2014 -- H 8042

========
LC005388
========

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. 2014

A N A C T

RELATING TO INSURANCE - INSURANCE COVERAGE FOR MENTAL ILLNESS AND SUBSTANCE USE DISORDERS

Introduced By: Representatives Serpa, Tomasso, Fellela, Ferri, and Silva

Date Introduced: April 10, 2014

Referred To: House Corporations

It is enacted by the General Assembly as follows:

SECTION 1. Section 27-38.2-1 of the General Laws in Chapter 27-38.2 entitled "Insurance Coverage for Mental Illness and Substance Abuse" is hereby amended to read as follows:

27-38.2-1. Mental illness coverage. -- Mental illness and substance abuse coverage. -- (a) Every health care insurer that delivers or issues for delivery or renews in this state a contract, plan, or policy except contracts providing supplemental coverage to Medicare or other governmental programs, shall provide coverage for the medical treatment of mental illness and substance abuse under the same terms and conditions as that coverage is provided for other illnesses and diseases. Insurance coverage offered pursuant to this statute must include the same durational limits, amount limits, deductibles, and co-insurance factors for mental illness as for other illnesses and diseases.

(b) In addition to the requirements of subsection (a), every healthcare insurer that delivers or issues for delivery or renews in this state a contract, plan, or policy, except contracts providing supplemental coverage to Medicare or other governmental programs, shall also provide prescription drug coverage for:

(1) Anti-opioid and anti-opiate drugs, including, but not limited to, narcan and other forms of naloxone for use of intervention in opioid overdoses;

(2) Drugs used for the treatment of substance use disorders, including, but not limited to,

methadone, suboxone, naltrexone, and buprenorphine; and

(3) Provided, the prescription drug coverage pursuant to subsection (b) of this section shall be under the same terms and conditions as that coverage is provided for other illnesses and diseases. Insurance coverage offered pursuant to subsection (b) of this section must include the same durational limits, amount limits, deductibles, and co-insurance factors for mental illness as for other illnesses and diseases.

SECTION 2. Sections 23-17.26-2 and 23-17.26-3 of the General Laws in Chapter 23-17.26 entitled "Comprehensive Discharge Planning" are hereby amended to read as follows:

23-17.26-2. Definitions. -- As used in this chapter:

(1) "Director" means the director of department of health.

(2) "Department" means the department of health.

(3) "Hospital" means a person or governmental entity licensed in accordance with chapter 17 of this title to establish, maintain and operate a hospital.

(4) "Health care clinic" means a health care facility licensed in accordance with chapter 17 of this title and which primarily delivers ambulatory care on an out-patient basis.

(5) "Urgent care center" means a health care facility licensed in accordance with chapter 17 of this title that primarily provides emergent health care services and urgent health care services as defined in § 23-17.12-2.

(6) "Emergency room diversion facility" means a health care facility approved by the Rhode Island department of behavioral healthcare, developmental disabilities and hospitals to act as an immediate alternative to a hospital or emergency room, and which concentrates on treating non-urgent substance use disorders that can be appropriately treated in alternative settings.

23-17.26-3. Comprehensive discharge planning. -- (a) On or before July 1, 2015, each hospital, health care clinic, and urgent care center and emergency room diversion facility, sometimes collectively referred to herein as the "health care facility," operating in the State of Rhode Island shall submit to the director:

(1) Evidence of participation in a high-quality comprehensive discharge planning and transitions improvement project operated by a nonprofit organization in this state; or

(2) A plan for the provision of comprehensive discharge planning and information to be shared with patients transitioning from the hospitals care. Such plan shall contain the adoption of evidence-based practices including, but not limited to:

(i) Providing in-hospital education prior to discharge;

(ii) Ensuring patient involvement such that, at discharge, patients, and caregivers understand the patient's conditions and medications and have a point of contact for follow-up

questions;

(iii) Attempting to identify patients' primary care providers and assisting with scheduling post-hospital follow-up appointments prior to patient discharge;

(iv) Expanding the transmission of the department of health's continuity of care form, or successor program, to include primary care providers' receipt of information at patient discharge when the primary care provider is identified by the patient; and

(v) Coordinating and improving communication with outpatient providers.

(3) Until March 1, 2018, such discharge plan and transition process shall also be made for patients with opioid and other substance use disorders, which plan and transition process shall include all the elements contained in subsections (a)(1) or (a)(2) of this section as applicable. In addition, such discharge plan and transition process shall also include:

(i) A requirement that there be a follow-up contact made with the patient within thirty (30) days post-discharge from the health care facility to assess the patient's progress;

(ii) A requirement that at least one follow-up appointment be scheduled for the patient within seven (7) days of discharge, either at the same health care facility, or at another appropriate facility. Said appointment shall be scheduled and the patient shall be informed of the appointment prior to the patient being discharged from the hospital; and

(iii) A requirement that the patient receive information about the real-time availability of in-patient and out-patient services.

(4) On or before January 1, 2015, the director of the department of health shall develop and disseminate to all hospitals, health care clinics, urgent care centers, and emergency room diversion facilities a model discharge plan and transition process for patients with opioid and other substance use disorders. This model plan may be used as a guide, but may be amended and modified to meet the specific needs of each hospital, health care clinic, urgent care center and emergency room diversion facility.

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

42-14.5-3. Powers and duties [Contingent effective date; see effective dates under this section.] -- 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 section 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 such

insurers operate and efforts to bring new health insurers into the Rhode Island market. Notice of not less than ten (10) days of said 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 web site 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 health care 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 such 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) above. 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 their 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) above, composed of health care 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 health care providers;

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

(4) Methods for health maintenance organizations as defined by section 27-41-1, and nonprofit hospital or medical service corporations as defined by chapters 27-19 and 27-20, 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/or 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/or 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 said 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 section 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 sections 27-18.5-8 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 27-18.5 and the small employer health insurance market as defined in chapter 27-50 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 section 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 their 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 health care providers and health

insurers for the purpose of coordinating the development of processes, guidelines, and standards to streamline health care administration that are to be adopted by payors and providers of health care services operating in the state. This workgroup shall include representatives with expertise that would contribute to the streamlining of health care administration and that 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 health care 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 such 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 or 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.

(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 sections 27-18-48.1, 27-18-60, 27-18-62, 27-18-64, similar provisions in title 27, chapters 19, 20 and 41, and subsection 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 (1), (2) and (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 healthcare delivery and value based payment arrangements, that shall include, but not limited to:

(1) Utilization review;

(2) Contracting; and

(3) Licensing and regulation.

(o) On or before October 1, 2015, and annually thereafter, the health insurance commissioner shall also assess the adequacy of each health plan's compliance with the provisions of § 27-38.2-1 regarding mental illness and medication assisted treatment coverage.

(p) On or before October 1, 2015, and annually thereafter, the department of health shall also assess the adequacy of those discharge plans and transition processes developed by hospitals, health care clinics, urgent care centers, and emergency room diversion facilities for patients with opioid and other substance use disorders pursuant to the provisions of § 23-17.26-3.

SECTION 4. Sunset provision. On or before November 1, 2017, the department of health and the health insurance commissioner shall submit to the governor, the speaker of the house and the president of the senate, recommendations as to the continuation of requirements of the special discharge plan and transition process requirements for patients with opioid and other substance use disorders as required in this act. Unless extended by the general assembly, the obligation to establish, implement and continue such a special discharge plan and transition process will cease on March 1, 2018.

SECTION 5. This act shall take effect on October 1, 2014, and shall be repealed on March 1, 2018.

========
LC005388
========

EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N A C T

RELATING TO INSURANCE - INSURANCE COVERAGE FOR MENTAL ILLNESS AND SUBSTANCE USE DISORDERS

***

This act would require mandatory health insurance coverage for certain listed drugs which treat opioid substance use disorders. This act would also require hospitals, health care clinics, urgent care centers and emergency room diversion facilities to amend their discharge plans and transition processes to address patients with opioid and other substance use disorders. The act would require at least one follow-up contact by the hospital, health care clinic, urgent care center or emergency room diversion facility with the patient after discharge, and the scheduling of at least one follow-up appointment with an appropriate facility for the patient. The health insurance commissioner would annually review the adequacy of each health insurer's coverage and the department of health would assess the adequacy of the discharge plans and transition processes developed by health care facilities.

This act would take effect on October 1, 2014, and would be repealed on March 1, 2018.

========
LC005388
========