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LC01835/SUB A/3
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STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2012

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A N A C T

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

Introduced By: Representatives Marcello, O'Neill, and Hearn

Date Introduced: February 28, 2012

Referred To: House Corporations

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. [Contingent effective date; see effective dates under**
5 **this section.] --** 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 section 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 such
10 insurers operate and efforts to bring new health insurers into the Rhode Island market. Notice of
11 not less than ten (10) days of said hearing(s) shall go to the general assembly, the governor, the
12 Rhode Island Medical Society, the Hospital Association of Rhode Island, the director of health,
13 the attorney general and the chambers of commerce. Public notice shall be posted on the
14 department's web site and given in the newspaper of general circulation, and to any entity in
15 writing requesting notice.

16 (b) To make recommendations to the governor and the house of representatives and
17 senate finance committees regarding health care insurance and the regulations, rates, services,
18 administrative expenses, reserve requirements, and operations of insurers providing health

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

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

27 (d) To establish and provide guidance and assistance to a subcommittee ("The
28 Professional Provider-Health Plan Work Group") of the advisory council created pursuant to
29 subsection (c) above, composed of health care providers and Rhode Island licensed health plans.
30 This subcommittee shall include in its annual report and presentation before the house and senate
31 finance committees the following information:

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

34 (ii) A standardized provider application and credentials verification process, for the

1 purpose of verifying professional qualifications of participating health care providers;

2 (iii) The uniform health plan claim form utilized by participating providers;

3 (iv) Methods for health maintenance organizations as defined by section 27-41-1, and
4 nonprofit hospital or medical service corporations as defined by chapters 27-19 and 27-20, to
5 make facility-specific data and other medical service-specific data available in reasonably
6 consistent formats to patients regarding quality and costs. This information would help consumers
7 make informed choices regarding the facilities and/or clinicians or physician practices at which to
8 seek care. Among the items considered would be the unique health services and other public
9 goods provided by facilities and/or clinicians or physician practices in establishing the most
10 appropriate cost comparisons.

11 (v) All activities related to contractual disclosure to participating providers of the
12 mechanisms for resolving health plan/provider disputes; and

13 (vi) The uniform process being utilized for confirming in real time patient insurance
14 enrollment status, benefits coverage, including co-pays and deductibles.

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

17 (viii) The feasibility of regular contract renegotiations between plans and the providers
18 in their networks.

19 (ix) Efforts conducted related to reviewing impact of silent PPOs on physician practices.

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

21 (f) To provide analysis of the Rhode Island Affordable Health Plan Reinsurance Fund.
22 The fund shall be used to effectuate the provisions of sections 27-18.5-8 and 27-50-17.

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

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

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

32 (iii) The analysis shall include examining the impact on rates in each of the individual
33 and small employer health insurance markets and the number of insureds in the context of
34 possible changes to the rating guidelines used for small employer groups, including: community

1 rating principles; expanding small employer rate bonds beyond the current range; increasing the
2 employer group size in the small group market; and/or adding rating factors for broker and/or
3 tobacco use.

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

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

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

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

22 (viii) The task force shall meet as necessary and include their findings in the annual
23 report and the commissioner shall include the information in the annual presentation before the
24 house and senate finance committees.

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

1 (1) Establishing a consistent standard for electronic eligibility and coverage verification.
2 Such standard shall:
3 (i) Include standards for eligibility inquiry and response and, wherever possible, be
4 consistent with the standards adopted by nationally recognized organizations, such as the centers
5 for Medicare and Medicaid services;
6 (ii) Enable providers and payors to exchange eligibility requests and responses on a
7 system-to-system basis or using a payor supported web browser;
8 (iii) Provide reasonably detailed information on a consumer's eligibility for health care
9 coverage, scope of benefits, limitations and exclusions provided under that coverage, cost-sharing
10 requirements for specific services at the specific time of the inquiry, current deductible amounts,
11 accumulated or limited benefits, out-of-pocket maximums, any maximum policy amounts, and
12 other information required for the provider to collect the patient's portion of the bill;
13 (iv) Reflect the necessary limitations imposed on payors by the originator of the
14 eligibility and benefits information;
15 (v) Recommend a standard or common process to protect all providers from the costs of
16 services to patients who are ineligible for insurance coverage in circumstances where a payor
17 provides eligibility verification based on best information available to the payor at the date of the
18 request of eligibility.
19 (2) Developing implementation guidelines and promoting adoption of such guidelines
20 for:
21 (i) The use of the national correct coding initiative code edit policy by payors and
22 providers in the state;
23 (ii) Publishing any variations from codes and mutually exclusive codes by payors in a
24 manner that makes for simple retrieval and implementation by providers;
25 (iii) Use of health insurance portability and accountability act standard group codes,
26 reason codes, and remark codes by payors in electronic remittances sent to providers;
27 (iv) The processing of corrections to claims by providers and payors.
28 (v) A standard payor denial review process for providers when they request a
29 reconsideration of a denial of a claim that results from differences in clinical edits where no
30 single, common standards body or process exists and multiple conflicting sources are in use by
31 payors and providers.
32 (vi) Nothing in this section or in the guidelines developed shall inhibit an individual
33 payor's ability to employ, and not disclose to providers, temporary code edits for the purpose of
34 detecting and deterring fraudulent billing activities. The guidelines shall require that each payor

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

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

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

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

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

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

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

24 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 - HEALTH CARE REFORM ACT
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1 This act would establish and facilitate a workgroup representing health care providers and
2 health insurers for the purpose of coordinating the development of processes, guidelines, and
3 standards to streamline health care administration that are to be adopted by payors and providers
4 of health care services operating in the state.

5 This act would take effect upon passage.

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