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S T A T E O F R H O D E I S L A N D

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2021

A N A C T

RELATING TO HEALTH AND SAFETY -- COMPREHENSIVE HEALTH INSURANCE PROGRAM

Introduced By: Representatives Morales, Ranglin-Vassell, Potter, McGaw, Tanzi, Henries, Lombardi, Felix, and Batista
Date Introduced: February 19, 2021

Referred To: House Finance

It is enacted by the General Assembly as follows:

SECTION 1. Chapter 42-14.5 of the General Laws entitled "The Rhode Island Health Care Reform Act of 2004 - Health Insurance Oversight" is hereby repealed in its entirety.

~~CHAPTER 42-14.5~~

~~The Rhode Island Health Care Reform Act of 2004 - Health Insurance Oversight~~

~~**42-14.5-1. Health insurance commissioner.**~~

~~There is hereby established, within the department of business regulation, an office of the health insurance commissioner. The health insurance commissioner shall be appointed by the governor, with the advice and consent of the senate. The director of business regulation shall grant to the health insurance commissioner reasonable access to appropriate expert staff.~~

~~**42-14.5-1.1. Legislative findings.**~~

~~The general assembly hereby finds and declares as follows:~~

~~(1) A substantial amount of health care services in this state are purchased for the benefit of patients by health care insurers engaged in the provision of health care financing services or is otherwise delivered subject to the terms of agreements between health care insurers and providers of the services.~~

~~(2) Health care insurers are able to control the flow of patients to providers of health care services through compelling financial incentives for patients in their plans to utilize only the services of providers with whom the insurers have contracted.~~

~~(3) Health care insurers also control the health care services rendered to patients through utilization review programs and other managed care tools and associated coverage and payment policies.~~

~~(4) By incorporation or merger the power of health care insurers in markets of this state for health care services has become great enough to create a competitive imbalance, reducing levels of competition and threatening the availability of high quality, cost effective health care.~~

~~(5) The power of health care insurers to unilaterally impose provider contract terms may jeopardize the ability of physicians and other health care providers to deliver the superior quality health care services that have been traditionally available in this state.~~

~~(6) It is the intention of the general assembly to authorize health care providers to jointly discuss with health care insurers topics of concern regarding the provision of quality health care through a committee established by an advisory to the health insurance commissioner.~~

~~42-14.5-2. Purpose.~~

~~With respect to health insurance as defined in § 42-14-5, the health insurance commissioner shall discharge the powers and duties of office to:~~

~~(1) Guard the solvency of health insurers;~~

~~(2) Protect the interests of consumers;~~

~~(3) Encourage fair treatment of health care providers;~~

~~(4) Encourage policies and developments that improve the quality and efficiency of health care service delivery and outcomes; and~~

~~(5) View the health care system as a comprehensive entity and encourage and direct insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access.~~

~~42-14.5-3. Powers and duties.~~

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

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

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

~~(c) To establish a consumer/business/labor/medical advisory council to obtain information and present concerns of consumers, business, and medical providers affected by health insurance decisions. The council shall develop proposals to allow the market for small business health insurance to be affordable and fairer. The council shall be involved in the planning and conduct of the quarterly public meetings in accordance with subsection (a). The advisory council shall develop measures to inform small businesses of an insurance complaint process to ensure that small businesses that experience rate increases in a given year may request and receive a formal review by the department. The advisory council shall assess views of the health provider community relative to insurance rates of reimbursement, billing, and reimbursement procedures, and the insurers' role in promoting efficient and high quality health care. The advisory council shall issue an annual report of findings and recommendations to the governor and the general assembly and present its findings at hearings before the house and senate finance committees. The advisory council is to be diverse in interests and shall include representatives of community consumer organizations; small businesses, other than those involved in the sale of insurance products; and hospital, medical, and other health provider organizations. Such representatives shall be nominated by their respective organizations. The advisory council shall be co-chaired by the health insurance commissioner and a community consumer organization or small business member to be elected by the full advisory council.~~

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

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

~~(2) A standardized provider application and credentials verification process, for the purpose of verifying professional qualifications of participating healthcare providers;~~

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

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

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

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

~~(7) Information related to temporary credentialing of providers seeking to participate in the plan's network and the impact of the activity on health plan accreditation;~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~workgroup shall consider and make recommendations for:~~

~~(1) Establishing a consistent standard for electronic eligibility and coverage verification. Such standard shall:~~

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

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

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

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

~~(v) Recommend a standard or common process to protect all providers from the costs of services to patients who are ineligible for insurance coverage in circumstances where a payor provides eligibility verification based on best information available to the payor at the date of the request of eligibility.~~

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

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

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

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

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

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

~~(vi) Nothing in this section, nor in the guidelines developed, shall inhibit an individual payor's ability to employ, and not disclose to providers, temporary code edits for the purpose of detecting and deterring fraudulent billing activities. The guidelines shall require that each payor~~

~~disclose to the provider its adjudication decision on a claim that was denied or adjusted based on the application of such edits and that the provider have access to the payor's review and appeal process to challenge the payor's adjudication decision.~~

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

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

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

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

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

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

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

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

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

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

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

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

~~(1) The impact of the current, mandated healthcare benefits as defined in §§ 27-18-48.1, 27-18-60, 27-18-62, 27-18-64, similar provisions in chapters 19, 20 and 41 of title 27, and §§ 27-18-3(c), 27-38.2-1 et seq., or others as determined by the commissioner, on the cost of health insurance for fully insured employers, subject to available resources;~~

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

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

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

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

~~(1) Utilization review;~~

~~(2) Contracting; and~~

~~(3) Licensing and regulation.~~

~~(o) On or before February 3, 2015, the office of the health insurance commissioner shall submit a report to the general assembly and the governor that describes, analyzes, and proposes~~

~~recommendations to improve compliance of insurers with the provisions of § 27-18-76 with regard to patients with mental health and substance use disorders.~~

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

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

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

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

~~**42-14.5-4. Actuary and subject matter experts.**~~

~~The health insurance commissioner may contract with an actuary and/or other subject matter experts to assist him or her in conducting the study required under subsection 42-14.5-3(g). The actuary or other expert shall serve under the direction of the health insurance commissioner. Health insurance companies doing business in this state, including, but not limited to, nonprofit hospital service corporations and nonprofit medical service corporations established pursuant to chapters 27-19 and 27-20, and health maintenance organizations established pursuant to chapter 27-41, shall be assessed according to a schedule of their direct writing of health insurance in this state to pay for the compensation of the actuary. The amount assessed to all health insurance companies doing business in this state for the study conducted under subsection 42-14.5-3(g) shall not exceed a total of one hundred thousand dollars ($100,000).~~

SECTION 2. Chapter 42-157 of the General Laws entitled "Rhode Island Health Benefit Exchange" is hereby repealed in its entirety.

~~CHAPTER 42-157~~

~~Rhode Island Health Benefit Exchange~~

~~**42-157-1. Establishment of exchange.**~~

~~Purpose. The department of administration is hereby authorized to establish the Rhode Island health benefit exchange, to be known as HealthSource RI, to exercise the powers and authority of a state-based exchange which shall meet the minimum requirements of the federal act.~~

~~**42-157-2. Definitions.**~~

~~As used in this section, the following words and terms shall have the following meanings, unless the context indicates another or different meaning or intent:~~

~~(1) "Director" means the director of the department of administration.~~

~~(2) "Federal act" means the Federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the Federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments to, or regulations or guidance issued under, those acts.~~

~~(3) "Health plan" and "qualified health plan" have the same meanings as those terms are defined in § 1301 of the Federal Act.~~

~~(4) "Insurer" means every medical service corporation, hospital service corporation, accident and sickness insurer, dental service corporation, and health maintenance organization licensed under title 27, or as defined in § 42-62-4.~~

~~(5) "Secretary" means the secretary of the Federal Department of Health and Human Services.~~

~~(6) "Qualified dental plan" means a dental plan as described in § 1311(d)(2)(B)(ii) of the Federal Act [42 U.S.C. § 18031].~~

~~(7) "Qualified individuals" and "qualified employers" shall have the same meaning as defined in federal law.~~

~~**42-157-3. General requirements.**~~

~~(a) The exchange shall make qualified health plans available to qualified individuals and qualified employers. The exchange shall not make available any health benefit plan that has not been certified by the exchange as a qualified health plan in accordance with federal law.~~

~~(b) The exchange shall allow an insurer to offer a plan that provides limited scope dental benefits meeting the requirements of § 9832(c)(2)(A) of the Internal Revenue Code of 1986 through the exchange, either separately or in conjunction with a qualified health plan, if the plan provides pediatric dental benefits meeting the requirements of § 1302(b)(1)(J) of the Federal Act [42 U.S.C. § 18022].~~

~~(c) Any health plan that delivers a benefit plan on the exchange that covers abortion services, as defined in 45 C.F.R. § 156.280(d)(1), shall comply with segregation of funding requirements, as well as an annual assurance statement to the Office of the Health Insurance Commissioner, in accordance with 45 C.F.R. §§ 156.680(e)(3) and (5).~~

~~(d) At least one plan variation for individual market plan designs offered on the exchange at each level of coverage, as defined by section 1302(d)(1) of the federal act [42 U.S.C. § 18022], at which the carrier is offering a plan or plans, shall exclude coverage for abortion services as defined in 45 C.F.R. § 156.280(d)(1). If the health plan proposes different rates for such plan~~

~~variations, each listed plan design shall include the associated rate. Except for Religious Employers (as defined in Section 6033(a)(3)(A)(i) of the Internal Revenue Code), employers selecting a plan under this religious exemption subsection may not designate it as the single plan for employees, but shall offer their employees full choice of small employer plans on the exchange, using the employer-selected plan as the base plan for coverage. The employer is not responsible for payment that exceeds that designated for the employer-selected plan.~~

~~(e) Health plans that offer a plan variation that excludes coverage for abortion services as defined in 45 C.F.R. § 156.280(d)(l) for a religious exemption variation in the small group market shall treat such a plan as a separate plan offering with a corresponding rate.~~

~~(f) An employer who elects a religious exemption variation shall provide written notice to prospective enrollees prior to enrollment that the plan excludes coverage for abortion services as defined in 45 C.F.R. § 156.280(d)(1). The carrier must include notice that the plan excludes coverage for abortion services as part of the Summary of Benefits and Coverage required by 42 U.S.C. § 300gg-15.~~

~~42-157-4. Financing.~~

~~(a) The department is authorized to assess insurers offering qualified health plans and qualified dental plans. To support the functions of the exchange, insurers offering qualified health plans and qualified dental plans must remit an assessment to the exchange each month, in a timeframe and manner established by the exchange, equal to three and one-half percent (3.5%) of the monthly premium charged by the insurer for each policy under the plan where enrollment is through the exchange. Revenues from the assessment shall be deposited in a restricted receipt account for the sole use of the exchange and shall be exempt from the indirect cost recovery provisions of § 35-4-27.~~

~~(b) The general assembly may appropriate general revenue to support the annual budget for the exchange in lieu of or to supplement revenues raised from the assessment under subsection (a) of this section.~~

~~(c) If the director determines that the level of resources obtained pursuant to subsection (a) will be in excess of the budget for the exchange, the department shall provide a report to the governor, the speaker of the house, and the senate president identifying the surplus and detailing how the assessment established pursuant to subsection (a) may be offset in a future year to reconcile with impacted insurers and how any future supplemental or annual budget submission to the general assembly may be revised accordingly.~~

~~42-157-5. Regional purchasing, efficiencies, and innovation.~~

~~To take advantage of economies of scale and to lower costs, the exchange is hereby~~

~~authorized to pursue opportunities to jointly negotiate, procure or otherwise purchase exchange services with or partner with another state or multiple states and to pursue a Federal Affordable Care Act 1332 Waiver.~~

~~**42-157-5.1. Small business health options program (SHOP) innovation waiver.**~~

~~(a) As small business owners and sole proprietors are the life blood of this state's economy, a recent change in the Federal Affordable Care Act effective on January 1, 2016, has caused irreparable harm to the economic well-being of small business owners and sole proprietors by requiring them to secure health insurance coverage on the individual market as opposed to securing health insurance coverage on the small group market.~~

~~(b) In an effort to reduce and/or eliminate the irreparable economic harm, the director of the department of administration, with assistance from the commissioner of health insurance, shall seek a waiver under Section 1332 of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, for the purpose of allowing businesses classified as self-employed and sole proprietors to purchase insurance in the small group market through the health source RI for employers SHOP program and not be forced into the individual market.~~

~~**42-157-6. Audit.**~~

~~(a) Annually, the exchange shall cause to have a financial and/or performance audit of its functions and operations performed in compliance with the generally accepted governmental auditing standards and conducted by the state office of internal audit or a certified public accounting firm qualified in performance audits.~~

~~(b) If the audit is not directly performed by the state office of internal audit, the selection of the auditor and the scope of the audit shall be subject to the approval of the state office of internal audit.~~

~~(c) The results of the audit shall be made public upon completion, posted on the department's website and otherwise made available for public inspection.~~

~~**42-157-7. Exchange advisory board.**~~

~~The exchange shall maintain an advisory board which shall be appointed by the director. The director shall consider the expertise of the members of the board and make appointments so that the board's composition reflects a range and diversity of skills, backgrounds and stakeholder perspectives.~~

~~**42-157-8. Reporting.**~~

~~HealthSource RI shall provide a monthly report to the chairpersons of the house finance committee and the senate finance committee by the fifteenth day of each month beginning in July~~

~~2015. The report shall include, but not be limited to, the following information: actual enrollment data by market and insurer, total new and renewed customers, number of paid customers, actual average premium costs by market and insurer, number of enrollees receiving financial assistance as defined in the Federal Act, as well as the number of inbound calls and the number of walk-ins received. The data on inbound calls shall be segregated by type of call.~~

~~42-157-9. Relation to other laws.~~

~~Nothing in this chapter, and no action taken by the exchange pursuant to this chapter. shall be construed to preempt or supersede the authority of the health insurance commissioner to regulate the business of insurance within this state, the director of the department of health to oversee the licensure of healthcare providers, the certification of health plans under chapter 17.13 of title 23, or the licensure of utilization review agents wider chapter 17.13 of title 23, or the director of the department of human services to oversee the provision of medical assistance under chapter 8 of title 40. In addition to the provisions of this chapter, all insurers offering qualified health plans or qualified dental plans in this state shall comply fully with all applicable health insurance laws and regulations of this state.~~

~~42-157-10. Severability.~~

~~The provisions of this chapter are severable, and if any provision hereof shall be held invalid in any circumstances, any invalidity shall not affect any other provisions or circumstances. This chapter shall be construed in all respects so as to meet any constitutional requirements. In carrying out the purposes and provisions of this chapter, all steps shall be taken which are necessary to meet constitutional requirements.~~

~~42-157-11. Exemptions from the shared responsibility payment penalty.~~

~~(a) Establishment of program. The exchange shall establish a program for determining whether to grant a certification that an individual is entitled to an exemption from the shared responsibility payment penalty set forth in § 44-30-101(c) by reason of religious conscience or hardship.~~

~~(b) Eligibility determinations. The exchange shall make determinations as to whether to grant a certification described in subsection (a) of this section. The exchange shall notify the individual and the tax administrator for the Rhode Island department of revenue of the determination in a time and manner as the exchange, in consultation with the tax administrator, shall prescribe. In notifying the tax administrator, the exchange shall adhere to the data privacy and data security standards adopted in accordance with 45 C.F.R. 155.260. The exchange shall only be required to notify the tax administrator to the extent that the exchange determines the disclosure is permitted under 45 C.F.R. 155.260.~~

~~(c) Appeals. Any person aggrieved by the exchange's determination of eligibility for an exemption under this section has the right to an appeal in accordance with the procedures contained within chapter 35 of this title.~~

~~42-157-12. Special enrollment period for qualified individuals assessed a shared responsibility payment penalty.~~

~~(a) Definitions. The following definition shall apply for purposes of this section:~~

~~(1) "Special enrollment period" means a period during which a qualified individual who is assessed a penalty in accordance with § 44-30-101 may enroll in a qualified health plan through the exchange outside of the annual open enrollment period.~~

~~(b) In the case of a qualified individual who is assessed a shared responsibility payment in accordance with § 44-30-101 and who is not enrolled in a qualified health plan, the exchange must provide a special enrollment period consistent with this section and the Federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the Federal Care and Reconciliation Act of 2010 (Public Law 111-152), and any amendments to, or regulations or guidance issued under, those acts.~~

~~(c) Effective date. The exchange must ensure that coverage is effective for a qualified individual who is eligible for a special enrollment period under this section on the first day of the month after the qualified individual completes enrollment in a qualified health plan through the exchange.~~

~~(d) Availability and length of special enrollment period. A qualified individual has sixty (60) days from the date he or she is assessed a penalty in accordance with § 44-30-101 to complete enrollment in a qualified health plan through the exchange. The date of assessment shall be determined in accordance with § 44-30-82.~~

~~42-157-13. Outreach to Rhode Island residents and individuals assessed a shared responsibility payment penalty.~~

~~Outreach. The exchange, in consultation with the office of the health insurance commissioner and the division of taxation, is authorized to engage in coordinated outreach efforts to educate Rhode Island residents about the importance of health insurance coverage; their responsibilities to maintain minimum essential coverage as defined in § 44-30-101; the penalties for failure to maintain coverage; and information on the services available through the exchange.~~

~~42-157-14. Regulatory authority.~~

~~The exchange may promulgate regulations as necessary to carry out the purposes of this chapter.~~

SECTION 3. Title 23 of the General Laws entitled "HEALTH AND SAFETY" is hereby

amended by adding thereto the following chapter:

CHAPTER 95

THE RHODE ISLAND COMPREHENSIVE HEALTH INSURANCE PROGRAM

23-95-1. Legislative findings.

(1) Health care is a human right, not a commodity available only to those who can afford it;

(2) Although the federal Affordable Care Act (ACA) allowed states to offer more people taxpayer subsidized private health insurance, the ACA has not provided universal, comprehensive, affordable coverage for all Rhode Islanders:

(i) In 2019, about four and three-tenths percent (4.3%) of Rhode Islanders forty three thousand (43,000), had no health insurance, causing about 43 (1 per 1,000 uninsured) unnecessary deaths each year;

(ii) An estimated forty-five percent (45%) of Rhode Islanders four hundred fifty thousand (450,000) are under-insured (e.g., not seeking health care because of high deductibles and co-pays);

(3) COVID-19 exacerbated and highlighted problems with the status quo health insurance system including:

(i) Coverage is too easily lost when health insurance is tied to jobs - between February and May, 2020, about 21,000 more Rhode Islanders lost their jobs and their health insurance;

(ii) Systemic racism is reinforced - Black and Hispanic/Latinx Rhode Islanders, more likely to be uninsured or underinsured, have suffered the highest rates of COVID-19 mortality and morbidity;

(iii) The fear of out-of-pocket costs for uninsured and underinsured puts everyone at risk because they avoid testing and treatment;

(4) The existing US health insurance system has failed to control the cost of health care and to provide universal access to health care in a system which is widely accepted to waste thirty percent (30%) of its revenues on activities that do not improve the health of Americans;

(5) Every industrialized nation in the world, except the United States, offers universal health care to its citizens and enjoys better health outcomes for less than two thirds (2/3) to one-half (1/2) the cost;

(6) Health care is rationed under our current multi-payer system, despite the fact that Rhode Island patients, businesses and taxpayers already pay enough to have comprehensive and universal health insurance under a single-payer system;

(7) About one-third (1/3) of every "health care" dollar spent in the U.S. is wasted on unnecessary administrative costs and excessive pharmaceutical company profits due to laws

preventing Medicare from negotiating prices and private health insurance companies lacking adequate market share to effectively negotiate prices;

(8) Private health insurance companies are incentivized to let the cost of health care rise because higher costs require health insurance companies to charge higher health insurance premiums, increasing companies' revenue and stock price;

(9) The health care marketplace is not an efficient market and because it represents only eighteen percent (18%) of the US domestic market, significantly restricts economic growth and thus the financial well-being of every American, including every Rhode Islander;

(10) Rhode Islanders cannot afford to keep the current multi-payer health insurance system:

(i) Between 1991 and 2014, health care spending in Rhode Island per person rose by over two hundred fifty percent (250%) rising much faster than income and greatly reducing disposable income;

(ii) It is estimated that by 2025, the cost of health insurance for an average family of four (4) will equal about one-half (1/2) of their annual income;

(iii) In the U.S., about two-thirds (2/3) of personal bankruptcies are medical cost-related and of these, about three-fourths (3/4) had health insurance at the onset of their medical problems; in no other industrialized country do people worry about going bankrupt over medical costs;

(11) Rhode Island private businesses bear most of the costs of employee health insurance coverage and spend significant time and money choosing from a confusing array of increasingly expensive plans which do not provide comprehensive coverage;

(12) Rhode Island employees and retirees lose significant wages and pensions as they are forced to pay higher amounts of health insurance and health care costs;

(13) Rhode Island's hospitals are under increasing financial distress i.e., closing, sold to out-of-state entities, attempting mergers largely due to health insurance reimbursement problems that other nations do not face and are fixed by a single-payer system;

(14) The state and its municipalities face enormous other post-employment benefits (OPEB) unfunded liabilities due mostly to health insurance costs;

(15) An improved Medicare-for-all-style single-payer program would, based on the performance of existing Medicare, eliminate fifty percent (50%) of the administrative waste in the current system of private insurance before other savings achieved through meaningful negotiation of prices and other savings are considered;

(16) The high costs of medical care could be lowered significantly if the state could negotiate on behalf of all its residents for bulk purchasing, as well as gain access to usage and price information currently kept confidential by private health insurers as "proprietary information;"

(17) Single payer health care would establish a true "free market" system where doctors compete for patients rather than health insurance companies dictating which patients are able to see which doctors and setting reimbursement rates;

(18) Health care providers would spend significantly less time with administrative work caused by multiple health insurance company requirements and barriers to care delivery and would spend significantly less for overhead costs because of streamlined billing;

(19) Rhode Island must act because there are currently no effective state or federal laws that can provide universal coverage and adequately control rising premiums, co-pays, deductibles and medical costs, or prevent private insurance companies from continuing to limit available providers and coverage;

(20) In 1962, Canada's successful single-payer program began in the province of Saskatchewan (with approximately the same population as Rhode Island) and became a national program within ten (10) years; and

(21) The proposed Rhode Island single payer program was studied by Professor Gerald Friedman at UMass Amherst in 2015 and he concluded that:

"Single-payer in Rhode Island will finance medical care with substantial savings compared with the existing multi-payer system of public and private insurers and would improve access to health care by extending coverage to the four percent (4%) of Rhode Island residents still without insurance under the Affordable Care Act and expanding coverage for the growing number with inadequate health care coverage. Single-payer would improve the economic health of Rhode Island by: increasing real disposable income for most residents; reducing the burden of health care on businesses and promoting increased employment; and shifting the costs of health care away from working and middle-class residents."

23-95-2. Legislative purpose.

It is the intent of the general assembly that this chapter establish a universal, comprehensive, affordable single-payer health care insurance program that will help control health care costs which shall be referred to as, "the Rhode Island comprehensive health insurance program" (RICHIP). The program will be paid for by consolidating government and private payments to multiple insurance carriers into a more economical and efficient improved Medicare-for-all style single-payer program and substituting lower progressive taxes for higher health insurance premiums, co-pays, deductibles and costs in excess of caps. This program will save Rhode Islanders from the current overly expensive, inefficient and unsustainable multi-payer health insurance system that unnecessarily prevents access to medically necessary health care.

23-95-3. Definitions.

As used in this chapter:

(1) "Affordable Care Act" or "ACA" means the Federal Patient Protection and Affordable Care Act (Pub. L. 111-148), as amended by the Federal Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), and any amendments to, or regulations or guidance issued under, those acts.

(2) "Carrier" means either a private health insurer authorized to sell health insurance in Rhode Island or a health care service plan, i.e., any person who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees, or any person, whether located within or outside of this state, who solicits or contracts with a subscriber or enrollee in this state to pay for or reimburse any part of the cost of, or who undertakes to arrange or arranges for, the provision of health care services that are to be provided wholly or in part in a foreign country in return for a prepaid or periodic charge paid by or on behalf of the subscriber or enrollee.

(3) "Dependent" has the same definition as set forth in Federal tax law (26 U.S.C. § 152).

(4) "Emergency and urgently needed services" has the same definition as set forth in the Federal Medicare law (42 CFR 422.113).

(5) "Federally matched public health program" means the state's Medicaid program under Title XIX of the Federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) and the state's Children's Health Insurance Program (CHIP) under Title XXI of the Federal Social Security Act (42 U.S.C. Sec. 1397aa et seq.).

(6) "For-profit provider" means any health care professional or health care institution that provides payments, profits or dividends to investors or owners who do not directly provide health care.

(7) "Medicaid" or "medical assistance" means a program that is one of the following:

(i) The state's Medicaid program under Title XIX of the Federal Social Security Act (42 U.S.C. Sec. 1396 et seq.); or

(ii) The state's Children's Health Insurance Program under Title XXI of the Federal Social Security Act (42 U.S.C. Sec. 1397aa et seq.).

(8) "Medically necessary" means medical, surgical or other services or goods (including prescription drugs) required for the prevention, diagnosis, cure, or treatment of a health-related condition including any such services that are necessary to prevent a detrimental change in either medical or mental health status. Medically necessary services must be provided in a cost-effective and appropriate setting and must not be provided solely for the convenience of the patient or service

provider. "Medically necessary" does not include services or goods that are primarily for cosmetic purposes; and does not include services or goods that are experimental, unless approved pursuant to § 23-95-6(b).

(9) "Medicare" means Title XVIII of the Federal Social Security Act (42 U.S.C. Sec. 1395 et seq.) and the programs thereunder.

(10) "Qualified health care provider" means any individual who meets requirements set forth in § 24-95-7(a)(1).

(11) "Qualified Rhode Island resident" means any individual who is a "resident" as defined by §§ 44-30-5(a)(1) and (a)(2) or a dependent of that resident.

(12) "RICHIP" or "Rhode Island comprehensive health insurance program" means the affordable, comprehensive and effective health insurance program as set forth in this chapter.

(13) "RICHIP participant" means a qualified Rhode Island resident who is enrolled in RICHIP (and not disenrolled or disqualified) at the time they seek health care.

23-95-4. Rhode Island health insurance program.

(a) Organization. This chapter creates the Rhode Island comprehensive health insurance program (RICHIP), as an independent state government agency.

(b) Director. A director shall be appointed by the governor, with the advice and consent of the senate, to lead RICHIP and serve a term of four (4) years, subject to oversight by an executive board and input from an advisory committee, as set forth below. The director shall be compensated in accordance with the job title and job classification established by the division of human resources and approved by the general assembly. The duties of the director shall include:

(1) Employ staff and authorize reasonable expenditures, as necessary, from the RICHIP trust fund, to pay program expenses and to administer the program, including creation and oversight of RICHIP budgets;

(2) Oversee management of the RICHIP trust fund set forth in § 23-95-12(a) to ensure the operational well-being and fiscal solvency of the program, including ensuring that all available funds from all appropriate sources are collected and placed into the trust fund;

(3) Work with the executive board and an advisory committee of health care professionals and other stakeholders pursuant to §§ 23-95-4(c)(2) and 23-95-4(d)(2) to carry out the provisions of this chapter;

(4) Annually establish a RICHIP benefits package for participants, including a formulary and a list of other medically necessary goods, as well as a procedure for handling complaints and appeals relating to the benefits package, pursuant to § 23-95-6;

(5) Establish RICHIP provider reimbursement and a procedure for handling provider

complaints and appeals as set forth in § 23-95-9;

(6) Implement standardized claims and reporting procedures;

(7) Provide for timely payments to participating providers through a structure that is well organized and that eliminates unnecessary administrative costs, i.e., coordinate with the state comptroller to facilitate billing from and payments to providers using the state's computerized financial system, the Rhode Island financial and accounting network system (RIFANS);

(8) Coordinate with federal health care programs, including Medicare and Medicaid, to obtain necessary waivers and streamline federal funding and reimbursement;

(9) Monitor billing and reimbursements to detect inappropriate behavior by providers and patients and create prohibitions and penalties regarding bad faith or criminal RICHIP participation, and procedures by which they will be enforced;

(10) Support the development of an integrated health care database for health care planning and quality assurance and ensure the legally required confidentiality of all health records it contains;

(11) Determine eligibility for RICHIP and establish procedures for enrollment, disenrollment and disqualification from RICHIP, as well as procedures for handling complaints and appeals from affected individuals, as set forth in § 29-95-5;

(12) Create RICHIP expenditure, status, and assessment reports, including, but not limited to, annual reports with the following:

(i) Performance of the program;

(ii) Fiscal condition of the program;

(iii) Recommendations for statutory changes;

(iv) Receipt of payments from the federal government;

(v) Whether current year goals and priorities were met; and

(vi) Future goals and priorities.

(13) Review RICHIP collections and disbursements on at least a quarterly basis and recommend adjustments needed to achieve budgetary targets and permit adequate access to care;

(14) Review budget proposals from providers pursuant to § 23-95-11(b);

(15) Develop procedures for accommodating:

(i) Employer retiree health benefits for people who have been members of RICHIP but go to live as retirees out of the state;

(ii) Employer retiree health benefits for people who earned or accrued those benefits while residing in the state prior to the implementation of RICHIP and live as retirees out of the state; and

(iii) RICHIP coverage of health care services currently covered under the workers'

compensation system, including whether and how to continue funding for those services under that system and whether and how to incorporate an element of experience rating.

(16) No later than two (2) years after the effective date of this section, develop a proposal, consistent with the principles of this chapter, for provision and funding by the program of long-term care coverage.

(c) Executive board. There shall be an executive board that provides oversight of the RICHIP director.

(1) The members of the executive board shall be as follows:

(i) The governor, or designee;

(ii) The general treasurer, or designee;

(iii) The secretary of the executive office of health and human services, or designee;

(iv) The director of the Rhode Island department of health, or designee; and

(v) The Rhode Island state controller, or designee.

All designees shall have significant experience or familiarity with health insurance policy or finance.

(2) Duties. The executive board shall exercise oversight over the director to ensure that the provisions of this title are properly executed and may remove or replace the director. Meetings shall be convened at least quarterly by the governor. The executive board shall consider recommendations of the advisory committee and ensure the director responds appropriately. All decisions of the executive board shall be made by a majority vote of all members.

(d) Advisory Committee.

(1) Members. The members of the advisory committee shall be as follows:

(i) Three (3) physicians, all of whom shall be board certified in their fields, and two (2) of whom shall be primary care providers, to be appointed by the executive board;

(ii) Three (3) representatives of the community who represent diverse populations (e.g., minorities, etc.), to be appointed by the executive board;

(iii) A professor of economics familiar with health care finance, to be appointed by the executive board;

(iv) The Medicaid director of the Rhode Island executive office of health and human services, or designee;

(v) The behavioral healthcare, developmental disabilities, and hospitals director of the Rhode Island executive office of health and human services, or designee;

(vi) The executive director of the Rhode Island Dental Association, or designee;

(vii) The president of the Rhode Island chapter of Physicians for a National Health

Program, or designee:

(viii) The executive director of the Rhode Island State Nurses Association, or designee;

(ix) The president of the Hospital Association of Rhode Island, or designee;

(x) The dean of the Brown School of Public Health, or designee;

(xi) The president of the Mental Health Association of Rhode Island, or designee;

(xii) The dean of the URI college of pharmacy, or designee;

(xiii) A representative of organized labor, to be appointed by the executive board;

(xiv) A representative of small business, which is a business that employs less than fifty (50) people, to be appointed by the executive board; and

(xv) A representative of large business, which is a business that employs more than fifty (50) people, to be appointed by the executive board.

(2) Duties. The advisory committee shall provide analyses and recommendations to the executive board and director concerning any issues relating to the execution of this chapter, and shall collect general concerns of RICHIP participants and providers. The committee shall prepare a report after each committee meeting summarizing major issues presented and recommendations for their resolution.

(3) Procedures. The committee shall adopt and publish its policies and procedures no later than one hundred eighty (180) days after the first meeting. In addition:

(i) The director shall set the time, place and date for the initial meeting of the committee. The initial meeting shall be scheduled not sooner than thirty (30) days nor later than ninety (90) days after the appointment of the chairperson. Subsequent meetings shall occur as determined by the committee, but not less than four (4) times annually.

(ii) The advisory committee shall elect a chair from among its members. The chairperson may call additional meetings.

(iii) A quorum shall be at least one more than half (1/2) the number of the advisory committee members. Vacancies shall not be counted when calculating the number needed for a quorum.

(iv) Advisory committee members shall not receive a salary, but shall be reimbursed for all necessary expenses incurred in the performance of their duties.

(v) The committee is subject to chapter 46 of title 42 (the "open meetings act");

(vi) A committee member shall be deemed to have abandoned office upon failure to attend at least seventy-five percent (75%) of the committee meetings in one year, without excuse approved by resolution of the committee.

(vii) Decisions at meetings of the committee shall be reached by majority vote of those

present in person and those present by electronic or telephonic means which permit, at a minimum, audio-video communication. Participation in a meeting pursuant to this subsection shall constitute presence at the meeting.

(4) Terms.

(i) The terms of the members shall be four (4) years from the date of appointment or until a successor has been appointed.

(ii) Of the initial members of the advisory committee: One-half (1/2) of the members shall serve initial terms of four (4) years; and one-half (1/2) of the members shall serve initial terms of two (2) years. The executive board will designate which members shall initially serve two (2) year terms.

(iii) After the initial terms, advisory committee members shall serve for a term of four (4) years.

(iv) Each vacancy on the committee shall be filled for the unexpired term by appointment in like manner as in case of expiration of the term of a member of the committee. A vacancy shall be filled by a representative from the same constituent group as the new member's predecessor.

23-95-5. Coverage.

(a) All qualified Rhode Island residents may participate in RICHIP. The director shall establish procedures to determine eligibility, enrollment, disenrollment and disqualification, including criteria and procedures by which RICHIP can:

(1) Identify, automatically enroll, and provide a RICHIP card to qualified Rhode Island residents;

(2) Process applications from individuals seeking to obtain RICHIP coverage for dependents after the implementation date;

(3) Ensure eligible residents are knowledgeable and aware of their rights to health care;

(4) Determine whether an individual should be disenrolled (e.g., for leaving the state);

(5) Determine whether an individual should be disqualified (e.g., for fraudulent receipt of benefits or reimbursements);

(6) Determine appropriate actions that should be taken with respect to individuals who are disenrolled or disqualified (including civil and criminal penalties); and

(7) Permit individuals to request review and appeal decisions to disenroll or disqualify them.

(b) Medicare and Medicaid eligible coverage under RICHIP shall be as follows:

(1) If all necessary federal waivers are obtained, qualified Rhode Island residents eligible for federal Medicare ("Medicare eligible residents") shall continue to pay required fees to the

federal government. RICHIP shall establish procedures to ensure that Medicare eligible residents shall have such amounts deducted from what they owe to RICHIP under § 23-95-12(h). RICHIP shall become the equivalent of qualifying coverage under Medicare part D and Medicare advantage programs, and as such shall be the vendor for coverage to RICHIP participants. RICHIP shall provide Medicare eligible residents benefits equal to those available to all other RICHIP participants and equal to or greater than those available through the federal Medicare program. To streamline the process, RICHIP shall seek to receive federal reimbursements for services and goods to Medicare eligible residents and administer all Medicare funds.

(2) If all necessary federal waivers are obtained, RICHIP shall become the state's sole Medicaid provider. RICHIP shall create procedures to enroll all qualified Rhode Island residents eligible for Medicaid ("Medicaid eligible residents") in the federal Medicaid program to ensure a maximum amount of federal Medicaid funds go to the RICHIP trust fund. RICHIP shall provide benefits to Medicaid eligible residents equal to those available to all other RICHIP participants.

(3) If all necessary federal waivers are not granted from the Medicaid or Medicare programs operated under Title XVIII or XIX of the Social Security Act, the Medicaid or Medicare program for which a waiver is not granted shall act as the primary insurer for those eligible for such coverage, and RICHIP shall serve as the secondary or supplemental plan of health insurance coverage. Until such time as a waiver is granted, the plan shall not pay for services for persons otherwise eligible for the same health care benefits under the Medicaid or Medicare program. The director shall establish procedures for determining amounts owed by Medicare and Medicaid eligible residents for supplemental RICHIP coverage and the extent of such coverage.

(4) The director may require Rhode Island residents to provide information necessary to determine whether the resident is eligible for a federally matched public health program or for Medicare, or any program or benefit under Medicare.

(5) As a condition of eligibility or continued eligibility for health care services under RICHIP, a qualified Rhode Island resident who is eligible for benefits under Medicare shall enroll in Medicare, including Parts A, B, and D.

(c) Veterans. RICHIP shall serve as the secondary or supplemental plan of health insurance coverage for military veterans. The director shall establish procedures for determining amounts owed by military veterans who are qualified residents for such supplemental RICHIP coverage and the extent of such coverage.

(d) This chapter does not create any employment benefit, nor require, prohibit, or limit the providing of any employment benefit.

(e) This chapter does not affect or limit collective action or collective bargaining on the

part of a health care provider with their employer or any other lawful collective action or collective bargaining.

23-95-6. Beneifts.

(a) This chapter shall provide insurance coverage for services and goods (including prescription drugs) deemed medically necessary by a qualified health care provider and that is currently covered under:

(1) The Federal Medicare program (Social Security Act title XVIII) parts A, B and D;

(2) The Federal Medicaid program except that long-term care shall be available only to those who currently qualify for Medicaid coverage;

(3) The state's Children's Health Insurance Program; and

(4) All essential health benefits mandated by the Affordable Care Act as of January 1, 2017, including, services and goods within the following categories:

(i) Primary and preventive care;

(ii) Approved dietary and nutritional therapies;

(iii) Inpatient care;

(iv) Outpatient care;

(v) Emergency and urgently needed care;

(vi) Prescription drugs and medical devices;

(vii) Laboratory and diagnostic services;

(viii) Palliative care;

(ix) Mental health services;

(x) Oral health, including dental services, periodontics, oral surgery, and endodontics;

(xi) Substance abuse treatment services;

(xii) Physical therapy and chiropractic services;

(xiii) Vision care and vision correction;

(xiv) Hearing services, including coverage of hearing aids;

(xv) Podiatric care;

(xvi) Comprehensive family planning, reproductive, maternity, and newborn care; and

(xvii) Short-term rehabilitative services and devices.

(b) Additional coverage. The director shall create a procedure in consultation with the RICHIP advisory committee that may permit additional medically necessary goods and services beyond that provided by federal laws cited herein and within the areas set forth in § 23-95-5, if the coverage is for services and goods deemed medically necessary based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant

medical community, physician specialty society recommendations, and the views of physicians practicing in relevant clinical areas and any other relevant factors. The director shall create procedures for handling complaints and appeals concerning the benefits package.

(c) Restrictions shall not apply. In order for RICHIP participants to be able to receive medically necessary goods and services, this chapter shall override any state law that restricts the provision or use of state funds for any medically necessary goods or services, including those related to family planning and reproductive health care.

(d) Medically necessary goods:

(1) Prescription drug formulary:

(i) In general. The director shall work with the executive office of health and human services (EOHHS) Rhode Island pharmacy & therapeutics committee to establish a prescription drug formulary system, which shall comply with §§ 24-95-6(a)(4)(i) through (a)(4)(xvii) and encourage best-practices in prescribing and discourage the use of ineffective, dangerous, or excessively costly medications when better alternatives are available.

(ii) Promotion of generics. The formulary under this subsection shall promote the use of generic medications to the greatest extent possible.

(iii) Formulary updates and petition rights. The formulary under this subsection shall be updated frequently and the director shall create a procedure for patients and providers to make requests and appeal denials to add new pharmaceuticals or to remove ineffective or dangerous medications from the formulary.

(iv) Use of off-formulary medications. The director shall promulgate rules regarding the use of off-formulary medications which allow for patient access but do not compromise the formulary.

(v) Approved devices and equipment. The director shall work with the executive office of health and human services (EOHHS) Rhode Island pharmacy and therapeutics committee to promulgate a list of medically necessary goods that shall be covered by RICHIP and comply with§§ 24-95-6(a)(4)(i) through (a)(4)(xvii).

(vi) Bulk purchasing. The director shall seek and implement ways to obtain goods at the lowest possible cost, including bulk purchasing agreements.

23-95-7. Providers.

(a) Rhode Island providers.

(1) Licensing. Participating providers must meet state licensing requirements in order to participate in RICHIP. No provider whose license is under suspension or has been revoked may participate in the program.

(2) Participation. All providers may participate in RICHIP by providing items on the RICHIP benefits list for which they are licensed. Providers may elect either to participate fully, or not at all, in the program.

(3) For-profit providers. For-profit providers may continue to offer services and goods in Rhode Island, but are prohibited from charging patients more than RICHIP reimbursement rates for covered services and goods and must notify qualified Rhode Island residents when the services and goods they offer will not be reimbursed fully under RICHIP.

(b) Out-of-state providers. Except for emergency and urgently needed service, as set forth in § 23-95-7(d), RICHIP shall not pay for health care services obtained outside of Rhode Island unless the following requirements are met:

(1) The patient secures a written referral from a qualified Rhode Island physician prior to seeking such services; and

(2) The referring physician determines that the services are not available in the state or cannot be performed within the state at the level of expertise that would provide medically necessary care.

(c) Out-of-state provider reimbursement. The program shall pay out-of-state health care providers an amount not to exceed RICHIP rates as set forth in § 23-95-9(a). RICHIP participants are responsible for paying out-of-state providers for costs in excess of RICHIP reimbursements. The RICHIP participant is responsible for paying all costs of out-of-state services that fail to meet the requirements of §§ 23-95-7(b)(1) and (b)(2).

(d) Out-of-state emergency provider reimbursement. The program shall pay for emergency and urgently needed services and goods that are obtained by the RICHIP participant anywhere outside of Rhode Island to the same extent allowed if such services or goods were provided in Rhode Island in accordance with § 23-95-9. RICHIP participants are responsible for paying out-of-state emergency providers for costs in excess of RICHIP reimbursements.

(e) Out-of-state residents.

(1) In general. Rhode Island providers who provide any services to individuals who are not RICHIP participants shall not be reimbursed by RICHIP and must seek reimbursement from those individuals or other sources.

(2) Emergency care exception. Nothing in this chapter shall prevent any individual from receiving or any provider from providing emergency health care services and goods in Rhode Island. The director shall adopt rules to provide reimbursement; however, the rules shall reasonably limit reimbursement to protect the fiscal integrity of RICHIP. The director shall implement procedures to secure reimbursement from any appropriate third-party funding source or from the

individual to whom the emergency services were rendered.

23-95-8. Cross border employees.

(a) State residents employed out-of-state. If an individual is employed out-of-state by an employer that is subject to Rhode Island state law, the employer and employee shall be required to pay the payroll taxes as to that employee as if the employment were in the state. If an individual is employed out-of-state by an employer that is not subject to Rhode Island state law, the employee health coverage provided by the out-of-state employer to a resident working out-of-state shall serve as the employee's primary plan of health coverage, and RICHIP shall serve as the employee's secondary plan of health coverage. The director shall establish procedures for determining amounts owed by residents employed out-of-state for such supplemental secondary RICHIP coverage and the extent of such coverage.

(b) Out-of-state residents employed in the state. The payroll tax set forth in § 23-95-12(i) shall apply to any out-of-state resident who is employed or self-employed in the state. However, such out-of-state residents shall be able to take a credit for amounts they spend on health benefits for themselves that would otherwise be covered by RICHIP if the individual were a RICHIP participant. The out-of-state resident's employer shall be able to take a credit against such payroll taxes regardless of the form of the health benefit (e.g., health insurance, a self-insured plan, direct services, or reimbursement for services), to ensure that the revenue proposal does not relate to employment benefits in violation of the Federal Employee Retirement Income Security Act ("ERISA") law. For non-employment-based spending by individuals, the credit shall be available for and limited to spending for health coverage (not out-of-pocket health spending). The credit shall be available without regard to how little is spent or how sparse the benefit. The credit may only be taken against the payroll taxes set forth in § 23-95-12(i). Any excess amount may not be applied to other tax liability. For employment-based health benefits, the credit shall be distributed between the employer and employee in the same proportion as the spending by each for the benefit. The employer and employee may each apply their respective portion of the credit to their respective portion of the payroll taxes set forth in § 23-95-12(i). If any provision of this clause or any application of it shall be ruled to violate ERISA, the provision or the application of it shall be null and void and the ruling shall not affect any other provision or application of this section or this chapter.

23-95-9. Provider reimbursement.

(a) Rates for services. RICHIP reimbursements to providers shall match the highest reimbursement rates offered by Medicare or Medicaid to Rhode Island qualified residents that are in effect at the time services and goods are provided. If the director determines that there are no

such federal reimbursement rates or that such rates are significantly different from those in neighboring states, the director shall set additional or alternative rates in consultation with the RICHIP advisory committee such that rates of reimbursement are fair and reasonable. The director in consultation with the RICHIP advisory committee shall review the rates at least annually and shall establish procedures by which complaints about reimbursement rates may be reviewed and appealed.

(b) Rates for goods. The prices to be paid to providers for medically necessary goods (e.g., prescription drugs, approved devices and equipment) shall be established annually by the director in consultation with the advisory committee.

(c) Billing and payments. Providers shall submit billing for services to RICHIP participants in the form of electronic invoices entered into RIFANS, the state's computerized financial system. The director shall coordinate the manner of processing and payment with the office of accounts and control and the RIFANS support team within the division of information technology. Payments shall be made by check or electronic funds transfer in accordance with terms and procedures coordinated by the director and the office of accounts and control and consistent with the fiduciary management of the RICHIP trust fund.

(d) Provider restrictions. Providers who accept any payment from RICHIP may not bill any patient for any covered benefit. Providers cannot use any of their operating budgets for expansion, profit, excessive executive income, marketing, or major capital purchases or leases.

23-95-10. Private insurance companies.

(a) Non-duplication. It is unlawful for a private health insurer to sell health insurance coverage to qualified Rhode Island residents that duplicates the benefits provided under this chapter. Nothing in this chapter shall be construed as prohibiting the sale of health insurance coverage for any additional benefits not covered by this chapter, including additional benefits that an employer may provide to employees or their dependents, or to former employees or their dependents (e.g., multiemployer plans can continue to provide wrap-around coverage for any benefits not provided by RICHIP).

(b) Displaced employees. Re-education and job placement of persons employed in Rhode Island-located enterprises who have lost their jobs as a result of this chapter shall be managed by the Rhode Island department of labor and training or an appropriate federal retraining program.

The director may provide funds from RICHIP or funds otherwise appropriated for this purpose for retraining and assisting job transition for individuals employed or previously employed in the fields of health insurance, health care service plans, and other third-party payments for health care or those individuals providing services to health care providers to deal with third-party payers

for health care, whose jobs may be or have been ended as a result of the implementation of the program, consistent with applicable laws.

23-95-11. Budgeting.

(a) Operating budget. Annually, the director shall create an operating budget for the program that includes the costs for all benefits set forth in § 23-95-5 and the costs for RICHIP administration. The director shall determine appropriate reimbursement rates for benefits pursuant to § 23-95-9(a). The operating budget shall be reviewed by the advisory committee and approved by the executive board prior to submission to the governor and general assembly.

(b) Capital expenditures. The director shall work with the advisory committee, representatives from state entities involved with provider capital expenditures (e.g., the Rhode Island department of administration office of capital projects, the Rhode Island Health and Educational Building Corporation, etc.), and providers to help ensure that capital expenditures proposed by providers, including amounts to be spent on construction and renovation of health facilities and major equipment purchases, will address health care needs of RICHIP participants. To the extent that providers are seeking to use RICHIP funds for capital expenditures, the director shall have the authority to approve or deny such expenditures.

(c) Prohibition against co-mingling operations and capital improvement funds. It is prohibited to use funds under this chapter that are earmarked:

(1) For operations for capital expenditures; or

(2) For capital expenditures for operations.

23-95-12. Financing.

(a) RICHIP trust fund. There shall be established a RICHIP trust fund into which funds collected pursuant to this chapter are deposited and from which funds are distributed. All money collected and received shall be used exclusively to finance RICHIP. The governor or general assembly may provide funds to the RICHIP trust fund, but may not remove or borrow funds from the RICHIP trust fund.

(b) Revenue proposal. After consulting with the RICHIP advisory committee and gaining approval of the RICHIP executive board, the director shall submit to the governor and the general assembly a revenue plan and, if required, legislation (referred to collectively in this section as the "revenue proposal") to provide the revenue necessary to finance RICHIP. The initial revenue proposal shall be submitted for the fiscal year commencing the year after this this chapter is enacted and annually, thereafter. The basic structure of the initial revenue proposal will be based on a consideration of:

(1) Anticipated savings from a single payer program;

(2) Government funds available for health care;

(3) Private funds available for health care; and

(4) Replacing current regressive health insurance payments made to multiple health insurance carriers with progressive contributions to a single payer (RICHIP) in order to make health care insurance affordable and remove unnecessary barriers to health care access.

Subsequent proposals shall adjust the RICHIP contributions, based on projections from the total RICHIP costs in the previous year, and shall include a five (5) year plan for adjusting RICHIP contributions to best meet the goals set forth in this section and § 23-95-2.

(c) Anticipated savings. It is anticipated that RICHIP will lower health care costs by:

(1) Eliminating payments to private health insurance carriers;

(2) Reducing paperwork and administrative expenses for both providers and payers created by the marketing, sales, eligibility checks, network contract management, issues associated multiple benefit packages, and other administrative waste associated with the current multi-payer private health insurance system;

(3) Allowing the planning and delivery of a public health strategy for the entire population of Rhode Island;

(4) Improving access to preventive health care; and

(5) Negotiating on behalf of the state for bulk purchasing of medical supplies and pharmaceuticals.

(d) Federal funds. The director shall seek and obtain waivers and other approvals relating to Medicaid, the Children's Health Insurance Program, Medicare, the ACA, and any other relevant federal programs so that:

(1) Federal funds and other subsidies for health care that would otherwise be paid to the state and its residents and health care providers, would be paid by the federal government to the state and deposited into the RICHIP trust fund;

(2) Programs would be waived and such funding from federal programs in Rhode Island would be replaced or merged into RICHIP so it can operate as a single payer program;

(3) Maximum federal funding for health care is sought even if any necessary waivers or approvals are not obtained and multiple sources of funding with RICHIP trust fund monies are pooled, so that RICHIP can act as much as possible like a single payer program to maximize benefits to Rhode Islanders; and

(4) Federal financial participation in the programs that are incorporated into RICHIP are not jeopardized.

(e) State funds. State funds that would otherwise be appropriated to any governmental

agency, office, program, instrumentality, or institution for services and benefits covered under RICHIP shall be directed into the RICHIP trust fund. Payments to the fund pursuant to this section shall be in an amount equal to the money appropriated for those purposes in the fiscal year beginning immediately preceding the effective date of this chapter.

(f) Private funds. Private grants (e.g., from nonprofit corporations) and other funds specifically ear-marked for health care (e.g., from litigation against tobacco companies, opioid manufacturers, etc.), shall also be put into the RICHIP trust fund.

(g) Assignments from RICHIP participants. Receipt of health care services under the plan shall be deemed an assignment by the RICHIP participant of any right to payment for services from a policy of insurance, a health benefit plan or other source. The other source of health care benefits shall pay to the fund all amounts it is obligated to pay to, or on behalf of, the RICHIP participant for covered health care services. The director may commence any action necessary to recover the amounts due.

(h) Replacing current health insurance payments with progressive contributions. Instead of making health insurance payments to multiple carriers (i.e., for premiums, co-pays, deductibles, and costs in excess of caps) for limited coverage, individuals and entities subject to Rhode Island taxation pursuant to § 44-30-1 shall pay progressive contributions to the RICHIP trust fund (referred to collectively in this section as the "RICHIP contributions") for comprehensive coverage. These RICHIP contributions shall be set and adjusted over time to an appropriate level to:

(1) Cover the actual cost of the program;

(2) Ensure that higher brackets of income subject to specified taxes shall be assessed at a higher marginal rate than lower brackets; and

(3) Protect the economic welfare of small businesses, low-income earners and working families through tax credits or exemptions.

(i) Contributions based on earned income. The amounts currently paid by employers and employees for health insurance shall initially be replaced by a ten percent (10%) payroll tax, based on the projected average payroll of employees over three (3) previous calendar years. The employer shall pay eighty percent (80%) and the employee shall pay twenty percent (20%) of this payroll tax, except that an employer may agree to pay all or part of the employee's share. Self- employed individuals shall initially pay one-hundred percent (100%) of the payroll tax. The ten percent (10%) initial rate will be adjusted by the director so that higher brackets of income subject to these taxes shall be assessed at a higher marginal rate than lower brackets and so that small businesses and lower income earners receive a credit or exemption.

(j) Contributions based on unearned income. There shall be a progressive contribution

based on unearned income, i.e., capital gains, dividends, interest, profits, and rents. Initially, the unearned income RICHIP contributions shall be equal to ten percent (10%) of such unearned income. The ten percent (10%) initial rate may be adjusted by the director to allow for a graduated progressive exemption or credit for individuals with lower unearned income levels.

23-95-13. Implementation.

(a) State laws and regulations.

(1) In general. The director shall work with the executive board and receive such assistance as may be necessary from other state agencies and entities to examine state laws and regulations and to make recommendations necessary to conform such laws and regulations to properly implement the RICHIP program. The director shall report recommendations to the governor and the general assembly.

(2) Anti-trust laws. The intent of this chapter is to exempt activities provided for under this chapter from state antitrust laws and to provide immunity from federal antitrust laws through the state action doctrine.

(b) The director shall complete an implementation plan to provide health care coverage for qualified residents in accordance with this chapter within six (6) months of the effective date.

(c) Severability. If any provision or application of this chapter shall be held to be invalid, or to violate or be inconsistent with any applicable federal law or regulation, that shall not affect other provisions or applications of this chapter which can be given effect without that provision or application; and to that end, the provisions and applications of this chapter are severable.

SECTION 4. This act shall take effect upon passage.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N A C T

RELATING TO HEALTH AND SAFETY -- COMPREHENSIVE HEALTH INSURANCE PROGRAM

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This act would repeal the "Rhode Island Health Care Reform Act of 2004 – Health Insurance Oversight" as well as the "Rhode Island Health Benefit Exchange." This act would also establish a universal, comprehensive, affordable single-payer health care insurance program and help control health care costs, which would be referred to as, "the Rhode Island Comprehensive Health Insurance Program" (RICHIP). The program would be paid for by consolidating government and private payments to multiple insurance carriers into a more economical and efficient improved Medicare-for-all style single-payer program and substituting lower progressive taxes for higher health insurance premiums, co-pays, deductibles and costs due to caps. This program will save Rhode Islanders from the current overly expensive, inefficient and unsustainable multi- payer health insurance system that unnecessarily prevents access to medically necessary health care.

This act would take effect upon passage.

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