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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. 2017

A N A C T

RELATING TO HEALTH AND SAFETY -- COMPREHENSIVE HEALTH INSURANCE PROGRAM

Introduced By: Representatives Regunberg, Walsh, Ajello, Ranglin-Vassell, and Amore

Date Introduced: January 11, 2017

Referred To: House Finance

It is enacted by the General Assembly as follows:

SECTION 1. Chapter 42-14.5 of the General Laws entitled "The Rhode Island Health Care Reform Act of 2004 - Health Insurance Oversight" is hereby repealed in its entirety.

~~CHAPTER 42-14.5~~

~~The Rhode Island Health Care Reform Act of 2004 - Health Insurance Oversight~~

~~**42-14.5-1. Health insurance commissioner.**~~

~~There is hereby established, within the department of business regulation, an office of the health insurance commissioner. The health insurance commissioner shall be appointed by the governor, with the advice and consent of the senate. The director of business regulation shall grant to the health insurance commissioner reasonable access to appropriate expert staff.~~

~~**42-14.5-1.1. Legislative findings.**~~

~~The general assembly hereby finds and declares as follows:~~

~~(1) A substantial amount of health care services in this state are purchased for the benefit of patients by health care insurers engaged in the provision of health care financing services or is otherwise delivered subject to the terms of agreements between health care insurers and providers of the services.~~

~~(2) Health care insurers are able to control the flow of patients to providers of health care services through compelling financial incentives for patients in their plans to utilize only the services of providers with whom the insurers have contracted.~~

~~(3) Health care insurers also control the health care services rendered to patients through utilization review programs and other managed care tools and associated coverage and payment policies.~~

~~(4) By incorporation or merger the power of health care insurers in markets of this state for health care services has become great enough to create a competitive imbalance, reducing levels of competition and threatening the availability of high quality, cost effective health care.~~

~~(5) The power of health care insurers to unilaterally impose provider contract terms may jeopardize the ability of physicians and other health care providers to deliver the superior quality health care services that have been traditionally available in this state.~~

~~(6) It is the intention of the general assembly to authorize health care providers to jointly discuss with health care insurers topics of concern regarding the provision of quality health care through a committee established by an advisory to the health insurance commissioner.~~

~~42-14.5-2. Purpose.~~

~~With respect to health insurance as defined in § 42-14-5, the health insurance commissioner shall discharge the powers and duties of office to:~~

~~(1) Guard the solvency of health insurers;~~

~~(2) Protect the interests of consumers;~~

~~(3) Encourage fair treatment of health care providers;~~

~~(4) Encourage policies and developments that improve the quality and efficiency of health care service delivery and outcomes; and~~

~~(5) View the health care system as a comprehensive entity and encourage and direct insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access.~~

~~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 § 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). 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 its 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), 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 § 27-41-2, and nonprofit hospital or medical service corporations, as defined by chapters 19 and 20 of title 27, 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 § 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 §§ 27-18.5-9 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 18.5 of title 27 and the small employer health insurance market as defined in chapter 50 of title 27 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 § 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 its 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 who would contribute to the streamlining of health care administration and who 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, nor 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.~~

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

~~(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 health care 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 health care benefits as defined in §§ 27-18-48.1, 27-18-60, 27-18-62, 27-18-64, similar provisions in chapters 19, 20 and 41, of title 27, and §§ 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 health care 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 (m)(1), (m)(2), and (m)(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 health care delivery and value-based payment arrangements, that shall include, but not be limited to:

~~(1) Utilization review;~~

~~(2) Contracting; and~~

~~(3) Licensing and regulation.~~

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

~~**42-14.5-4. Actuary and subject matter experts.**~~

~~The health insurance commissioner may contract with an actuary and/or other subject matter experts to assist him or her in conducting the study required under subsection 42-14.5-3(g). The actuary or other expert shall serve under the direction of the health insurance commissioner. Health insurance companies doing business in this state, including, but not limited to, nonprofit hospital service corporations and nonprofit medical service corporations established pursuant to chapters 27-19 and 27-20, and health maintenance organizations established pursuant to chapter 27-41, shall be assessed according to a schedule of their direct writing of health insurance in this state to pay for the compensation of the actuary. The amount assessed to all health insurance companies doing business in this state for the study conducted under subsection 42-14.5-3(g) shall not exceed a total of one hundred thousand dollars ($100,000).~~

SECTION 2. Chapter 42-157 of the General Laws entitled "Rhode Island Health Benefit Exchange" is hereby repealed in its entirety.

~~CHAPTER 42-157~~

~~Rhode Island Health Benefit Exchange~~

~~**42-157-1. Establishment of exchange.**~~

~~Purpose. The department of administration is hereby authorized to establish the Rhode Island health benefit exchange, to be known as HealthSource RI, to exercise the powers and authority of a state-based exchange which shall meet the minimum requirements of the federal act.~~

~~**42-157-2. Definitions.**~~

~~As used in this section, the following words and terms shall have the following meanings, unless the context indicates another or different meaning or intent:~~

~~(1) "Director" means the director of the department of administration.~~

~~(2) "Federal act" means the Federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the Federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments to, or regulations or guidance issued under, those~~

~~acts.~~

~~(3) "Health plan" and "qualified health plan" have the same meanings as those terms are defined in § 1301 of the Federal Act.~~

~~(4) "Insurer" means every medical service corporation, hospital service corporation, accident and sickness insurer, dental service corporation, and health maintenance organization licensed under title 27, or as defined in § 42-62-4.~~

~~(5) "Secretary" means the secretary of the Federal Department of Health and Human Services.~~

~~(6) "Qualified dental plan" means a dental plan as described in § 1311(d)(2)(B)(ii) of the Federal Act [42 U.S.C. § 18031].~~

~~(7) "Qualified individuals" and "qualified employers" shall have the same meaning as defined in federal law.~~

~~**42-157-3. General requirements.**~~

~~(a) The exchange shall make qualified health plans available to qualified individuals and qualified employers. The exchange shall not make available any health benefit plan that has not been certified by the exchange as a qualified health plan in accordance with federal law.~~

~~(b) The exchange shall allow an insurer to offer a plan that provides limited scope dental benefits meeting the requirements of § 9832(c)(2)(A) of the Internal Revenue Code of 1986 through the exchange, either separately or in conjunction with a qualified health plan, if the plan provides pediatric dental benefits meeting the requirements of § 1302(b)(1)(J) of the Federal Act [42 U.S.C. § 18022].~~

~~(c) Any health plan that delivers a benefit plan on the exchange that covers abortion services, as defined in 45 C.F.R. § 156.280(d)(1), shall comply with segregation of funding requirements, as well as an annual assurance statement to the Office of the Health Insurance Commissioner, in accordance with 45 C.F.R. §§ 156.680(e)(3) and (5).~~

~~(d) At least one plan variation for individual market plan designs offered on the exchange at each level of coverage, as defined by section 1302(d)(1) of the federal act [42 U.S.C. § 18022] at which the carrier is offering a plan or plans, shall exclude coverage for abortion services as defined in 45 C.F.R. § 156.280(d)(1). If the health plan proposes different rates for such plan variations, each listed plan design shall include the associated rate. Except for Religious Employers (as defined in Section 6033(a)(3)(A)(i) of the Internal Revenue Code), employers selecting a plan under this religious exemption subsection may not designate it as the single plan for employees, but shall offer their employees full choice of small employer plans on the exchange, using the employer-selected plan as the base plan for coverage. The employer is not~~

~~responsible for payment that exceeds that designated for the employer-selected plan.~~

~~(e) Health plans that offer a plan variation that excludes coverage for abortion services as defined in 45 C.F.R. § 156.280(d)(l) for a religious exemption variation in the small group market shall treat such a plan as a separate plan offering with a corresponding rate.~~

~~(f) An employer who elects a religious exemption variation shall provide written notice to prospective enrollees prior to enrollment that the plan excludes coverage for abortion services as defined in 45 C.F.R. § 156.280(d)(1). The carrier must include notice that the plan excludes coverage for abortion services as part of the Summary of Benefits and Coverage required by 42 U.S.C. § 300gg-15.~~

~~42-157-4. Financing.~~

~~(a) The department is authorized to assess insurers offering qualified health plans and qualified dental plans. The revenue raised in accordance with this subsection shall not exceed the revenue able to be raised through the federal government assessment and shall be established in accordance and conformity with the federal government assessment upon those insurers offering products on the Federal Health Benefit exchange. Revenues from the assessment shall be deposited in a restricted receipt account for the sole use of the exchange and shall be exempt from the indirect cost recovery provisions of § 35-4-27 of the general laws.~~

~~(b) The general assembly may appropriate general revenue to support the annual budget for the exchange in lieu of or to supplement revenues raised from the assessment under § 42-157-4(a).~~

~~(c) If the director determines that the level of resources obtained pursuant to § 42-157-4(a) will be in excess of the budget for the exchange, the department shall provide a report to the governor, the speaker of the house and the senate president identifying the surplus and detailing how the assessment established pursuant to § 42-157-4(a) may be offset in a future year to reconcile with impacted insurers and how any future supplemental or annual budget submission to the general assembly may be revised accordingly.~~

~~42-157-5. Regional purchasing, efficiencies, and innovation.~~

~~To take advantage of economies of scale and to lower costs, the exchange is hereby authorized to pursue opportunities to jointly negotiate, procure or otherwise purchase exchange services with or partner with another state or multiple states and to pursue a Federal Affordable Care Act 1332 Waiver.~~

~~42-157-6. Audit.~~

~~(a) Annually, the exchange shall cause to have a financial and/or performance audit of its functions and operations performed in compliance with the generally accepted governmental~~

~~auditing standards and conducted by the state office of internal audit or a certified public accounting firm qualified in performance audits.~~

~~(b) If the audit is not directly performed by the state office of internal audit, the selection of the auditor and the scope of the audit shall be subject to the approval of the state office of internal audit.~~

~~(c) The results of the audit shall be made public upon completion, posted on the department's website and otherwise made available for public inspection.~~

~~42-157-7. Exchange advisory board.~~

~~The exchange shall maintain an advisory board which shall be appointed by the director. The director shall consider the expertise of the members of the board and make appointments so that the board's composition reflects a range and diversity of skills, backgrounds and stakeholder perspectives.~~

~~42-157-8. Reporting.~~

~~HealthSource RI shall provide a monthly report to the chairpersons of the house finance committee and the senate finance committee by the fifteenth day of each month beginning in July 2015. The report shall include, but not be limited to, the following information: actual enrollment data by market and insurer, total new and renewed customers, number of paid customers, actual average premium costs by market and insurer, number of enrollees receiving financial assistance as defined in the Federal Act, as well as the number of inbound calls and the number of walk-ins received. The data on inbound calls shall be segregated by type of call.~~

~~42-157-9. Relation to other laws.~~

~~Nothing in this chapter, and no action taken by the exchange pursuant to this chapter. shall be construed to preempt or supersede the authority of the health insurance commissioner to regulate the business of insurance within this state, the director of the department of health to oversee the licensure of health care providers, the certification of health plans under chapter 17.13 of title 23, or the licensure of utilization review agents wider chapter 17.13 of title 23, or the director of the department of human services to oversee the provision of medical assistance under chapter 8 of title 40. In addition to the provisions of this chapter, all insurers offering qualified health plans or qualified dental plans in this state shall comply fully with all applicable health insurance laws and regulations of this state.~~

~~42-157-10. Severability.~~

~~The provisions of this chapter are severable, and if any provision hereof shall be held invalid in any circumstances, any invalidity shall not affect any other provisions or circumstances. This chapter shall be construed in all respects so as to meet any constitutional~~

~~requirements. In carrying out the purposes and provisions of this chapter, all steps shall be taken which are necessary to meet constitutional requirements.~~

SECTION 3. Title 23 of the General Laws entitled "HEALTH AND SAFETY" is hereby amended by adding thereto the following chapter:

CHAPTER 94

THE RHODE ISLAND COMPREHENSIVE HEALTH INSURANCE PROGRAM

23-94-1. Legislative findings and purpose.

The general assembly finds that Rhode Island residents face significant and increasingly overwhelming problems obtaining adequate affordable health insurance due to unnecessary costs and obstacles created by our current health insurance system, and that removing the burden on Rhode Island businesses to secure health insurance for employees will benefit the state's economic development. This chapter, therefore, creates an affordable, comprehensive, and effective health insurance program to benefit all Rhode Island residents.

23-94-2. Definitions.

As used in this chapter:

(1) "Dependent" has the same definition as set forth in federal tax law (26 U.S.C. §152).

(2) "Emergency and urgently needed services" has the same definition as set forth in the federal Medicare law (42 CFR 422.113).

(3) "For-profit provider" means any health care professional or health care institution that provides payments, profits or dividends to investors or owners who do not directly provide health care.

(4) "Program" means, "the Rhode Island comprehensive health insurance program" (RICHIP).

(5) "Qualified Rhode Island resident" means any individual who is a "resident" as defined by §§44-30-5(a)(1) and (2) or a dependent of that resident.

(6) "RICHIP" or "Rhode Island comprehensive health insurance program" means affordable, comprehensive and effective health insurance as set forth in §23-94-3.

(7) "RICHIP Premiums" means funds from qualified Rhode Island residents that are placed into the RICHIP trust fund pursuant to §23-94-11, and are based on income and unearned income including capital gains.

23-94-3. Rhode Island Comprehensive Health Insurance Program.

(a) Organization. This chapter creates the Rhode Island comprehensive health insurance program (RICHIP), an independent government agency consisting of a director and staff, as set forth below.

(b) Director. A director shall be appointed by the governor with the advice and consent of the senate to lead RICHIP and serve a term of six (6) years. The director shall be compensated in accordance with the job title and job classification established by the division of human resources and approved by the general assembly. The director may be removed by a two-thirds (2/3) majority vote of each house of the general assembly. The director shall have the following duties:

(1) Oversee management of the RICHIP trust fund;

(2) Create and oversee RICHIP budgets;

(3) Appoint an advisory committee of health care professionals and others (hereinafter, the "RICHIP advisory committee");

(4) Establish RICHIP benefits as set forth in §23-94-5;

(5) Establish RICHIP provider reimbursement as set forth in §23-94-8;

(6) Coordinate with the state comptroller to facilitate billing from and payments to providers using the state's computerized financial system, the Rhode Island financial and accounting network system (RIFANS);

(7) Coordinate with federal health care programs, including Medicare and Medicaid, to streamline federal funding and reimbursement;

(8) Monitor billing and reimbursements to detect inappropriate behavior by providers and patients;

(9) Oversee RICHIP registration for qualified Rhode Island residents;

(10) Create RICHIP expenditure, status, and assessment reports;

(11) Review RICHIP disbursements on a quarterly basis and recommend adjustments in fee schedules needed to achieve budgetary targets and permit adequate access to care;

(12) Review capital budget proposals from providers;

(13) Create a committee to study long-term care and develop a plan to deal with this health care necessity;

(14) Create other prohibitions regarding RICHIP participation, and procedures by which they will be enforced.

23-94-4. Extent of coverage.

(a) Eligibility. All qualified Rhode Island residents are eligible to be covered under RICHIP.

(b) Registration. The director shall develop procedures by which:

(1) RICHIP can identify, automatically register, and provide a RICHIP card to qualified Rhode Island residents identified by September 1, 2017; and

(2) RICHIP can process applications from individuals seeking to become qualified Rhode

Island residents or obtain RICHIP coverage for dependents after September 1, 2017.

(c) Disqualification. The director shall establish criteria and procedures for disqualifying individuals from receiving RICHIP benefits or funds, including for ceasing to be a resident of Rhode Island, and for RICHIP-related criminal activity (e.g., the fraudulent receiving of benefits or reimbursements). Disqualified individuals shall be required to reimburse RICHIP for all benefits or funds they received upon disqualification and may be subject to civil and criminal penalties.

(d) Medicare eligible residents. Qualified Rhode Island residents eligible for federal Medicare ("Medicare eligible residents") shall continue to pay required fees to the federal government. RICHIP shall establish procedures to ensure that Medicare eligible residents shall have such amounts deducted from what they owe to RICHIP under §23-94-11. RICHIP shall become the equivalent of qualifying coverage under Medicare part D and Medicare advantage programs, and as such shall be the vendor for coverage to qualified Rhode Island residents. RICHIP shall provide Medicare eligible residents benefits equal to those available to all other RICHIP participants and equal to or greater than those available through the federal Medicare programs. To streamline the process, RICHIP shall seek to receive federal reimbursements for services to Medicare eligible residents and administer all Medicare funds.

(e) Medicaid eligible residents. RICHIP shall become the state's sole Medicaid provider. RICHIP shall create procedures to enroll all qualified Rhode Island residents eligible for Medicaid ("Medicaid eligible residents" in the federal Medicaid program to ensure a maximum amount of federal Medicaid funds go to the RICHIP trust fund. RICHIP shall provide benefits to Medicaid eligible residents equal to those available to all other RICHIP participants.

23-94-5. RICHIP benefits.

(a) In general. This chapter shall provide insurance coverage for services, goods and prescription drugs currently covered under the federal Medicare program (Social Security Act title XVIII) parts A, B and D. The director may permit additional medically necessary coverage within the following general categories:

(1) Primary and preventive care;

(2) Approved dietary and nutritional therapies;

(3) Inpatient care;

(4) Outpatient care;

(5) Emergency and urgently needed care;

(6) Prescription drugs;

(7) Approved medical goods;

(8) Palliative care;

(9) Mental health services;

(10) Dental services, including periodontics, oral surgery, and endodontics;

(11) Substance abuse treatment services;

(12) Physical therapy and chiropractic services;

(13) Vision care and vision correction;

(14) Hearing services, including coverage of hearing aids; and

(15) Podiatric care.

(b) RICHIP benefits. RICHIP benefits shall, at a minimum, be the same as those covered by the federal Medicare program, as defined by applicable federal statute and regulations. The director shall create a procedure that permits increases in coverage beyond that provided by the federal Medicare program within the areas set forth in §23-94-5(a) in consultation with the RICHIP advisory committee.

23-94-6. Providers.

(a) Rhode Island providers.

(1) Licensing. Participating providers must meet state licensing requirements in order to participate in the program. No provider whose license is under suspension or has been revoked may participate in the program.

(2) Participation. All providers may participate in RICHIP by providing items on the RICHIP benefits list for which they are licensed. Providers may elect either to participate fully, or not at all, in the program.

(3) For-profit providers. For-profit providers may continue to offer services and goods in Rhode Island, but are prohibited from charging patients more than RICHIP reimbursement rates for covered services and goods and must notify qualified Rhode Island residents when the services and goods they offer will not be reimbursed under RICHIP.

(b) Out-of-state providers. Except for emergency and urgently needed service, as set forth in §23-94-7, RICHIP shall not pay for health care services obtained outside of Rhode Island unless the following requirements are met:

(1) The patient secures a written referral from a qualified Rhode Island physician prior to seeking such services; and

(2) The referring physician determines that the services are not available in the state or cannot be performed within the state at the level of expertise medically necessary.

(c) Out-of-state provider reimbursement. The program shall pay out-of-state health care providers an amount not to exceed the RICHIP rate. The qualified Rhode Island resident is

responsible for paying all costs of out-of-state services that fail to meet the requirements of §§23-94-6(b)(1) and (b)(2). Qualified Rhode Island residents are responsible for paying out-of-state providers for costs in excess of RICHIP reimbursements.

(d) Out-of-state residents. Rhode Island providers who provide any services to individuals who are not qualified Rhode Island residents shall not be reimbursed by RICHIP and must seek reimbursement from those individuals or other sources.

23-94-7. Emergency and urgently needed services exceptions.

(a) In Rhode Island. Nothing in this chapter prevents any individual from receiving or any provider from giving emergency or urgently needed services in Rhode Island. RICHIP shall reimburse all providers for emergency and urgently needed services given to qualified Rhode Island residents to the extent provided for under the federal Medicare program in accordance with §23-94-9.

(b) Out-of-State. The program shall pay for emergency and urgently needed services that are obtained by qualified Rhode Island residents anywhere outside Rhode Island to the same extent allowed under the federal Medicare program in accordance with §23-94-9. Qualified Rhode Island residents are responsible for paying out-of-state providers for costs in excess of RICHIP reimbursements.

23-94-8. Private Insurance Companies.

(a) Non-duplication. It is unlawful for a private health insurer to sell health insurance coverage to qualified Rhode Island residents outside of employer-provided health benefit programs that duplicates the benefits provided under this chapter.

(b) Displaced employees. Re-education and job placement of persons employed in Rhode Island-located enterprises who have lost their jobs as a result of this chapter shall be managed by the Rhode Island department of labor and training or an appropriate federal retraining program.

23-94-9. Provider Reimbursement.

(a) Rates. RICHIP reimbursements to providers shall be the same as the federal Medicare program reimbursement rates in effect at the time services, goods or prescription drugs are provided. If the director determines that there are no applicable Medicare reimbursement rates or that such rates are significantly different from those in neighboring states, the director shall create such rates in consultation with the RICHIP advisory committee.

(b) Billing and payments. Providers shall submit billing for services to qualified Rhode Island residents in the form of electronic invoices entered into RIFANS, the state's computerized financial system. The director shall coordinate the manner of processing and payment with the

office of accounts and control and the RIFANS support team within the division of information technology. Payments shall be made by check or electronic funds transfer in accordance with terms and procedures coordinated by the director and the office of accounts and control and consistent with the fiduciary management of the RICHIP trust fund.

(c) Provider restrictions. Providers who accept any payment from RICHIP may not bill any patient for any covered benefit. Providers cannot use any of their operating budgets for expansion, profit, excessive executive income, marketing, or major capital purchases or leases.

23-94-10. Budgeting.

(a) Operating budget. Annually, the director shall create an operating budget for the program that includes the costs for all benefits set forth in §23-94-5 and the costs for RICHIP administration. The director shall determine appropriate reimbursement rates for benefits pursuant to §23-94-9(a).

(b) Capital Expenditures. The director and the Rhode Island department of administration office of capital projects shall review the capital expenditure budgets proposed by providers, including amounts to be spent on construction and renovation of health facilities and major equipment purchases. To the extent that providers are seeking RICHIP funds for capital expenditures, the director shall have the authority to approve or deny such funding.

(c) Prohibition against co-mingling operations and capital improvement funds. It is prohibited to use funds under this chapter that are earmarked:

(1) For operations for capital expenditures; or

(2) For capital expenditures for operations.

(d) Limits. The total overhead and administrative portion of the program budget may not exceed twelve percent (12%) of the total operating budget of the program for the first two (2) years that the program is in operation; eight percent (8%) for the following two (2) years; and five percent (5%) for each year thereafter.

23-94-11. Financing.

(a) RICHIP trust fund. There shall be established a RICHIP trust fund into which funds collected pursuant to this chapter are deposited and from which funds are distributed. The governor or general assembly may provide funds to the RICHIP trust fund, but may not remove or borrow funds from the RICHIP trust fund.

(b) Savings. RICHIP will lower health care costs by:

(1) Eliminating payments for expensive, non-comprehensive private health care insurance;

(2) Reducing paperwork and administrative expenses;

(3) Allowing public health strategic planning; and

(4) Improving access to preventive health care.

(c) Funding. Funds sufficient to carry out this chapter shall be obtained in the following ways and may be changed only by a two-thirds (2/3) majority vote of each house of the general assembly.

(1) Seeking the maximum amount of existing and future federal government funds available for Rhode Island residents' health care, including, but not limited to, funds under the Medicare program, under title XVIII of the Social Security Act, under the Medicaid program under title XIX of such act, and under the children's health insurance program under title XXI of such act;

(2) Collecting RICHIP premiums;

(3) Applying any other funds specifically ear-marked for health care or health care education, such as settlements from litigation.

23-94-12. Compliance with federal laws.

RICHIP shall comply with all applicable federal laws, including the ACA and privacy laws.

SECTION 4. 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 -- COMPREHENSIVE HEALTH INSURANCE PROGRAM

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This act would repeal the "Rhode Island Health Care Reform Act of 2004 – Health Insurance Oversight" as well as the "Rhode Island Health Benefit Exchange. This act would also establish the Rhode Island comprehensive health insurance program, a new affordable, and effective health insurance program to benefit all Rhode Islanders.

This act would take effect upon passage.

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