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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. 2014

A N A C T

RELATING TO HEALTH AND SAFETY -- HEALTH CARE ACCESSIBILITY AND QUALITY ASSURANCE ACT

Introduced By: Senators McCaffrey, Miller, Satchell, Archambault, and Gallo

Date Introduced: February 27, 2014

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

SECTION 1. Section 23-17.13-3 of the General Laws in Chapter 23-17.13 entitled "Health Care Accessibility and Quality Assurance Act" is hereby amended to read as follows:

23-17.13-3. Certification of health plans. -- (a) Certification process.

(1) Certification.

(i) The director shall establish a process for certification of health plans meeting the requirements of certification in subsection (b).

(ii) The director shall act upon the health plan's completed application for certification within ninety (90) days of receipt of such application for certification.

(2) Review and recertification. - To ensure compliance with subsection (b), the director shall establish procedures for the periodic review and recertification of qualified health plans not less than every five (5) years; provided, however, that the director may review the certification of a qualified health plan at any time if there exists evidence that a qualified health plan may be in violation of subsection (b).

(3) Cost of certification. - The total cost of obtaining and maintaining certification under this title and compliance with the requirements of the applicable rules and regulations are borne by the entities so certified and shall be one hundred and fifty percent (150%) of the total salaries paid to the certifying personnel of the department engaged in those certifications less any salary

reimbursements and shall be paid to the director to and for the use of the department. That assessment shall be in addition to any taxes and fees otherwise payable to the state.

(4) Standard definitions. - To help ensure a patient's ability to make informed decisions regarding their health care, the director shall promulgate regulation(s) to provide for standardized definitions (unless defined in existing statute) of the following terms in this subdivision, provided, however, that no definition shall be construed to require a health care entity to add any benefit, to increase the scope of any benefit, or to increase any benefit under any contract:

(i) Allowable charge;

(ii) Capitation;

(iii) Co-payments;

(iv) Co-insurance;

(v) Credentialing;

(vi) Formulary;

(vii) Grace period;

(viii) Indemnity insurance;

(ix) In-patient care;

(x) Maximum lifetime cap;

(xi) Medical necessity;

(xii) Out-of-network;

(xiii) Out-patient;

(xiv) Pre-existing conditions;

(xv) Point of service;

(xvi) Risk sharing;

(xvii) Second opinion;

(xviii) Provider network;

(xix) Urgent care.

(b) Requirements for certification. - The director shall establish standards and procedures for the certification of qualified health plans that conduct business in this state and who have demonstrated the ability to ensure that health care services will be provided in a manner to assure availability and accessibility, adequate personnel and facilities, and continuity of service, and has demonstrated arrangements for ongoing quality assurance programs regarding care processes and outcomes; other standards shall consist of, but are not limited to, the following:

(1) Prospective and current enrollees in health plans must be provided information as to the terms and conditions of the plan consistent with the rules and regulations promulgated under

chapter 12.3 of title 42 so that they can make informed decisions about accepting and utilizing the health care services of the health plan. This must be standardized so that customers can compare the attributes of the plans, and all information required by this paragraph shall be updated at intervals determined by the director. Of those items required under this section, the director shall also determine which items shall be routinely distributed to prospective and current enrollees as listed in this subsection and which items may be made available upon request. The items to be disclosed are:

(i) Coverage provisions, benefits, and any restriction or limitations on health care services, including but not limited to, any exclusions as follows: by category of service, and if applicable, by specific service, by technology, procedure, medication, provider or treatment modality, diagnosis and condition, the latter three (3) of which shall be listed by name.

(ii) Experimental treatment modalities that are subject to change with the advent of new technology may be listed solely by the broad category "Experimental Treatments". The information provided to consumers shall include the plan's telephone number and address where enrollees may call or write for more information or to register a complaint regarding the plan or coverage provision.

(2) Written statement of the enrollee's right to seek a second opinion, and reimbursement if applicable.

(3) Written disclosure regarding the appeals process described in section 23-17.12-1 et seq. and in the rules and regulations for the utilization review of care services, promulgated by the department of health, the telephone numbers and addresses for the plan's office which handles complaints as well as for the office which handles the appeals process under section 23-17.12-1 et seq. and the rules and regulations for the utilization of health.

(4) Written statement of prospective and current enrollees' right to confidentiality of all health care record and information in the possession and/or control of the plan, its employees, its agents and parties with whom a contractual agreement exists to provide utilization review or who in any way have access to care information. A summary statement of the measures taken by the plan to ensure confidentiality of an individual's health care records shall be disclosed.

(5) Written disclosure of the enrollee's right to be free from discrimination by the health plan and the right to refuse treatment without jeopardizing future treatment.

(6) Written disclosure of a plan's policy to direct enrollees to particular providers. Any limitations on reimbursement should the enrollee refuse the referral must be disclosed.

(7) A summary of prior authorization or other review requirements including preauthorization review, concurrent review, post-service review, post-payment review and any

procedure that may lead the patient to be denied coverage for or not be provided a particular service.

(8) Any health plan that operates a provider incentive plan shall not enter into any compensation agreement with any provider of covered services or pharmaceutical manufacturer pursuant to which specific payment is made directly or indirectly to the provider as an inducement or incentive to reduce or limit services, to reduce the length of stay or the use of alternative treatment settings or the use of a particular medication with respect to an individual patient, provided however, that capitation agreements and similar risk sharing arrangements are not prohibited.

(9) Health plans must disclose to prospective and current enrollees the existence of financial arrangements for capitated or other risk sharing arrangements that exist with providers in a manner described in paragraphs (i), (ii), and (iii):

(i) "This health plan utilizes capitated arrangements, with its participating providers, or contains other similar risk sharing arrangements;

(ii) This health plan may include a capitated reimbursement arrangement or other similar risk sharing arrangement, and other financial arrangements with your provider;

(iii) This health plan is not capitated and does not contain other risk sharing arrangements."

(10) Written disclosure of criteria for accessing emergency health care services as well as a statement of the plan's policies regarding payment for examinations to determine if emergency health care services are necessary, the emergency care itself, and the necessary services following emergency treatment or stabilization. The health plan must respond to the request of the treating provider for post-stabilization treatment by approving or denying it as soon as possible.

(11) Explanation of how health plan limitations impact enrollees, including information on enrollee financial responsibility for payment for co-insurance, co-payment, or other non-covered, out-of-pocket, or out-of-plan services. This shall include information on deductibles and benefits limitations including, but not limited to, annual limits and maximum lifetime benefits.

(12) The terms under which the health plan may be renewed by the plan enrollee, including any reservation by the plan of any right to increase premiums.

(13) Summary of criteria used to authorize treatment.

(14) A schedule of revenues and expenses, including direct service ratios and other statistical information which meets the requirements set forth below on a form prescribed by the director.

(15) Plan costs of health care services, including but not limited to all of the following:

(i) Physician services;

(ii) Hospital services, including both inpatients and outpatient services;

(iii) Other professional services;

(iv) Pharmacy services, excluding pharmaceutical products dispensed in a physician's office;

(v) Health education;

(vi) Substance abuse services and mental health services.

(16) Plan complaint, adverse decision, and prior authorization statistics. This statistical data shall be updated annually:

(i) The ratio of the number of complaints received to the total number of covered persons, reported by category, listed in paragraphs (b)(15)(i) -- (vi);

(ii) The ratio of the number of adverse decisions issued to the number of complaints received, reported by category;

(iii) The ratio of the number of prior authorizations denied to the number of prior authorizations requested, reported by category;

(iv) The ratio of the number of successful enrollee appeals to the total number of appeals filed.

(17) Plans must demonstrate that:

(i) They have reasonable access to providers, so that all covered health care services will be provided. This requirement cannot be waived and must be met in all areas where the health plan has enrollees;

(ii) Urgent health care services, if covered, shall be available within a time frame that meets standards set by the director.

(18) A comprehensive list of participating providers listed by office location, specialty if applicable, and other information as determined by the director, updated annually and made publically available to enrollees online or in hard copy format.

(19) On or before July 1, 2015, and annually thereafter, plans except contracts providing supplemental coverage to Medicare or other governmental programs, as well as qualified health plans sold in the health exchange ("The Marketplace") and in the small group and individual markets that market a preferred provider benefit plan, shall report to the director of health and office of the health insurance commissioner for approval or modification, on an annual basis, their contracts with physicians and health care providers to assure that all medical and health care services and items in the package of benefits for which coverage is provided in a manner that

assures both availability and accessibility of adequate, qualified personnel, specialty care and facilities. Plans shall provide a detailed document that shall include, but not be limited to, the following information:

(i) Process for monitoring and updating network adequacy;

(ii) Efforts to address enrollees with special health needs;

(iii) Procedures to enable enrollees to change primary care physicians;

(iv) A process for ensuring continuity of care in the event of a contract termination;

(v) Methods to assess enrollee satisfaction and provide the director with information on an annual basis;

(vi) Marketing practices,

(vii) Efforts and initiatives underway to address community providers in underserved areas; and

(viii) Information on quality measures for health plan performance.

(20) Plans that market a preferred provider benefit plan shall provide to an insured on request information on:

(i) Whether a physician or other health care provider is a participating provider in the insurer's preferred provider network;

(ii) Whether proposed health care services are covered by the health insurance policy;

(iii) What the insured's personal responsibility will be for payment of applicable copayment or deductible amounts; and

(iv) Coinsurance amounts owed based on the provider's contracted rate for in-network services or the insurer's usual and customary reimbursement rate for out-of-network services.

~~(19)~~(21) Plans must provide to the director, at intervals determined by the director, enrollee satisfaction measures. The director is authorized to specify reasonable requirements for these measures consistent with industry standards to assure an acceptable degree of statistical validity and comparability of satisfaction measures over time and among plans. The director shall publish periodic reports for the public providing information on health plan enrollee satisfaction.

(c) Issuance of certification.

(1) Upon receipt of an application for certification, the director shall notify and afford the public an opportunity to comment upon the application.

(2) A health care plan will meet the requirements of certification, subsection (b) by providing information required in subsection (b) to any state or federal agency in conformance with any other applicable state or federal law, or in conformity with standards adopted by an accrediting organization provided that the director determines that the information is substantially

similar to the previously mentioned requirements and is presented in a format that provides a meaningful comparison between health plans.

(3) All health plans shall be required to establish a mechanism, under which providers, including local providers participating in the plan, provide input into the plan's health care policy, including technology, medications and procedures, utilization review criteria and procedures, quality and credentialing criteria, and medical management procedures.

(4) All health plans shall be required to establish a mechanism under which local individual subscribers to the plan provide input into the plan's procedures and processes regarding the delivery of health care services.

(5) A health plan shall not refuse to contract with or compensate for covered services an otherwise eligible provider or non-participating provider solely because that provider has in good faith communicated with one or more of his or her patients regarding the provisions, terms or requirements of the insurer's products as they relate to the needs of that provider's patients.

(6) (i) All health plans shall be required to publicly notify providers within the health plans' geographic service area of the opportunity to apply for credentials. This notification process shall be required only when the plan contemplates adding additional providers and may be specific as to geographic area and provider specialty. Any provider not selected by the health plan may be placed on a waiting list.

(ii) This credentialing process shall begin upon acceptance of an application from a provider to the plan for inclusion.

(iii) Each application shall be reviewed by the plan's credentialing body.

(iv) All health plans shall develop and maintain credentialing criteria to be utilized in adding providers from the plans' network. Credentialing criteria shall be based on input from providers credentialed in the plan and these standards shall be available to applicants. When economic considerations are part of the decisions, the criteria must be available to applicants. Any economic profiling must factor the specialty utilization and practice patterns and general information comparing the applicant to his or her peers in the same specialty will be made available. Any economic profiling of providers must be adjusted to recognize case mix, severity of illness, age of patients and other features of a provider's practice that may account for higher than or lower than expected costs. Profiles must be made available to those so profiled.

(7) A health plan shall not exclude a provider of covered services from participation in its provider network based solely on:

(i) The provider's degree or license as applicable under state law; or

(ii) The provider of covered services lack of affiliation with, or admitting privileges at a

hospital, if that lack of affiliation is due solely to the provider's type of license.

(8) Health plans shall not discriminate against providers solely because the provider treats a substantial number of patients who require expensive or uncompensated medical care.

(9) The applicant shall be provided with all reasons used if the application is denied.

(10) Plans shall not be allowed to include clauses in physician or other provider contracts that allow for the plan to terminate the contract "without cause"; provided, however, cause shall include lack of need due to economic considerations.

(11) (i) There shall be due process for non-institutional providers for all adverse decisions resulting in a change of privileges of a credentialed non-institutional provider. The details of the health plan's due process shall be included in the plan's provider contracts.

(ii) A health plan is deemed to have met the adequate notice and hearing requirement of this section with respect to a non-institutional provider if the following conditions are met (or are waived voluntarily by the non-institutional provider):

(A) The provider shall be notified of the proposed actions and the reasons for the proposed action.

(B) The provider shall be given the opportunity to contest the proposed action.

(C) The health plan has developed an internal appeals process that has reasonable time limits for the resolution of an internal appeal.

(12) If the plan places a provider or provider group at financial risk for services not provided by the provider or provider group, the plan must require that a provider or group has met all appropriate standards of the department of business regulation.

(13) A health plan shall not include a most favored rate clause in a provider contract.

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 HEALTH AND SAFETY -- HEALTH CARE ACCESSIBILITY AND QUALITY ASSURANCE ACT

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This act would require that on or before July 1, 2015, and annually thereafter, certain health plans submit their contracts with physicians and healthcare providers to the director of the department of health and the office of the health insurance commissioner for approval or modification to assure the availability and accessibility of adequate, qualified personnel, specialty care and facilities. The act would also require a plan be submitted annually to inform, educate and assist all enrollees in making informed decisions as to participating physicians, healthcare providers, applicable co-payments, deductibles and coinsurance amounts. The act would further provide that a comprehensive list of participating providers be made available to enrollees online or in hard copy format.

This act would take effect upon passage.

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