

2017 -- S 0330 SUBSTITUTE A

LC001276/SUB A

STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2017

A N A C T

RELATING TO STATE AFFAIRS AND GOVERNMENT -- THE RHODE ISLAND HEALTH CARE REFORM ACT OF 2004--HEALTH INSURANCE OVERSIGHT

Introduced By: Senators Coyne, Miller, Crowley, Sosnowski, and Goodwin

Date Introduced: February 16, 2017

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

1           SECTION 1. Section 42-14.5-3 of the General Laws in Chapter 42-14.5 entitled "The  
2   Rhode Island Health Care Reform Act of 2004 - Health Insurance Oversight" is hereby amended  
3   to read as follows:

4           **42-14.5-3. Powers and duties [Contingent effective date; see effective dates under**  
5   **this section].**

6           The health insurance commissioner shall have the following powers and duties:

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

17           (b) To make recommendations to the governor and the house of representatives and  
18   senate finance committees regarding health-care insurance and the regulations, rates, services,

1 administrative expenses, reserve requirements, and operations of insurers providing health  
2 insurance in the state, and to prepare or comment on, upon the request of the governor or  
3 chairpersons of the house or senate finance committees, draft legislation to improve the regulation  
4 of health insurance. In making such recommendations, the commissioner shall recognize that it is  
5 the intent of the legislature that the maximum disclosure be provided regarding the  
6 reasonableness of individual administrative expenditures as well as total administrative costs. The  
7 commissioner shall make recommendations on the levels of reserves, including consideration of:  
8 targeted reserve levels; trends in the increase or decrease of reserve levels; and insurer plans for  
9 distributing excess reserves.

10 (c) To establish a consumer/business/labor/medical advisory council to obtain  
11 information and present concerns of consumers, business, and medical providers affected by  
12 health-insurance decisions. The council shall develop proposals to allow the market for small  
13 business health insurance to be affordable and fairer. The council shall be involved in the  
14 planning and conduct of the quarterly public meetings in accordance with subsection (a). The  
15 advisory council shall develop measures to inform small businesses of an insurance complaint  
16 process to ensure that small businesses that experience rate increases in a given year may request  
17 and receive a formal review by the department. The advisory council shall assess views of the  
18 health-provider community relative to insurance rates of reimbursement, billing, and  
19 reimbursement procedures, and the insurers' role in promoting efficient and high-quality health  
20 care. The advisory council shall issue an annual report of findings and recommendations to the  
21 governor and the general assembly and present its findings at hearings before the house and  
22 senate finance committees. The advisory council is to be diverse in interests and shall include  
23 representatives of community consumer organizations; small businesses, other than those  
24 involved in the sale of insurance products; and hospital, medical, and other health-provider  
25 organizations. Such representatives shall be nominated by their respective organizations. The  
26 advisory council shall be co-chaired by the health insurance commissioner and a community  
27 consumer organization or small business member to be elected by the full advisory council.

28 (d) To establish and provide guidance and assistance to a subcommittee ("the  
29 professional-provider-health-plan work group") of the advisory council created pursuant to  
30 subsection (c), composed of health-care providers and Rhode Island licensed health plans. This  
31 subcommittee shall include in its annual report and presentation before the house and senate  
32 finance committees the following information:

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

1 (2) A standardized provider application and credentials-verification process, for the  
2 purpose of verifying professional qualifications of participating health-care providers;

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

4 (4) Methods for health maintenance organizations, as defined by § 27-41-2, and nonprofit  
5 hospital or medical-service corporations, as defined by chapters 19 and 20 of title 27, to make  
6 facility-specific data and other medical service-specific data available in reasonably consistent  
7 formats to patients regarding quality and costs. This information would help consumers make  
8 informed choices regarding the facilities and/or clinicians or physician practices at which to seek  
9 care. Among the items considered would be the unique health services and other public goods  
10 provided by facilities and/or clinicians or physician practices in establishing the most appropriate  
11 cost comparisons;

12 (5) All activities related to contractual disclosure to participating providers of the  
13 mechanisms for resolving health plan/provider disputes;

14 (6) The uniform process being utilized for confirming, in real time, patient insurance  
15 enrollment status, benefits coverage, including co-pays and deductibles;

16 (7) Information related to temporary credentialing of providers seeking to participate in  
17 the plan's network and the impact of said activity on health-plan accreditation;

18 (8) The feasibility of regular contract renegotiations between plans and the providers in  
19 their networks; and

20 (9) Efforts conducted related to reviewing impact of silent PPOs on physician practices.

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

22 (f) To provide analysis of the Rhode Island affordable health plan reinsurance fund. The  
23 fund shall be used to effectuate the provisions of §§ 27-18.5-9 and 27-50-17.

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

27 (1) The analysis shall forecast the likely rate increases required to effect the changes  
28 recommended pursuant to the preceding subsection (g) in the direct-pay market and small-  
29 employer-health-insurance market over the next five (5) years, based on the current rating  
30 structure and current products.

31 (2) The analysis shall include examining the impact of merging the individual and small-  
32 employer markets on premiums charged to individuals and small-employer groups.

33 (3) The analysis shall include examining the impact on rates in each of the individual and  
34 small-employer-health-insurance markets and the number of insureds in the context of possible

1 changes to the rating guidelines used for small-employer groups, including: community rating  
2 principles; expanding small-employer rate bonds beyond the current range; increasing the  
3 employer group size in the small-group market; and/or adding rating factors for broker and/or  
4 tobacco use.

5 (4) The analysis shall include examining the adequacy of current statutory and regulatory  
6 oversight of the rating process and factors employed by the participants in the proposed, new  
7 merged market.

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

12 (6) The health insurance commissioner shall work with an insurance market merger task  
13 force to assist with the analysis. The task force shall be chaired by the health insurance  
14 commissioner and shall include, but not be limited to, representatives of the general assembly, the  
15 business community, small-employer carriers as defined in § 27-50-3, carriers offering coverage  
16 in the individual market in Rhode Island, health-insurance brokers, and members of the general  
17 public.

18 (7) For the purposes of conducting this analysis, the commissioner may contract with an  
19 outside organization with expertise in fiscal analysis of the private-insurance market. In  
20 conducting its study, the organization shall, to the extent possible, obtain and use actual health-  
21 plan data. Said data shall be subject to state and federal laws and regulations governing  
22 confidentiality of health care and proprietary information.

23 (8) The task force shall meet as necessary and include its findings in the annual report,  
24 and the commissioner shall include the information in the annual presentation before the house  
25 and senate finance committees.

26 (h) To establish and convene a workgroup representing health-care providers and health  
27 insurers for the purpose of coordinating the development of processes, guidelines, and standards  
28 to streamline health-care administration that are to be adopted by payors and providers of health-  
29 care services operating in the state. This workgroup shall include representatives with expertise  
30 who would contribute to the streamlining of health-care administration and who are selected from  
31 hospitals, physician practices, community behavioral-health organizations, each health insurer,  
32 and other affected entities. The workgroup shall also include at least one designee each from the  
33 Rhode Island Medical Society, Rhode Island Council of Community Mental Health  
34 Organizations, the Rhode Island Health Center Association, and the Hospital Association of

1 Rhode Island. The workgroup shall consider and make recommendations for:

2 (1) Establishing a consistent standard for electronic eligibility and coverage verification.

3 Such standard shall:

4 (i) Include standards for eligibility inquiry and response and, wherever possible, be

5 consistent with the standards adopted by nationally recognized organizations, such as the Centers

6 for Medicare and Medicaid Services;

7 (ii) Enable providers and payors to exchange eligibility requests and responses on a

8 system-to-system basis or using a payor-supported web browser;

9 (iii) Provide reasonably detailed information on a consumer's eligibility for health-care

10 coverage; scope of benefits; limitations and exclusions provided under that coverage; cost-sharing

11 requirements for specific services at the specific time of the inquiry; current deductible amounts;

12 accumulated or limited benefits; out-of-pocket maximums; any maximum policy amounts; and

13 other information required for the provider to collect the patient's portion of the bill;

14 (iv) Reflect the necessary limitations imposed on payors by the originator of the

15 eligibility and benefits information;

16 (v) Recommend a standard or common process to protect all providers from the costs of

17 services to patients who are ineligible for insurance coverage in circumstances where a payor

18 provides eligibility verification based on best information available to the payor at the date of the

19 request of eligibility.

20 (2) Developing implementation guidelines and promoting adoption of such guidelines

21 for:

22 (i) The use of the National Correct Coding Initiative code-edit policy by payors and

23 providers in the state;

24 (ii) Publishing any variations from codes and mutually exclusive codes by payors in a

25 manner that makes for simple retrieval and implementation by providers;

26 (iii) Use of Health Insurance Portability and Accountability Act standard group codes,

27 reason codes, and remark codes by payors in electronic remittances sent to providers;

28 (iv) The processing of corrections to claims by providers and payors.

29 (v) A standard payor-denial review process for providers when they request a

30 reconsideration of a denial of a claim that results from differences in clinical edits where no

31 single, common-standards body or process exists and multiple conflicting sources are in use by

32 payors and providers.

33 (vi) Nothing in this section, nor in the guidelines developed, shall inhibit an individual

34 payor's ability to employ, and not disclose to providers, temporary code edits for the purpose of

1 detecting and deterring fraudulent billing activities. The guidelines shall require that each payor  
2 disclose to the provider its adjudication decision on a claim that was denied or adjusted based on  
3 the application of such edits and that the provider have access to the payor's review and appeal  
4 process to challenge the payor's adjudication decision.

5 (vii) Nothing in this subsection shall be construed to modify the rights or obligations of  
6 payors or providers with respect to procedures relating to the investigation, reporting, appeal, or  
7 prosecution under applicable law of potentially fraudulent billing activities.

8 (3) Developing and promoting widespread adoption by payors and providers of  
9 guidelines to:

10 (i) Ensure payors do not automatically deny claims for services when extenuating  
11 circumstances make it impossible for the provider to obtain a preauthorization before services are  
12 performed or notify a payor within an appropriate standardized timeline of a patient's admission;

13 (ii) Require payors to use common and consistent processes and time frames when  
14 responding to provider requests for medical management approvals. Whenever possible, such  
15 time frames shall be consistent with those established by leading national organizations and be  
16 based upon the acuity of the patient's need for care or treatment. For the purposes of this section,  
17 medical management includes prior authorization of services, preauthorization of services,  
18 precertification of services, post-service review, medical-necessity review, and benefits advisory;

19 (iii) Develop, maintain, and promote widespread adoption of a single, common website  
20 where providers can obtain payors' preauthorization, benefits advisory, and preadmission  
21 requirements;

22 (iv) Establish guidelines for payors to develop and maintain a website that providers can  
23 use to request a preauthorization, including a prospective clinical necessity review; receive an  
24 authorization number; and transmit an admission notification.

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

29 (i) To issue an anti-cancer medication report. Not later than June 30, 2014 and annually  
30 thereafter, the office of the health insurance commissioner (OHIC) shall provide the senate  
31 committee on health and human services, and the house committee on corporations, with: (1)  
32 Information on the availability in the commercial market of coverage for anti-cancer medication  
33 options; (2) For the state employee's health benefit plan, the costs of various cancer-treatment  
34 options; (3) The changes in drug prices over the prior thirty-six (36) months; and (4) Member

1 utilization and cost-sharing expense.

2 (j) To monitor the adequacy of each health plan's compliance with the provisions of the  
3 federal Mental Health Parity Act, including a review of related claims processing and  
4 reimbursement procedures. Findings, recommendations, and assessments shall be made available  
5 to the public.

6 (k) To monitor the transition from fee-for-service and toward global and other alternative  
7 payment methodologies for the payment for health-care services. Alternative payment  
8 methodologies should be assessed for their likelihood to promote access to affordable health  
9 insurance, health outcomes, and performance.

10 (l) To report annually, no later than July 1, 2014, then biannually thereafter, on hospital  
11 payment variation, including findings and recommendations, subject to available resources.

12 (m) Notwithstanding any provision of the general or public laws or regulation to the  
13 contrary, provide a report with findings and recommendations to the president of the senate and  
14 the speaker of the house, on or before April 1, 2014, including, but not limited to, the following  
15 information:

16 (1) The impact of the current, mandated health-care benefits as defined in §§ 27-18-48.1,  
17 27-18-60, 27-18-62, 27-18-64, similar provisions in chapters 19, 20 and 41, of title 27, and §§ 27-  
18 18-3(c), 27-38.2-1 et seq., or others as determined by the commissioner, on the cost of health  
19 insurance for fully insured employers, subject to available resources;

20 (2) Current provider and insurer mandates that are unnecessary and/or duplicative due to  
21 the existing standards of care and/or delivery of services in the health-care system;

22 (3) A state-by-state comparison of health-insurance mandates and the extent to which  
23 Rhode Island mandates exceed other states benefits; and

24 (4) Recommendations for amendments to existing mandated benefits based on the  
25 findings in (m)(1), (m)(2), and (m)(3) above.

26 (n) On or before July 1, 2014, the office of the health insurance commissioner, in  
27 collaboration with the director of health and lieutenant governor's office, shall submit a report to  
28 the general assembly and the governor to inform the design of accountable care organizations  
29 (ACOs) in Rhode Island as unique structures for comprehensive health-care delivery and value-  
30 based payment arrangements, that shall include, but not be limited to:

31 (1) Utilization review;

32 (2) Contracting; and

33 (3) Licensing and regulation.

34 (o) On or before February 3, 2015, the office of the health insurance commissioner shall

1 submit a report to the general assembly and the governor that describes, analyzes, and proposes  
2 recommendations to improve compliance of insurers with the provisions of § 27-18-76 with  
3 regard to patients with mental-health and substance-use disorders.

4 (p) On or before January 1, 2018, the office of the health insurance commissioner shall  
5 submit recommendations based on the preliminary results of a market conduct examination to the  
6 general assembly and the governor that ensure compliance of insurers with the mental health  
7 parity provisions of §27-38.2-1.

8 (q) On or before January 1, 2018, the commissioner shall make recommendations  
9 regarding:

10 (1) Strategies to reduce unreasonable prior authorizations and utilization review  
11 requirements that result in barriers to access both quantitative and non-quantitative treatments;

12 (2) Methods to remediate areas of insurer noncompliance with the mental health parity  
13 provisions of §27-38.2-1;

14 (3) Adequate telemedicine reimbursement rates that will ensure quality access to mental  
15 health and behavioral health providers; and

16 (4) Innovative cost-sharing methodologies that ensure that patient payment obligations  
17 are not a barrier to care for mental health and behavioral health patients.

18 SECTION 2. This act shall take effect upon passage.

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LC001276/SUB A  
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EXPLANATION  
BY THE LEGISLATIVE COUNCIL  
OF  
A N A C T  
RELATING TO STATE AFFAIRS AND GOVERNMENT -- THE RHODE ISLAND HEALTH  
CARE REFORM ACT OF 2004--HEALTH INSURANCE OVERSIGHT

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- 1           This act would require the health insurance commissioner to make recommendations to
- 2   the general assembly to ensure compliance with mental health parity provisions required by
- 3   existing law.
- 4           This act would take effect upon passage.

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