

2020 -- S 2525 SUBSTITUTE A

LC004557/SUB A

STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2020

A N A C T

RELATING TO STATE AFFAIRS AND GOVERNMENT -- THE RHODE ISLAND HEALTH CARE REFORM ACT OF 2004--HEALTH INSURANCE OVERSIGHT

Introduced By: Senators Miller, Goldin, Valverde, Satchell, and Goodwin

Date Introduced: February 25, 2020

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

1 SECTION 1. The general assembly finds and declares that:

2 (1) It is necessary to foster greater coordination between patients, healthcare providers, and
3 health insurers to ensure patient health and well-being. Easing administrative burdens imposed on
4 healthcare providers, such as prior authorization requirements, better facilitates quality patient care,
5 allows providers to spend more time on patient care, better enables delivery of healthcare services,
6 and improves timeliness of care.

7 (2) During the COVID-19 crisis it has become clear that patients and providers benefit
8 substantially from having access to telemedicine services that are covered by health insurers on the
9 same basis as in-person services.

10 (3) It is essential to facilitate the delivery of telemedicine services as a convenient, easily
11 accessible, and affordable option to both health care providers and patients. Low-cost telephone
12 and other internet-based audio-only and live video technologies are widely available and accessible
13 to health care providers and patients. These technologies enable the delivery of clinically
14 appropriate, medically necessary health care services, including behavioral health care services, to
15 patients in a safe and accessible manner.

16 (4) There is a need in this state to embrace efforts that will encourage patients, health
17 insurers and healthcare providers to support the use of telemedicine, and that will also encourage
18 all state agencies to evaluate and amend their policies and rules to remove any regulatory barriers

1 prohibiting the use of telemedicine services or reimbursing for such services on a discriminatory
2 basis relative to in-person services.

3 SECTION 2. Section 42-14.5-3 of the General Laws in Chapter 42-14.5 entitled "The
4 Rhode Island Health Care Reform Act of 2004 - Health Insurance Oversight" is hereby amended
5 to read as follows:

6 **42-14.5-3. Powers and duties.**

7 The health insurance commissioner shall have the following powers and duties:

8 (a) To conduct quarterly public meetings throughout the state, separate and distinct from
9 rate hearings pursuant to § 42-62-13, regarding the rates, services, and operations of insurers
10 licensed to provide health insurance in the state; the effects of such rates, services, and operations
11 on consumers, medical care providers, patients, and the market environment in which the insurers
12 operate; and efforts to bring new health insurers into the Rhode Island market. Notice of not less
13 than ten (10) days of the hearing(s) shall go to the general assembly, the governor, the Rhode Island
14 Medical Society, the Hospital Association of Rhode Island, the director of health, the attorney
15 general, and the chambers of commerce. Public notice shall be posted on the department's website
16 and given in the newspaper of general circulation, and to any entity in writing requesting notice.

17 (b) To make recommendations to the governor and the house of representatives and senate
18 finance committees regarding health-care insurance and the regulations, rates, services,
19 administrative expenses, reserve requirements, and operations of insurers providing health
20 insurance in the state, and to prepare or comment on, upon the request of the governor or
21 chairpersons of the house or senate finance committees, draft legislation to improve the regulation
22 of health insurance. In making the recommendations, the commissioner shall recognize that it is
23 the intent of the legislature that the maximum disclosure be provided regarding the reasonableness
24 of individual administrative expenditures as well as total administrative costs. The commissioner
25 shall make recommendations on the levels of reserves, including consideration of: targeted reserve
26 levels; trends in the increase or decrease of reserve levels; and insurer plans for distributing excess
27 reserves.

28 (c) To establish a consumer/business/labor/medical advisory council to obtain information
29 and present concerns of consumers, business, and medical providers affected by health-insurance
30 decisions. The council shall develop proposals to allow the market for small business health
31 insurance to be affordable and fairer. The council shall be involved in the planning and conduct of
32 the quarterly public meetings in accordance with subsection (a). The advisory council shall develop
33 measures to inform small businesses of an insurance complaint process to ensure that small
34 businesses that experience rate increases in a given year may request and receive a formal review

1 by the department. The advisory council shall assess views of the health-provider community
2 relative to insurance rates of reimbursement, billing, and reimbursement procedures, and the
3 insurers' role in promoting efficient and high-quality health care. The advisory council shall issue
4 an annual report of findings and recommendations to the governor and the general assembly and
5 present its findings at hearings before the house and senate finance committees. The advisory
6 council is to be diverse in interests and shall include representatives of community consumer
7 organizations; small businesses, other than those involved in the sale of insurance products; and
8 hospital, medical, and other health-provider organizations. Such representatives shall be nominated
9 by their respective organizations. The advisory council shall be co-chaired by the health insurance
10 commissioner and a community consumer organization or small business member to be elected by
11 the full advisory council.

12 (d) To establish and provide guidance and assistance to a subcommittee ("the professional-
13 provider-health-plan work group") of the advisory council created pursuant to subsection (c),
14 composed of health-care providers and Rhode Island licensed health plans. This subcommittee shall
15 include in its annual report and presentation before the house and senate finance committees the
16 following information:

17 (1) A method whereby health plans shall disclose to contracted providers the fee schedules
18 used to provide payment to those providers for services rendered to covered patients;

19 (2) A standardized provider application and credentials-verification process, for the
20 purpose of verifying professional qualifications of participating health-care providers;

21 (3) The uniform health plan claim form utilized by participating providers;

22 (4) Methods for health maintenance organizations, as defined by § 27-41-2, and nonprofit
23 hospital or medical-service corporations, as defined by chapters 19 and 20 of title 27, to make
24 facility-specific data and other medical service-specific data available in reasonably consistent
25 formats to patients regarding quality and costs. This information would help consumers make
26 informed choices regarding the facilities and clinicians or physician practices at which to seek care.
27 Among the items considered would be the unique health services and other public goods provided
28 by facilities and clinicians or physician practices in establishing the most appropriate cost
29 comparisons;

30 (5) All activities related to contractual disclosure to participating providers of the
31 mechanisms for resolving health plan/provider disputes;

32 (6) The uniform process being utilized for confirming, in real time, patient insurance
33 enrollment status, benefits coverage, including co-pays and deductibles;

34 (7) Information related to temporary credentialing of providers seeking to participate in the

1 plan's network and the impact of the activity on health-plan accreditation;

2 (8) The feasibility of regular contract renegotiations between plans and the providers in
3 their networks; and

4 (9) Efforts conducted related to reviewing impact of silent PPOs on physician practices.

5 (e) To enforce the provisions of Title 27 and Title 42 as set forth in § 42-14-5(d).

6 (f) To provide analysis of the Rhode Island affordable health plan reinsurance fund. The
7 fund shall be used to effectuate the provisions of §§ 27-18.5-9 and 27-50-17.

8 (g) To analyze the impact of changing the rating guidelines and/or merging the individual
9 health-insurance market, as defined in chapter 18.5 of title 27, and the small-employer-health-
10 insurance market, as defined in chapter 50 of title 27, in accordance with the following:

11 (1) The analysis shall forecast the likely rate increases required to effect the changes
12 recommended pursuant to the preceding subsection (g) in the direct-pay market and small-
13 employer-health-insurance market over the next five (5) years, based on the current rating structure
14 and current products.

15 (2) The analysis shall include examining the impact of merging the individual and small-
16 employer markets on premiums charged to individuals and small-employer groups.

17 (3) The analysis shall include examining the impact on rates in each of the individual and
18 small-employer health-insurance markets and the number of insureds in the context of possible
19 changes to the rating guidelines used for small-employer groups, including: community rating
20 principles; expanding small-employer rate bonds beyond the current range; increasing the employer
21 group size in the small-group market; and/or adding rating factors for broker and/or tobacco use.

22 (4) The analysis shall include examining the adequacy of current statutory and regulatory
23 oversight of the rating process and factors employed by the participants in the proposed, new
24 merged market.

25 (5) The analysis shall include assessment of possible reinsurance mechanisms and/or
26 federal high-risk pool structures and funding to support the health-insurance market in Rhode Island
27 by reducing the risk of adverse selection and the incremental insurance premiums charged for this
28 risk, and/or by making health insurance affordable for a selected at-risk population.

29 (6) The health insurance commissioner shall work with an insurance market merger task
30 force to assist with the analysis. The task force shall be chaired by the health insurance
31 commissioner and shall include, but not be limited to, representatives of the general assembly, the
32 business community, small-employer carriers as defined in § 27-50-3, carriers offering coverage in
33 the individual market in Rhode Island, health-insurance brokers, and members of the general
34 public.

1 (7) For the purposes of conducting this analysis, the commissioner may contract with an
2 outside organization with expertise in fiscal analysis of the private-insurance market. In conducting
3 its study, the organization shall, to the extent possible, obtain and use actual health-plan data. Said
4 data shall be subject to state and federal laws and regulations governing confidentiality of health
5 care and proprietary information.

6 (8) The task force shall meet as necessary and include its findings in the annual report, and
7 the commissioner shall include the information in the annual presentation before the house and
8 senate finance committees.

9 (h) To establish and convene a workgroup representing health-care providers and health
10 insurers for the purpose of coordinating the development of processes, guidelines, and standards to
11 streamline health-care administration that are to be adopted by payors and providers of health-care
12 services operating in the state. This workgroup shall include representatives with expertise who
13 would contribute to the streamlining of health-care administration and who are selected from
14 hospitals, physician practices, community behavioral-health organizations, each health insurer, and
15 other affected entities. The workgroup shall also include at least one designee each from the Rhode
16 Island Medical Society, Rhode Island Council of Community Mental Health Organizations, the
17 Rhode Island Health Center Association, and the Hospital Association of Rhode Island. The
18 workgroup shall consider and make recommendations for:

19 (1) Establishing a consistent standard for electronic eligibility and coverage verification.

20 Such standard shall:

21 (i) Include standards for eligibility inquiry and response and, wherever possible, be
22 consistent with the standards adopted by nationally recognized organizations, such as the Centers
23 for Medicare and Medicaid Services;

24 (ii) Enable providers and payors to exchange eligibility requests and responses on a system-
25 to-system basis or using a payor-supported web browser;

26 (iii) Provide reasonably detailed information on a consumer's eligibility for health-care
27 coverage; scope of benefits; limitations and exclusions provided under that coverage; cost-sharing
28 requirements for specific services at the specific time of the inquiry; current deductible amounts;
29 accumulated or limited benefits; out-of-pocket maximums; any maximum policy amounts; and
30 other information required for the provider to collect the patient's portion of the bill;

31 (iv) Reflect the necessary limitations imposed on payors by the originator of the eligibility
32 and benefits information;

33 (v) Recommend a standard or common process to protect all providers from the costs of
34 services to patients who are ineligible for insurance coverage in circumstances where a payor

1 provides eligibility verification based on best information available to the payor at the date of the
2 request of eligibility.

3 (2) Developing implementation guidelines and promoting adoption of the guidelines for:

4 (i) The use of the National Correct Coding Initiative code-edit policy by payors and
5 providers in the state;

6 (ii) Publishing any variations from codes and mutually exclusive codes by payors in a
7 manner that makes for simple retrieval and implementation by providers;

8 (iii) Use of Health Insurance Portability and Accountability Act standard group codes,
9 reason codes, and remark codes by payors in electronic remittances sent to providers;

10 (iv) The processing of corrections to claims by providers and payors.

11 (v) A standard payor-denial review process for providers when they request a
12 reconsideration of a denial of a claim that results from differences in clinical edits where no single,
13 common-standards body or process exists and multiple conflicting sources are in use by payors and
14 providers.

15 (vi) Nothing in this section, nor in the guidelines developed, shall inhibit an individual
16 payor's ability to employ, and not disclose to providers, temporary code edits for the purpose of
17 detecting and deterring fraudulent billing activities. The guidelines shall require that each payor
18 disclose to the provider its adjudication decision on a claim that was denied or adjusted based on
19 the application of such edits and that the provider have access to the payor's review and appeal
20 process to challenge the payor's adjudication decision.

21 (vii) Nothing in this subsection shall be construed to modify the rights or obligations of
22 payors or providers with respect to procedures relating to the investigation, reporting, appeal, or
23 prosecution under applicable law of potentially fraudulent billing activities.

24 (3) Developing and promoting widespread adoption by payors and providers of guidelines
25 to:

26 (i) Ensure payors do not automatically deny claims for services when extenuating
27 circumstances make it impossible for the provider to obtain a preauthorization before services are
28 performed or notify a payor within an appropriate standardized timeline of a patient's admission;

29 (ii) Require payors to use common and consistent processes and time frames when
30 responding to provider requests for medical management approvals. Whenever possible, such time
31 frames shall be consistent with those established by leading national organizations and be based
32 upon the acuity of the patient's need for care or treatment. For the purposes of this section, medical
33 management includes prior authorization of services, preauthorization of services, precertification
34 of services, post-service review, medical-necessity review, and benefits advisory;

1 (iii) Develop, maintain, and promote widespread adoption of a single, common website
2 where providers can obtain payors' preauthorization, benefits advisory, and preadmission
3 requirements;

4 (iv) Establish guidelines for payors to develop and maintain a website that providers can
5 use to request a preauthorization, including a prospective clinical necessity review; receive an
6 authorization number; and transmit an admission notification.

7 (4) To provide a report to the house and senate, on or before January 1, 2017, with
8 recommendations for establishing guidelines and regulations for systems that give patients
9 electronic access to their claims information, particularly to information regarding their obligations
10 to pay for received medical services, pursuant to 45 C.F.R. 164.524.

11 (i) To issue an anti-cancer medication report. Not later than June 30, 2014 and annually
12 thereafter, the office of the health insurance commissioner (OHIC) shall provide the senate
13 committee on health and human services, and the house committee on corporations, with: (1)
14 Information on the availability in the commercial market of coverage for anti-cancer medication
15 options; (2) For the state employee's health benefit plan, the costs of various cancer-treatment
16 options; (3) The changes in drug prices over the prior thirty-six (36) months; and (4) Member
17 utilization and cost-sharing expense.

18 (j) To monitor the adequacy of each health plan's compliance with the provisions of the
19 federal Mental Health Parity Act, including a review of related claims processing and
20 reimbursement procedures. Findings, recommendations, and assessments shall be made available
21 to the public.

22 (k) To monitor the transition from fee-for-service and toward global and other alternative
23 payment methodologies for the payment for health-care services. Alternative payment
24 methodologies should be assessed for their likelihood to promote access to affordable health
25 insurance, health outcomes, and performance.

26 (l) To report annually, no later than July 1, 2014, then biannually thereafter, on hospital
27 payment variation, including findings and recommendations, subject to available resources.

28 (m) Notwithstanding any provision of the general or public laws or regulation to the
29 contrary, provide a report with findings and recommendations to the president of the senate and the
30 speaker of the house, on or before April 1, 2014, including, but not limited to, the following
31 information:

32 (1) The impact of the current, mandated health-care benefits as defined in §§ 27-18-48.1,
33 27-18-60, 27-18-62, 27-18-64, similar provisions in chapters 19, 20 and 41, of title 27, and §§ 27-
34 18-3(c), 27-38.2-1 et seq., or others as determined by the commissioner, on the cost of health

1 insurance for fully insured employers, subject to available resources;

2 (2) Current provider and insurer mandates that are unnecessary and/or duplicative due to
3 the existing standards of care and/or delivery of services in the health-care system;

4 (3) A state-by-state comparison of health-insurance mandates and the extent to which
5 Rhode Island mandates exceed other states benefits; and

6 (4) Recommendations for amendments to existing mandated benefits based on the findings
7 in (m)(1), (m)(2), and (m)(3) above.

8 (n) On or before July 1, 2014, the office of the health insurance commissioner, in
9 collaboration with the director of health and lieutenant governor's office, shall submit a report to
10 the general assembly and the governor to inform the design of accountable care organizations
11 (ACOs) in Rhode Island as unique structures for comprehensive health-care delivery and value-
12 based payment arrangements, that shall include, but not be limited to:

13 (1) Utilization review;

14 (2) Contracting; and

15 (3) Licensing and regulation.

16 (o) On or before February 3, 2015, the office of the health insurance commissioner shall
17 submit a report to the general assembly and the governor that describes, analyzes, and proposes
18 recommendations to improve compliance of insurers with the provisions of § 27-18-76 with regard
19 to patients with mental-health and substance-use disorders.

20 (p) To work to ensure the health insurance coverage of behavioral health care under the
21 same terms and conditions as other health care, and to integrate behavioral health parity
22 requirements into the office of the health insurance commissioner insurance oversight and health
23 care transformation efforts.

24 (q) To work with other state agencies to seek delivery system improvements that enhance
25 access to a continuum of mental-health and substance-use disorder treatment in the state; and
26 integrate that treatment with primary and other medical care to the fullest extent possible.

27 (r) To direct insurers toward policies and practices that address the behavioral health needs
28 of the public and greater integration of physical and behavioral health care delivery.

29 (s) The office of the health insurance commissioner shall conduct an analysis of the impact
30 of the provisions of § 27-38.2-1(i) on health insurance premiums and access in Rhode Island and
31 submit a report of its findings to the general assembly on or before June 1, 2023.

32 (t) On or before January 1, 2021, the office of the health insurance commissioner shall
33 adopt a uniform set of medical criteria for prior authorization and create and disseminate a
34 standardized electronic or written prior authorization form that shall be used by a health insurer

1 [whenever prior authorization is required by the health insurer.](#)

2 SECTION 3. Sections 27-81-2, 27-81-3 and 27-81-4 of the General Laws in Chapter 27-
3 81 entitled "The Telemedicine Coverage Act" are hereby amended to read as follows:

4 **27-81-2. Purpose.**

5 The general assembly hereby finds and declares that:

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

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

15 [\(3\) During the COVID-19 crisis, it has become clear that patients and providers benefit](#)
16 [substantially from having access to telemedicine services that are covered by health insurers on the](#)
17 [same basis as in-person services.](#)

18 [\(4\) It is essential to facilitate the delivery of telemedicine services as a convenient, easily](#)
19 [accessible, and affordable option to both health care providers and patients. Low-cost telephone](#)
20 [and other internet-based audio-only and live video technologies are widely available and accessible](#)
21 [to health care providers and patients. These technologies enable the delivery of clinically](#)
22 [appropriate, medically necessary health care services, including behavioral health care services, to](#)
23 [patients in a safe and accessible manner.](#)

24 ~~(3)~~[\(5\) There is a need in this state to embrace efforts that will encourage patients, health](#)
25 [insurers and health-care providers to support the use of telemedicine, and that will also encourage](#)
26 [all state agencies to evaluate and amend their policies and rules to remove any regulatory barriers](#)
27 [prohibiting the use of telemedicine services or reimbursing for such services on a discriminatory](#)
28 [basis relative to in-person services.](#)

29 **27-81-3. Definitions.**

30 As used in this chapter:

31 (1) "Distant site" means a site at which a health-care provider is located while providing
32 health-care services by means of telemedicine.

33 (2) "Health-care facility" means an institution providing health-care services or a health-
34 care setting, including, but not limited to: hospitals and other licensed, inpatient centers; ambulatory

1 surgical or treatment centers; skilled nursing centers; residential treatment centers; diagnostic,
2 laboratory and imaging centers; and rehabilitation and other therapeutic-health settings.

3 (3) "Health-care professional" means a physician or other health-care practitioner licensed,
4 accredited, or certified to perform specified health-care services consistent with state law.

5 (4) "Health-care provider" means a health-care professional or a health-care facility.

6 (5) "Health-care services" means any services included in the furnishing to any individual
7 of medical, podiatric, or dental care, or hospitalization, or incident to the furnishing of that care or
8 hospitalization, and the furnishing to any person of any and all other services for the purpose of
9 preventing, alleviating, curing, or healing human illness, injury, or physical disability.

10 (6) "Health insurer" means any person, firm, or corporation offering and/or insuring health-
11 care services on a prepaid basis, including, but not limited to, a nonprofit service corporation, a
12 health-maintenance organization, or an entity offering a policy of accident and sickness insurance.

13 (7) "Health-maintenance organization" means a health-maintenance organization as
14 defined in chapter 41 of this title.

15 (8) "Nonprofit service corporation" means a nonprofit, hospital-service corporation as
16 defined in chapter 19 of this title, or a nonprofit, medical-service corporation as defined in chapter
17 20 of this title.

18 (9) "Originating site" means a site at which a patient is located at the time health-care
19 services are provided to them by means of telemedicine. ~~which can be a patient's home where~~
20 ~~medically appropriate; provided, however, notwithstanding any other provision of law, health~~
21 ~~insurers and health care providers may agree to alternative siting arrangements deemed appropriate~~
22 ~~by the parties. Patients may receive telemedicine at any location.~~

23 (10) "Policy of accident and sickness insurance" means a policy of accident and sickness
24 insurance as defined in chapter 18 of this title.

25 (11) "Store-and-forward technology" means the technology used to enable the transmission
26 of a patient's medical information from an originating site to the health-care provider at the distant
27 site without the patient being present.

28 (12) "Telemedicine" means the delivery of clinical health-care services by means of real
29 time audio-only telephone conversation or; two-way electronic audiovisual communications,
30 including the application of secure video conferencing or store-and-forward technology to provide
31 or support health-care delivery, which facilitate the assessment, diagnosis, treatment, and care
32 management of a patient's health care while such patient is at an originating site and the health-care
33 provider is at a distant site, consistent with applicable federal laws and regulations. Telemedicine
34 does not include an ~~audio-only telephone conversation~~, email message, or facsimile transmission

1 between the provider and patient, or an automated computer program used to diagnose and/or treat
2 ocular or refractive conditions.

3 **27-81-4. Coverage of telemedicine services.**

4 (a) Each health insurer that issues individual or group accident-and-sickness insurance
5 policies for health-care services and/or provides a health-care plan for health-care services shall
6 provide coverage for the cost of such covered health-care services provided through telemedicine
7 services, as provided in this section.

8 (b) ~~A health insurer shall not exclude a health care service for coverage solely because the
9 health care service is provided through telemedicine and is not provided through in person
10 consultation or contact, so long as such health care services are medically appropriate to be
11 provided through telemedicine services and, as such, may be subject to the terms and conditions of
12 a telemedicine agreement between the insurer and the participating health care provider or provider
13 group.~~

14 All telemedicine services delivered by in-network providers shall be reimbursed at rates
15 not lower than the same services would have been had they been delivered in-person. Telemedicine
16 services shall be subject to the same health insurer policies as in-person services, including medical
17 necessity determinations and appeal rights.

18 (c) Benefit plans offered by a health insurer ~~may~~ shall not impose a deductible, copayment,
19 ~~or~~ coinsurance, or other cost sharing requirement for a covered health-care service provided
20 through telemedicine.

21 (d) Benefit plans offered by a health insurer shall not require prior authorization for health-
22 care services provided through telemedicine.

23 ~~(e)~~(e) The requirements of this section shall apply to all policies and health plans issued,
24 reissued, or delivered in the state of Rhode Island ~~on and after January 1, 2018.~~

25 ~~(e)~~(f) This chapter shall not apply to: short-term travel, accident-only, limited or specified
26 disease; or individual conversion policies or health plans; nor to policies or health plans designed
27 for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known
28 as Medicare; ~~or any other similar coverage under state or federal governmental plans.~~

29 (g) Health insurers shall establish reasonable requirements for the coverage of telemedicine
30 services, in accordance with guidance issued by the Office of the Health Insurance Commissioner,
31 including with respect to documentation and recordkeeping, but may not impose any requirements
32 more restrictive than those contained in “The Rhode Island Office of Health Insurance
33 Commissioner and Medicaid Program Instructions During the COVID-19 State of Emergency”
34 issued March 13, 2020; “Emergency Telemedicine Measures to Address and Stop the Spread of

1 COVID-19” issued on March 20, 2020; “Rhode Island Office of the Health Insurance
2 Commissioner & Medicaid Program Guidance for Preventive Care Visits During COVID-19 State
3 of Emergency” issued May 7, 2020; and the Telehealth Benefits for Medicare beneficiaries; and
4 any subsequent guidance issued by the Office of the Health Insurance Commissioner or the state
5 Medicaid program. No health insurer shall impose any specific requirements on the technologies
6 used to deliver telemedicine services, including any limitations on audio-only or live video
7 technologies.

8 (h) The Office of the Health Insurance Commissioner may promulgate rules and
9 regulations consistent with the provisions of this chapter.

10 (i) Pursuant to § 40-8-17 of the General Laws, the Executive Office of Health and Human
11 Services shall apply for and use its best efforts to obtain any necessary waiver(s), waiver
12 amendment(s) and/or state plan amendment(s) from the Secretary of the United States Department
13 of Health and Human Services, necessary to ensure that individual Medicaid beneficiaries have
14 access to telemedicine services consistent with this chapter. EOHHS may promulgate rules and
15 regulations in accordance with this chapter.

16 SECTION 4. This act shall take effect upon passage.

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LC004557/SUB A
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EXPLANATION
BY THE LEGISLATIVE COUNCIL
OF

A N A C T

RELATING TO STATE AFFAIRS AND GOVERNMENT -- THE RHODE ISLAND HEALTH
CARE REFORM ACT OF 2004--HEALTH INSURANCE OVERSIGHT

1 This act would have the health insurance commissioner adopt a uniform set of medical
2 criteria for prior authorization and create required forms to be used by a health insurer, including
3 telemedicine coverage.

4 This act would take effect upon passage.

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