued a license limited to telemedicine by the [State] Medical Board. The holder of such limited license shall be subject to the disciplinary jurisdiction of the [State] Medical board in the same manner as if (s)he held a full license to practice medicine.

Section 56. Network Adequacy and Limitation

(a) An insurer shall not solely use telemedicine or telehealth to satisfy network adequacy requirements with regard to a health care service.

(b) [An insurer shall not limit coverage only-exclusively to services delivered by select-a single third party telemedicine or telehealth organizations].

Section 67. Rules

The [chief State insurance regulator and the chief medical licensing regulator] may adopt rules regulating that are consistent with this Act.

Section 78. Effective Date

This Act shall become effective immediately upon being enacted into law.

Commented [BCBSA5]: We recommend replacing 'emergent' with the state's existing emergency services standard. The term 'emergent' is undefined and open to more than one interpretation, including an emergency-care meaning and a 'newly arising' meaning. To avoid disputes over which telemedicine services qualify, we recommend that the provision specify the state's existing emergency services standard, which would limit the carve-out to genuine emergencies.

Commented [BCBSA6]: We recommend narrowing subsection (b) so the prohibition applies to reliance on a single exclusive vendor, not to preferred multi-vendor arrangements. As written, subsection (b)'s prohibition on 'select' third-party organizations could be read to bar any meaningful vendor preference, including preferred arrangements with a limited set of vendors that carry volume-based pricing and integration benefits for members. Narrowing the prohibition to exclusive single-vendor reliance preserves the consumer-protection intent by preventing a monopoly arrangement that limits member access, while allowing plans to maintain preferred vendor relationships that support cost efficiency, consistent quality, and member experience.

Section 89. Severability

If any provision of this Act is held by a court to be invalid, such invalidity shall not affect the remaining provisions of this Act, and to this end the provisions of this Act are hereby declared severable.