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STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2022

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 DiMario, Miller, Euer, Lawson, Valverde, Zurier, Murray, and Burke

Date Introduced: January 25, 2022

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

1 SECTION 1. Section 42-14.5-3 of the General Laws in Chapter 42-14.5 entitled "The  
2 Rhode Island Health Care Reform Act of 2004 - Health Insurance Oversight" is hereby amended  
3 to read as follows:

4 **42-14.5-3. Powers and duties.**

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

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

15 (b) To make recommendations to the governor and the house of representatives and senate  
16 finance committees regarding healthcare insurance and the regulations, rates, services,  
17 administrative expenses, reserve requirements, and operations of insurers providing health  
18 insurance in the state, and to prepare or comment on, upon the request of the governor or

1 chairpersons of the house or senate finance committees, draft legislation to improve the regulation  
2 of health insurance. In making the recommendations, the commissioner shall recognize that it is  
3 the intent of the legislature that the maximum disclosure be provided regarding the reasonableness  
4 of individual administrative expenditures as well as total administrative costs. The commissioner  
5 shall make recommendations on the levels of reserves, including consideration of: targeted reserve  
6 levels; trends in the increase or decrease of reserve levels; and insurer plans for distributing excess  
7 reserves.

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

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

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

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

- 1 (3) The uniform health plan claim form utilized by participating providers;
- 2 (4) Methods for health maintenance organizations, as defined by § 27-41-2, and nonprofit  
3 hospital or medical-service corporations, as defined by chapters 19 and 20 of title 27, to make  
4 facility-specific data and other medical service-specific data available in reasonably consistent  
5 formats to patients regarding quality and costs. This information would help consumers make  
6 informed choices regarding the facilities and clinicians or physician practices at which to seek care.  
7 Among the items considered would be the unique health services and other public goods provided  
8 by facilities and clinicians or physician practices in establishing the most appropriate cost  
9 comparisons;
- 10 (5) All activities related to contractual disclosure to participating providers of the  
11 mechanisms for resolving health plan/provider disputes;
- 12 (6) The uniform process being utilized for confirming, in real time, patient insurance  
13 enrollment status, benefits coverage, including co-pays and deductibles;
- 14 (7) Information related to temporary credentialing of providers seeking to participate in the  
15 plan's network and the impact of the activity on health plan accreditation;
- 16 (8) The feasibility of regular contract renegotiations between plans and the providers in  
17 their networks; and
- 18 (9) Efforts conducted related to reviewing impact of silent PPOs on physician practices.
- 19 (e) To enforce the provisions of Title 27 and Title 42 as set forth in § 42-14-5(d).
- 20 (f) To provide analysis of the Rhode Island affordable health plan reinsurance fund. The  
21 fund shall be used to effectuate the provisions of §§ 27-18.5-9 and 27-50-17.
- 22 (g) To analyze the impact of changing the rating guidelines and/or merging the individual  
23 health insurance market, as defined in chapter 18.5 of title 27, and the small-employer health  
24 insurance market, as defined in chapter 50 of title 27, in accordance with the following:
- 25 (1) The analysis shall forecast the likely rate increases required to effect the changes  
26 recommended pursuant to the preceding subsection (g) in the direct-pay market and small-employer  
27 health insurance market over the next five (5) years, based on the current rating structure and  
28 current products.
- 29 (2) The analysis shall include examining the impact of merging the individual and small-  
30 employer markets on premiums charged to individuals and small-employer groups.
- 31 (3) The analysis shall include examining the impact on rates in each of the individual and  
32 small-employer health insurance markets and the number of insureds in the context of possible  
33 changes to the rating guidelines used for small-employer groups, including: community rating  
34 principles; expanding small-employer rate bonds beyond the current range; increasing the employer

1 group size in the small-group market; and/or adding rating factors for broker and/or tobacco use.

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

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

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

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

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

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

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

34 (i) Include standards for eligibility inquiry and response and, wherever possible, be

1 consistent with the standards adopted by nationally recognized organizations, such as the Centers  
2 for Medicare and Medicaid Services;

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

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

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

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

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

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

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

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

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

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

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

34 (vii) Nothing in this subsection shall be construed to modify the rights or obligations of

1 payors or providers with respect to procedures relating to the investigation, reporting, appeal, or  
2 prosecution under applicable law of potentially fraudulent billing activities.

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

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

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

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

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

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

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

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

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

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

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

11 (1) The impact of the current, mandated healthcare benefits as defined in §§ 27-18-48.1,  
12 27-18-60, 27-18-62, 27-18-64, similar provisions in chapters 19, 20 and 41 of title 27, and §§ 27-  
13 18-3(c), 27-38.2-1 et seq., or others as determined by the commissioner, on the cost of health  
14 insurance for fully insured employers, subject to available resources;

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

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

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

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

26 (1) Utilization review;

27 (2) Contracting; and

28 (3) Licensing and regulation.

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

33 (p) To work to ensure the health insurance coverage of behavioral health care under the  
34 same terms and conditions as other health care, and to integrate behavioral health parity

1 requirements into the office of the health insurance commissioner insurance oversight and health  
2 care transformation efforts.

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

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

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

11 (t) On or before January 1, 2023, the office of the health insurance commissioner shall  
12 adopt a uniform set of medical criteria for prior authorization and create and disseminate a  
13 standardized electronic or written prior authorization form that shall be used by a health insurer  
14 whenever prior authorization is required by the health insurer.

15 SECTION 2. This act shall take effect upon passage.

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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

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- 1           This act would require the health insurance commissioner to adopt a uniform set of medical
- 2 criteria for prior authorization and create a required form to be used by a health insurer.
- 3           This act would take effect upon passage.

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