

2012 -- H 7790

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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 INSURANCE
OVERSIGHT

Introduced By: Representative Arthur Handy

Date Introduced: February 28, 2012

Referred To: House Corporations

It is enacted by the General Assembly as follows:

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

2 (1) Reducing readmissions, preventing hospital acquired conditions, placing greater
3 emphasis on primary and preventative care, and other improvements, are critical to reducing costs
4 and improving healthcare quality;

5 (2) That the fee-for-service (FFS) model is a payment mechanism wherein a provider is
6 paid for each individual service rendered to a patient;

7 (3) That under the fee-for-service reimbursement model, efforts such as reducing
8 readmissions, preventing hospital acquired conditions, and placing greater emphasis on primary
9 and preventative care can result in reduced revenue to hospitals;

10 (4) That insurers and hospitals are beginning to implement new payment methodologies
11 that better align financial incentives with improved safety, care, and quality;

12 (5) That the 2011 special senate commission to study cost containment, efficiency, and
13 transparency in the delivery of quality patient care and access by hospitals testimony
14 recommended expediting the full transition away from fee-for-service payment methodologies by
15 2014; and

16 (6) That monitoring the market transition away from fee-for-service models and reporting
17 this information to the general assembly is critical to ensuring this transition is taking place and
18 informing any measures the general assembly may elect to consider to further encourage and

1 [accelerate this transition.](#)

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

5 **42-14.5-3. Powers and duties. [Contingent effective date; see effective dates under**
6 **this section.] --** The health insurance commissioner shall have the following powers and duties:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 general public.

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

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

10 (h)(i) To monitor a transition away from fee-for-service and toward global and other
11 alternative payment methodologies for the payment of healthcare, and to promote access to
12 affordable health insurance, the health insurance commissioner shall:

13 (A) Annually collect from each health insurer operating in the State of Rhode Island
14 information regarding the number and percentage of their hospital contracts that continue to use
15 fee-for-service payment methodologies and the number and percentage of their hospital contracts
16 that use alternative payment methodologies.

17 (B) Annually collect from each health insurer operating in the State of Rhode Island de-
18 identified information regarding the types of alternative payment methodologies implemented
19 with hospitals.

20 (C) By March 31, 2013 and the same date each subsequent year, submit a report to the
21 general assembly detailing:

22 (I) The extent that fee-for-service payment methodologies are being phased out;

23 (II) The number, percentage, and types of alternative methodologies that have been
24 adopted; and

25 (III) Any improvements towards administrative simplification in hospital and insurer
26 payment transactions that can be attributed to the adoption of alternative payment methodologies.

27 (D) Notwithstanding any other provision of this subsection, the commissioner shall
28 encourage and assist providers with the voluntary adoption of alternative payment methodologies
29 as much as practicable relative to funding and resources available to the office under this chapter.

30 SECTION 3. This act shall take effect upon passage.

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EXPLANATION
BY THE LEGISLATIVE COUNCIL
OF

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1 This act would require the health insurance commissioner monitor a transition away from
2 fee-for-service and toward global and other alternative payment methodologies for the payment
3 of healthcare.

4 This act would take effect upon passage.

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