

STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2017

A N A C T

RELATING TO INSURANCE - INSURANCE COVERAGE FOR MENTAL HEALTH AND
SUBSTANCE ABUSE DISORDERS

Introduced By: Senators Goldin, Miller, Satchell, Calkin, and Sheehan

Date Introduced: February 15, 2017

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

1 SECTION 1. Legislative findings. - The general assembly hereby finds and declares as
2 follows:

3 (1) A substantial amount of health care debt incurred by patients in this state is due to the
4 increasing amount of patient responsibility for covered services outside of the premium of an
5 insurance policy.

6 (2) It has been shown that patients, especially those in need of mental health and
7 substance use disorder treatment have been discouraged from seeking treatment based upon the
8 increasing amount of patient financial liability for such covered services.

9 (3) The imposition of coinsurance by insurers as a percentage of the allowable payment
10 brings much confusion to consumers in attempting to control health care costs. Collection of
11 coinsurance at the point of service by a provider is difficult due to the calculation of a percentage
12 of an insurer's allowable cost of a service prior to the filing of a claim. This confusion further
13 compounds a patient's financial and emotional stress in obtaining necessary covered services and
14 meeting the patient's financial responsibility for such covered service.

15 (4) The power of insurers to unilaterally impose coinsurance based upon a percentage of
16 an allowable cost of a covered service determined after the provider has filed a claim may further
17 jeopardize the ability of patients and consumers to be educated and knowledgeable in their full
18 financial responsibility under a health insurance plan or contract.

1 It is the intention of the general assembly to enable those in need of mental health and
2 substance use disorder treatment to have greater access for care with fewer financial burdens that
3 may result in avoidance of needed care. It is also the intention of the general assembly to lessen
4 the financial complexity and burden on patients and easing the difficulty in the imposition of
5 cost-sharing under health insurance plans.

6 SECTION 2. Section 27-18-8 of the General Laws in Chapter 27-18 entitled "Accident
7 and Sickness Insurance Policies" is hereby amended to read as follows:

8 **27-18-8. Filing of accident and sickness insurance policy forms.**

9 (a) Any insurance company authorized to do an accident and sickness business within
10 this state in accordance with the provisions of this title shall file all accident and sickness
11 insurance policy forms and rates used by it in the state with the insurance commissioner,
12 including the forms of any rider, endorsement, application blank, and other matter generally used
13 or incorporated by reference in its policies or contracts of insurance. [No such form shall be](#)
14 [approved if it utilizes a coinsurance method, as defined in §27-18-83, for the collection of patient](#)
15 [financial requirements for covered benefits.](#) No such form shall be used if disapproved by the
16 commissioner under this section, or if the commissioner's approval has been withdrawn under §
17 27-18-8.3, or until the expiration of the waiting period established under § 27-18-8.3. Such a
18 company shall comply with its filed and approved forms. If the commissioner finds from an
19 examination of any form that it is contrary to the public interest, or the requirements of this code
20 or duly promulgated regulations, he or she shall forbid its use, and shall notify the company in
21 writing as provided in § 27-18-8.2.

22 (b) Each rate filing shall include a certification by a qualified actuary that to the best of
23 the actuary's knowledge and judgment, the entire rate filing is in compliance with applicable laws
24 and that the benefits offered or proposed to be offered are reasonable in relation to the premium
25 to be charged. A health insurance carrier shall comply with its filed and approved rates and forms.

26 SECTION 3. Section 27-19-7.2 of the General Laws in Chapter 27-19 entitled "Nonprofit
27 Hospital Service Corporations" is hereby amended to read as follows:

28 **27-19-7.2. Filing of policy forms.**

29 (a) A nonprofit hospital service corporation shall file all policy forms and rates used by it
30 in the state with the commissioner, including the forms of any rider, endorsement, application
31 blank, and other matter generally used or incorporated by reference in its policies or contracts of
32 insurance. [No such form shall be approved if it utilizes a coinsurance method, as defined in §27-](#)
33 [19-74, for the collection of patient financial requirements for covered benefits.](#) No such form
34 shall be used if disapproved by the commissioner under this section, or if the commissioner's

1 approval has been withdrawn after notice and an opportunity to be heard, or until the expiration
2 of sixty (60) days following the filing of the form. Such a company shall comply with its filed
3 and approved forms. If the commissioner finds from an examination of any form that it is
4 contrary to the public interest, or the requirements of this code or duly promulgated regulations,
5 he or she shall forbid its use, and shall notify the corporation in writing.

6 (b) Each rate filing shall include a certification by a qualified actuary that to the best of
7 the actuary's knowledge and judgment, the entire rate filing is in compliance with applicable laws
8 and that the benefits offered or proposed to be offered are reasonable in relation to the premium
9 to be charged. A health insurance carrier shall comply with its filed and approved rates and forms.

10 SECTION 4. Section 27-20-6.2 of the General Laws in Chapter 27-20 entitled "Nonprofit
11 Medical Service Corporations" is hereby amended to read as follows:

12 **27-20-6.2. Filing of policy forms.**

13 (a) A nonprofit medical service corporation shall file all policy forms and rates used by it
14 in the state with the commissioner, including the forms of any rider, endorsement, application
15 blank, and other matter generally used or incorporated by reference in its policies or contracts of
16 insurance. [No such form shall be approved if it utilizes a coinsurance method, as defined in §27-](#)
17 [20-70, for the collection of patient financial requirements for covered benefits.](#) No such form
18 shall be used if disapproved by the commissioner under this section, or if the commissioner's
19 approval has been withdrawn after notice and an opportunity to be heard, or until the expiration
20 of sixty (60) days following the filing of the form. Such a company shall comply with its filed
21 and approved forms. If the commissioner finds from an examination of any form that it is
22 contrary to the public interest, or the requirements of this code or duly promulgated regulations,
23 he or she shall forbid its use, and shall notify the corporation in writing.

24 (b) Each rate filing shall include a certification by a qualified actuary that to the best of
25 the actuary's knowledge and judgment, the entire rate filing is in compliance with applicable laws
26 and that the benefits offered or proposed to be offered are reasonable in relation to the premium
27 to be charged. A health insurance carrier shall comply with its filed and approved rates and forms.

28 SECTION 5. Sections 27-38.2-1 and 27-38.2-2 of the General Laws in Chapter 27-38.2
29 entitled "Insurance Coverage for Mental Illness and Substance Abuse" are hereby amended to
30 read as follows:

31 **27-38.2-1. Coverage for the treatment of mental health and substance use disorders.**

32 (a) A group health plan and an individual or group health insurance plan shall provide
33 coverage for the treatment of mental health and substance-use disorders under the same terms and
34 conditions as that coverage is provided for other illnesses and diseases.

1 (b) Coverage for the treatment of mental health and substance-use disorders shall not
2 impose any annual or lifetime dollar limitation.

3 (c) Financial requirements ~~and quantitative~~ as defined in §27-38.2-2 shall not apply to
4 coverage for the treatment of mental health and substance use disorders. Quantitative treatment
5 limitations on coverage for the treatment of mental health and substance-use disorders shall be no
6 more restrictive than the ~~predominant financial requirements~~ limitations applied to substantially
7 all coverage for medical conditions in each treatment classification.

8 (d) Coverage shall not impose non-quantitative treatment limitations for the treatment of
9 mental health and substance-use disorders unless the processes, strategies, evidentiary standards,
10 or other factors used in applying the non-quantitative treatment limitation, as written and in
11 operation, are comparable to, and are applied no more stringently than, the processes, strategies,
12 evidentiary standards, or other factors used in applying the limitation with respect to
13 medical/surgical benefits in the classification.

14 (e) The following classifications shall be used to apply the coverage requirements of this
15 chapter: (1) Inpatient, in-network; (2) Inpatient, out-of-network; (3) Outpatient, in-network; (4)
16 Outpatient, out-of-network; (5) Emergency care; and (6) Prescription drugs.

17 (f) Medication-assisted treatment or medication-assisted maintenance services of
18 substance-use disorders, opioid overdoses, and chronic addiction, including methadone,
19 buprenorphine, naltrexone, or other clinically appropriate medications, is included within the
20 appropriate classification based on the site of the service.

21 (g) Payors shall rely upon the criteria of the American Society of Addiction Medicine
22 when developing coverage for levels of care for substance-use disorder treatment.

23 **27-38.2-2. Definitions.**

24 For the purposes of this chapter, the following words and terms have the following
25 meanings:

26 (1) "Financial requirements" means deductibles, copayments, ~~coinsurance~~, or out-of-
27 pocket maximums.

28 (2) "Group health plan" means an employee welfare benefit plan as defined in 29 USC
29 1002(1) to the extent that the plan provides health benefits to employees or their dependents
30 directly or through insurance, reimbursement, or otherwise. For purposes of this chapter, a group
31 health plan shall not include a plan that provides health benefits directly to employees or their
32 dependents, except in the case of a plan provided by the state or an instrumentality of the state.

33 (3) "Health insurance plan" means health insurance coverage offered, delivered, issued
34 for delivery, or renewed by a health insurer.

1 (4) "Health insurers" means all persons, firms, corporations, or other organizations
2 offering and assuring health services on a prepaid or primarily expense-incurred basis, including
3 but not limited to, policies of accident or sickness insurance, as defined by chapter 18 of this title;
4 nonprofit hospital or medical service plans, whether organized under chapter 19 or 20 of this title
5 or under any public law or by special act of the general assembly; health maintenance
6 organizations, or any other entity that insures or reimburses for diagnostic, therapeutic, or
7 preventive services to a determined population on the basis of a periodic premium. Provided, this
8 chapter does not apply to insurance coverage providing benefits for:

9 (i) Hospital confinement indemnity;

10 (ii) Disability income;

11 (iii) Accident only;

12 (iv) Long-term care;

13 (v) Medicare supplement;

14 (vi) Limited benefit health;

15 (vii) Specific disease indemnity;

16 (viii) Sickness or bodily injury or death by accident or both; and

17 (ix) Other limited benefit policies.

18 (5) "Mental health or substance use disorder" means any mental disorder and substance
19 use disorder that is listed in the most recent revised publication or the most updated volume of
20 either the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the
21 American Psychiatric Association or the International Classification of Disease Manual (ICO)
22 published by the World Health Organization; provided, that tobacco and caffeine are excluded
23 from the definition of "substance" for the purposes of this chapter.

24 (6) "Non-quantitative treatment limitations" means: (i) Medical management standards;
25 (ii) Formulary design and protocols; (iii) Network tier design; (iv) Standards for provider
26 admission to participate in a network; (v) Reimbursement rates and methods for determining
27 usual, customary, and reasonable charges; and (vi) Other criteria that limit scope or duration of
28 coverage for services in the treatment of mental health and substance use disorders, including
29 restrictions based on geographic location, facility type, and provider specialty.

30 (7) "Quantitative treatment limitations" means numerical limits on coverage for the
31 treatment of mental health and substance use disorders based on the frequency of treatment,
32 number of visits, days of coverage, days in a waiting period, or other similar limits on the scope
33 or duration of treatment.

34 SECTION 6. Section 27-41-29.2 of the General Laws in Chapter 27-41 entitled "Health

1 Maintenance Organizations" is hereby amended to read as follows:

2 **27-41-29.2. Filing of policy forms.**

3 (a) A health maintenance organization shall file all policy forms and rates used by it in
4 the state with the commissioner, including the forms of any rider, endorsement, application blank,
5 and other matter generally used or incorporated by reference in its policies or contracts of
6 insurance. No such form shall be approved if it utilizes a coinsurance method, as defined in §27-
7 41-87, for the collection of patient financial requirements for covered benefits. No such form
8 shall be used if disapproved by the commissioner under this section, or if the commissioner's
9 approval has been withdrawn after notice and an opportunity to be heard, or until the expiration
10 of sixty (60) days following the filing of the form. Such a company shall comply with its filed
11 and approved forms. If the commissioner finds from an examination of any form that it is
12 contrary to the public interest or the requirements of this code or duly promulgated regulations, he
13 or she shall forbid its use, and shall notify the corporation in writing.

14 (b) Each rate filing shall include a certification by a qualified actuary that to the best of
15 the actuary's knowledge and judgment, the entire rate filing is in compliance with applicable laws
16 and that the benefits offered or proposed to be offered are reasonable in relation to the premium
17 to be charged. A health insurance carrier shall comply with its filed and approved rates and forms.

18 SECTION 7. Chapter 27-18 of the General Laws entitled "Accident and Sickness
19 Insurance Policies" is hereby amended by adding thereto the following section:

20 **27-18-83. Patient financial requirements.**

21 Every individual or group hospital or medical expense insurance policy or individual or
22 group hospital or medical services plan contract delivered, issued for delivery, or renewed in this
23 state on or after January 1, 2019, shall not utilize coinsurance as a method for collecting amounts
24 due from patients beyond the premium responsibility for covered services as required under the
25 insured's benefit plan. For purposes of this section, "coinsurance" is defined as a percentage of the
26 allowable charge, after a copayment, if any, that an insured will pay for covered benefits.
27 Provided, however, this section shall not apply to insurance coverage providing benefits for:

28 (1) Hospital confinement indemnity;

29 (2) Disability income;

30 (3) Accident only;

31 (4) Long-term care;

32 (5) Medicare supplement;

33 (6) Limited benefit health;

34 (7) Specified disease indemnity;

1 (8) Sickness or bodily injury or death by accident or both; and

2 (9) Other limited benefit policies.

3 SECTION 8. Chapter 27-19 of the General Laws entitled "Nonprofit Hospital Service
4 Corporations" is hereby amended by adding thereto the following section:

5 **27-19-74. Patient financial requirements.**

6 Every individual or group hospital or medical expense insurance policy or individual or
7 group hospital or medical services plan contract delivered, issued for delivery, or renewed in this
8 state on or after January 1, 2019, shall not utilize coinsurance as a method for collecting amounts
9 due from patients beyond the premium responsibility for covered services as required under the
10 insured's benefit plan. For purposes of this section, "coinsurance" is defined as a percentage of the
11 allowable charge, after a copayment, if any, that an insured will pay for covered benefits.

12 SECTION 9. Chapter 27-20 of the General Laws entitled "Nonprofit Medical Service
13 Corporations" is hereby amended by adding thereto the following section:

14 **27-20-70. Patient financial requirements.**

15 Every individual or group hospital or medical expense insurance policy or individual or
16 group hospital or medical services plan contract delivered, issued for delivery, or renewed in this
17 state on or after January 1, 2019, shall not utilize coinsurance as a method for collecting amounts
18 due from patients beyond the premium responsibility for covered services as required under the
19 insured's benefit plan. For purposes of this section, "coinsurance" is defined as a percentage of the
20 allowable charge, after a copayment, if any, that an insured will pay for covered benefits.

21 SECTION 10. Chapter 27-41 of the General Laws entitled "Health Maintenance
22 Organizations" is hereby amended by adding thereto the following section:

23 **27-41-87. Patient financial requirements.**

24 Every individual or group hospital or medical expense insurance policy or individual or
25 group hospital or medical services plan contract delivered, issued for delivery, or renewed in this
26 state on or after January 1, 2019, shall not utilize coinsurance as a method for collecting amounts
27 due from patients beyond the premium responsibility for covered services as required under the
28 insured's benefit plan. For purposes of this section, "coinsurance" is defined as a percentage of the
29 allowable charge, after a copayment, if any, that an insured will pay for covered benefits.

30 SECTION 11. This act shall take effect upon passage.

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EXPLANATION
BY THE LEGISLATIVE COUNCIL
OF
A N A C T
RELATING TO INSURANCE - INSURANCE COVERAGE FOR MENTAL HEALTH AND
SUBSTANCE ABUSE DISORDERS

1 This act would define coinsurance as a percentage of the allowable charge, after a
2 copayment that an insured will pay for covered benefits. It would prohibit insurance contracts or
3 policies from using coinsurance to calculate and collect additional funds from patients, including
4 mental health and substance abuse patients.

5 This act would take effect upon passage.

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