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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. 2018

A N A C T

RELATING TO HEALTH AND SAFETY -- INSURANCE COVERAGE FOR MENTAL ILLNESS AND SUBSTANCE ABUSE

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

Date Introduced: March 01, 2018

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

SECTION 1. Section 5-37.3-4 of the General Laws in Chapter 5-37.3 entitled "Confidentiality of Health Care Communications and Information Act" is hereby amended to read as follows:

5-37.3-4. Limitations on and permitted disclosures.

(a) (1) Except as provided in subsection (b) of this section, or as specifically provided by the law, a patient's confidential health care information shall not be released or transferred without the written consent of the patient, or his or her authorized representative, on a consent form meeting the requirements of subsection (d) of this section. A copy of any notice used pursuant to subsection (d) of this section, and of any signed consent shall, upon request, be provided to the patient prior to his or her signing a consent form. Any and all managed care entities and managed care contractors writing policies in the state shall be prohibited from providing any information related to enrollees that is personal in nature and could reasonably lead to identification of an individual and is not essential for the compilation of statistical data related to enrollees, to any international, national, regional, or local medical information database. This provision shall not restrict or prohibit the transfer of information to the department of health to carry out its statutory duties and responsibilities.

(2) Any person who violates the provisions of this section may be liable for actual and punitive damages.

(3) The court may award a reasonable attorney's fee at its discretion to the prevailing party in any civil action under this section.

(4) Any person who knowingly and intentionally violates the provisions of this section shall, upon conviction, be fined not more than five thousand ($5,000) dollars for each violation, or imprisoned not more than six (6) months for each violation, or both.

(5) Any contract or agreement that purports to waive the provisions of this section shall be declared null and void as against public policy.

(b) No consent for release or transfer of confidential health care information shall be required in the following situations:

(1) To a physician, dentist, or other medical personnel who believes, in good faith, that the information is necessary for diagnosis or treatment of that individual in a medical or dental emergency;

(2) To medical and dental peer review boards, or the board of medical licensure and discipline, or board of examiners in dentistry;

(3) To qualified personnel for the purpose of conducting scientific research, management audits, financial audits, program evaluations, actuarial, insurance underwriting, or similar studies; provided, that personnel shall not identify, directly or indirectly, any individual patient in any report of that research, audit, or evaluation, or otherwise disclose patient identities in any manner;

(4) (i) By a health care provider to appropriate law enforcement personnel, or to a person if the health care provider believes that person, or his or her family, is in danger from a patient; or to appropriate law enforcement personnel if the patient has, or is attempting to obtain, narcotic drugs from the health care provider illegally; or to appropriate law enforcement personnel, or appropriate child protective agencies, if the patient is a minor child or the parent or guardian of said child and/or the health care provider believes, after providing health care services to the patient, that the child is, or has been, physically, psychologically, or sexually abused and neglected as reportable pursuant to § 40-11-3; or to appropriate law enforcement personnel or the division of elderly affairs if the patient is an elder person and the healthcare provider believes, after providing healthcare services to the patient, that the elder person is, or has been, abused, neglected, or exploited as reportable pursuant to § 42-66-8; or to law enforcement personnel in the case of a gunshot wound reportable under § 11-47-48;

(A) Provided further, consistent with applicable law and standards of ethical conduct, a health care provider may disclose a patient's protected health information related to a substance use disorder to a person or persons if:

(I) The health care provider, in good faith, believes the use or disclosure is necessary to

prevent or lessen a serious and imminent threat to the patient's health through continued substance use upon discharge; and

(II) Is to a person or persons reasonably able to prevent or lessen the threat of continued substance use upon discharge;

(ii) A health care provider may disclose protected health information in response to a law enforcement official's request for such information for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, provided that the health care provider may disclose only the following information:

(A) Name and address;

(B) Date and place of birth;

(C) Social security number;

(D) ABO blood type and rh factor;

(E) Type of injury;

(F) Date and time of treatment;

(G) Date and time of death, if applicable; and

(H) A description of distinguishing physical characteristics, including height, weight, gender, race, hair and eye color, presence or absence of facial hair (beard or moustache), scars, and tattoos.

(I) Except as permitted by this subsection, the health care provider may not disclose for the purposes of identification or location under this subsection any protected health information related to the patient's DNA or DNA analysis, dental records, or typing, samples, or analysis of body fluids or tissue.

(iii) A health care provider may disclose protected health information in response to a law enforcement official's request for such information about a patient who is, or is suspected to be, a victim of a crime, other than disclosures that are subject to subsection (b)(4)(vii) of this section, if:

(A) The patient agrees to the disclosure; or

(B) The health care provider is unable to obtain the patient's agreement because of incapacity or other emergency circumstances provided that:

(1) The law enforcement official represents that such information is needed to determine whether a violation of law by a person other than the victim has occurred, and such information is not intended to be used against the victim;

(2) The law enforcement official represents that immediate law enforcement activity that depends upon the disclosure would be materially and adversely affected by waiting until the

patient is able to agree to the disclosure; and

(3) The disclosure is in the best interests of the patient as determined by the health care provider in the exercise of professional judgment.

(iv) A health care provider may disclose protected health information about a patient who has died to a law enforcement official for the purpose of alerting law enforcement of the death of the patient if the health care provider has a suspicion that such death may have resulted from criminal conduct.

(v) A health care provider may disclose to a law enforcement official protected health information that the health care provider believes in good faith constitutes evidence of criminal conduct that occurred on the premises of the health care provider.

(vi) (A) A health care provider providing emergency health care in response to a medical emergency, other than such emergency on the premises of the covered health care provider, may disclose protected health information to a law enforcement official if such disclosure appears necessary to alert law enforcement to:

(1) The commission and nature of a crime;

(2) The location of such crime or of the victim(s) of such crime; and

(3) The identity, description, and location of the perpetrator of such crime.

(B) If a health care provider believes that the medical emergency described in subsection (b)(4)(vi)(A) of this section is the result of abuse, neglect, or domestic violence of the individual in need of emergency health care, subsection (b)(4)(vi)(A) of this section does not apply and any disclosure to a law enforcement official for law enforcement purposes is subject to subsection (b)(4)(vii) of this section.

(vii) (A) Except for reports permitted by subsection (b)(4)(i) of this section, a health care provider may disclose protected health information about a patient the health care provider reasonably believes to be a victim of abuse, neglect, or domestic violence to law enforcement or a government authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence:

(1) To the extent the disclosure is required by law and the disclosure complies with, and is limited to, the relevant requirements of such law;

(2) If the patient agrees to the disclosure; or

(3) To the extent the disclosure is expressly authorized by statute or regulation and:

(i) The health care provider, in the exercise of professional judgment, believes the disclosure is necessary to prevent serious harm to the patient or other potential victims; or

(ii) If the patient is unable to agree because of incapacity, a law enforcement or other

public official authorized to receive the report represents that the protected health information for which disclosure is sought is not intended to be used against the patient and that an immediate enforcement activity that depends upon the disclosure would be materially and adversely affected by waiting until the patient is able to agree to the disclosure.

(B) A health care provider that makes a disclosure permitted by subsection (b)(4)(vii)(A) of this section must promptly inform the patient that such a report has been, or will be, made, except if:

(1) The health care facility, in the exercise of professional judgment, believes informing the patient would place the individual at risk of serious harm; or

(2) The health care provider would be informing a personal representative, and the health care provider reasonably believes the personal representative is responsible for the abuse, neglect, or other injury, and that informing such person would not be in the best interests of the individual as determined by the covered entity in the exercise of professional judgment.

(viii) The disclosures authorized by this subsection shall be limited to the minimum amount of information necessary to accomplish the intended purpose of the release of information.

(5) Between, or among, qualified personnel and health care providers within the health care system for purposes of coordination of health care services given to the patient and for purposes of education and training within the same health care facility; or

(6) To third party health insurers, including to utilization review agents as provided by § 23-17.12-9(c)(4), third party administrators licensed pursuant to chapter 20.7 of title 27, and other entities that provide operational support to adjudicate health insurance claims or administer health benefits;

(7) To a malpractice insurance carrier or lawyer if the health care provider has reason to anticipate a medical liability action; or

(8) (i) To the health care provider's own lawyer or medical liability insurance carrier if the patient whose information is at issue brings a medical liability action against a health care provider.

(ii) Disclosure by a health care provider of a patient's health care information that is relevant to a civil action brought by the patient against any person or persons other than that health care provider may occur only under the discovery methods provided by the applicable rules of civil procedure (federal or state). This disclosure shall not be through ex parte contacts and not through informal ex parte contacts with the provider by persons other than the patient or his or her legal representative.

Nothing in this section shall limit the right of a patient, or his or her attorney, to consult with that patient's own physician and to obtain that patient's own health care information;

(9) To public health authorities in order to carry out their functions as described in this title and titles 21 and 23 and rules promulgated under those titles. These functions include, but are not restricted to, investigations into the causes of disease, the control of public health hazards, enforcement of sanitary laws, investigation of reportable diseases, certification and licensure of health professionals and facilities, review of health care such as that required by the federal government and other governmental agencies;

(10) To the state medical examiner in the event of a fatality that comes under his or her jurisdiction;

(11) In relation to information that is directly related to a current claim for workers' compensation benefits or to any proceeding before the workers' compensation commission or before any court proceeding relating to workers' compensation;

(12) To the attorneys for a health care provider whenever that provider considers that release of information to be necessary in order to receive adequate legal representation;

(13) By a health care provider to appropriate school authorities of disease, health screening, and/or immunization information required by the school; or when a school-age child transfers from one school or school district to another school or school district;

(14) To a law enforcement authority to protect the legal interest of an insurance institution, agent, or insurance-support organization in preventing and prosecuting the perpetration of fraud upon them;

(15) To a grand jury, or to a court of competent jurisdiction, pursuant to a subpoena or subpoena duces tecum when that information is required for the investigation or prosecution of criminal wrongdoing by a health care provider relating to his, her or its provisions of health care services and that information is unavailable from any other source; provided, that any information so obtained, is not admissible in any criminal proceeding against the patient to whom that information pertains;

(16) To the state board of elections pursuant to a subpoena or subpoena duces tecum when that information is required to determine the eligibility of a person to vote by mail ballot and/or the legitimacy of a certification by a physician attesting to a voter's illness or disability;

(17) To certify, pursuant to chapter 20 of title 17, the nature and permanency of a person's illness or disability, the date when that person was last examined and that it would be an undue hardship for the person to vote at the polls so that the person may obtain a mail ballot;

(18) To the central cancer registry;

(19) To the Medicaid fraud control unit of the attorney general's office for the investigation or prosecution of criminal or civil wrongdoing by a health care provider relating to his, her or its provision of health care services to then-Medicaid-eligible recipients or patients, residents, or former patients or residents of long-term residential care facilities; provided, that any information obtained shall not be admissible in any criminal proceeding against the patient to whom that information pertains;

(20) To the state department of children, youth and families pertaining to the disclosure of health care records of children in the custody of the department;

(21) To the foster parent, or parents, pertaining to the disclosure of health care records of children in the custody of the foster parent, or parents; provided, that the foster parent or parents receive appropriate training and have ongoing availability of supervisory assistance in the use of sensitive information that may be the source of distress to these children;

(22) A hospital may release the fact of a patient's admission and a general description of a patient's condition to persons representing themselves as relatives or friends of the patient or as a representative of the news media. The access to confidential health care information to persons in accredited educational programs under appropriate provider supervision shall not be deemed subject to release or transfer of that information under subsection (a) of this section; or

(23) To the workers' compensation fraud prevention unit for purposes of investigation under §§ 42-16.1-12 -- 42-16.1-16. The release or transfer of confidential health care information under any of the above exceptions is not the basis for any legal liability, civil or criminal, nor considered a violation of this chapter; or

(24) To a probate court of competent jurisdiction, petitioner, respondent, and/or their attorneys, when the information is contained within a decision-making assessment tool that conforms to the provisions of § 33-15-47.

(c) Third parties receiving, and retaining, a patient's confidential health care information must establish at least the following security procedures:

(1) Limit authorized access to personally identifiable, confidential health care information to persons having a "need to know" that information; additional employees or agents may have access to that information that does not contain information from which an individual can be identified;

(2) Identify an individual, or individuals, who have responsibility for maintaining security procedures for confidential health care information;

(3) Provide a written statement to each employee or agent as to the necessity of maintaining the security and confidentiality of confidential health care information, and of the

penalties provided for in this chapter for the unauthorized release, use, or disclosure of this information. The receipt of that statement shall be acknowledged by the employee or agent, who signs and returns the statement to his or her employer or principal, who retains the signed original. The employee or agent shall be furnished with a copy of the signed statement; and

(4) Take no disciplinary or punitive action against any employee or agent solely for bringing evidence of violation of this chapter to the attention of any person.

(d) Consent forms for the release or transfer of confidential health care information shall contain, or in the course of an application or claim for insurance be accompanied by a notice containing, the following information in a clear and conspicuous manner:

(1) A statement of the need for and proposed uses of that information;

(2) A statement that all information is to be released or clearly indicating the extent of the information to be released; and

(3) A statement that the consent for release or transfer of information may be withdrawn at any future time and is subject to revocation, except where an authorization is executed in connection with an application for a life or health insurance policy in which case the authorization expires two (2) years from the issue date of the insurance policy, and when signed in connection with a claim for benefits under any insurance policy, the authorization shall be valid during the pendency of that claim. Any revocation shall be transmitted in writing.

(e) Except as specifically provided by law, an individual's confidential health care information shall not be given, sold, transferred, or in any way relayed to any other person not specified in the consent form or notice meeting the requirements of subsection (d) of this section without first obtaining the individual's additional written consent on a form stating the need for the proposed new use of this information or the need for its transfer to another person.

(f) Nothing contained in this chapter shall be construed to limit the permitted disclosure of confidential health care information and communications described in subsection (b) of this section.

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

23-17.26-3. Comprehensive discharge planning.

(a) On or before January 1, 2017, each hospital and freestanding, emergency-care facility operating in the state of Rhode Island shall submit to the director a comprehensive discharge plan that includes:

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

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

(i) Providing education in the hospital or freestanding, emergency-care facility prior to discharge;

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

(iii) With patient consent, attempting to notify the person(s) listed as the patient's emergency contacts and recovery coach before discharge. If the patient refuses to consent to the notification of emergency contacts, such refusal shall be noted in the patient's medical record;

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

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

(vi) Coordinating and improving communication with outpatient providers.

(3) The discharge plan and transition process shall include recovery planning tools for patients with substance-use disorders, opioid overdoses, and chronic addiction, which plan and transition process shall include the elements contained in subsections (a)(1) or (a)(2), as applicable. In addition, such discharge plan and transition process shall also include:

(i) That, with patient consent, each patient presenting to a hospital or freestanding, emergency-care facility with indication of a substance-use disorder, opioid overdose, or chronic addiction shall receive a substance-~~abuse~~ use evaluation, in accordance with the standards in subsection (a)(4)(ii), before discharge. Prior to the dissemination of the standards in subsection (a)(4)(ii), with patient consent, each patient presenting to a hospital or freestanding, emergency-care facility with indication of a substance-use disorder, opioid overdose, or chronic addiction shall receive a substance-~~abuse~~ use evaluation, in accordance with best practices standards, before discharge;

(ii) That if, after the completion of a substance-~~abuse~~ use evaluation, in accordance with the standards in subsection (a)(4)(ii), the clinically appropriate inpatient and outpatient services for the treatment of substance-use disorders, opioid overdose, or chronic addiction contained in subsection (a)(3)(iv) are not immediately available, the hospital or freestanding, emergency-care

facility shall provide medically necessary and appropriate services with patient consent, until the appropriate transfer of care is completed;

(iii) That, with patient consent, pursuant to 21 C.F.R. § 1306.07, a physician in a hospital or freestanding, emergency-care facility, who is not specifically registered to conduct a narcotic treatment program, may administer narcotic drugs, including buprenorphine, to a person for the purpose of relieving acute, opioid-withdrawal symptoms, when necessary, while arrangements are being made for referral for treatment. Not more than one day's medication may be administered to the person or for the person's use at one time. Such emergency treatment may be carried out for not more than three (3) days and may not be renewed or extended;

(iv) That each patient presenting to a hospital or freestanding, emergency-care facility with indication of a substance-use disorder, opioid overdose, or chronic addiction, shall receive information, made available to the hospital or freestanding, emergency-care facility in accordance with subsection (a)(4)(v), about the availability of clinically appropriate inpatient and outpatient services for the treatment of substance-use disorders, opioid overdose, or chronic addiction, including:

(A) Detoxification;

(B) Stabilization;

(C) Medication-assisted treatment or medication-assisted maintenance services, including methadone, buprenorphine, naltrexone, or other clinically appropriate medications;

(D) Inpatient and residential treatment;

(E) Licensed clinicians with expertise in the treatment of substance-use disorders, opioid overdoses, and chronic addiction;

(F) Certified recovery coaches; and

(v) That, when the real-time patient-services database outlined in subsection (a)(4)(vi) becomes available, each patient shall receive real-time information from the hospital or freestanding, emergency-care facility about the availability of clinically appropriate inpatient and outpatient services.

(4) On or before January 1, 2017, the director of the department of health, with the director of the department of behavioral healthcare, developmental disabilities and hospitals, shall:

(i) Develop and disseminate, to all hospitals and freestanding, emergency-care facilities, a regulatory standard for the early introduction of a recovery coach during the pre-admission and/or admission process for patients with substance-use disorders, opioid overdose, or chronic addiction;

(ii) Develop and disseminate, to all hospitals and freestanding, emergency-care facilities, substance-~~abuse~~ use evaluation standards for patients with substance-use disorders, opioid overdose, or chronic addiction;

(iii) Develop and disseminate, to all hospitals and freestanding, emergency-care facilities, pre-admission, admission, and discharge regulatory standards, a recovery plan, and voluntary transition process for patients with substance-use disorders, opioid overdose, or chronic addiction. Recommendations from the 2015 Rhode Island governor's overdose prevention and intervention task force strategic plan may be incorporated into the standards as a guide, but may be amended and modified to meet the specific needs of each hospital and freestanding, emergency-care facility;

(iv) Develop and disseminate best practices standards for health care clinics, urgent-care centers, and emergency-diversion facilities regarding protocols for patient screening, transfer, and referral to clinically appropriate inpatient and outpatient services contained in subsection (a)(3)(iv);

(v) Develop regulations for patients presenting to hospitals and freestanding, emergency-care facilities with indication of a substance-use disorder, opioid overdose, or chronic addiction to ensure prompt, voluntary access to clinically appropriate inpatient and outpatient services contained in subsection (a)(3)(iv);

(vi) Develop a strategy to assess, create, implement, and maintain a database of real-time availability of clinically appropriate inpatient and outpatient services contained in subsection (a)(3)(iv) of this section on or before January 1, 2018.

(5) On or before September 1, 2017, each hospital and freestanding, emergency-care facility operating in the state of Rhode Island shall submit to the director a discharge plan and transition process that shall include provisions for patients with a primary diagnosis of a mental health disorder without a co-occurring substance use disorder.

(6) On or before January 1, 2018, the director of the department of health, with the director of the department of behavioral healthcare, developmental disabilities and hospitals, shall develop and disseminate mental health best practices standards for health care clinics, urgent care centers, and emergency diversion facilities regarding protocols for patient screening, transfer, and referral to clinically appropriate inpatient and outpatient services. The best practice standards shall include information and strategies to facilitate clinically appropriate prompt transfers and referrals from hospitals and freestanding, emergency-care facilities to less intensive settings.

(7) Nothing contained in this chapter shall be construed to limit the permitted disclosure of confidential health care information and communications permitted under § 5-37.3-

4(b)(4)(i)(A) of the "confidentiality of health care communications and information act".

SECTION 3. Chapter 23-17.26 of the General Laws entitled "Comprehensive Discharge Planning" is hereby amended by adding thereto the following section:

23-17.26-5. Comprehensive patient consent form.

Each hospital and freestanding emergency-care facility shall incorporate patient consent for certified peer recovery specialist and peer recovery coach services into a comprehensive patient consent form to be implemented no later than January 1, 2019.

SECTION 4. Section 27-38.2-1 of the General Laws in Chapter 27-38.2 entitled "Insurance Coverage for Mental Illness and Substance Abuse" is hereby amended to read as follows:

27-38.2-1. Coverage for treatment of mental health and substance use disorders. [Effective April 1, 2018.].

(a) A group health plan and an individual or group health insurance plan, and any contract between the Rhode Island Medicaid program and any health insurance carrier, as defined under chapters 18, 19, 20, and 41 of title 27, shall provide coverage for the treatment of mental health and substance-use disorders under the same terms and conditions as that coverage is provided for other illnesses and diseases.

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

(c) Financial requirements and quantitative treatment limitations on coverage for the treatment of mental health and substance-use disorders shall be no more restrictive than the predominant financial requirements applied to substantially all coverage for medical conditions in each treatment classification.

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

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

(f) Medication-assisted treatment or medication-assisted maintenance services of substance-use disorders, opioid overdoses, and chronic addiction, including methadone,

buprenorphine, naltrexone, or other clinically appropriate medications, is included within the appropriate classification based on the site of the service.

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

(h) Patients with substance-use disorders shall have access to evidence-based, non-opioid treatment for pain, therefore coverage shall apply to medically necessary chiropractic care and osteopathic manipulative treatment performed by an individual licensed under § 5-37-2.

(i) Consistent with coverage for medical and surgical services, a health plan as defined in subsection (a) of this section shall cover clinically appropriate residential or inpatient services, including detoxification and stabilization services, for the treatment of mental health and/or substance use disorders, including alcohol use disorders, in accordance with this subsection. After an assessment for substance use disorders, including alcohol use disorders, based upon the criteria of the American Society of Addiction Medicine, or after an appropriate psychiatric assessment for mental health disorders, conducted upon an emergency admission or for continuation of care, if a qualified medical and/or clinical professional determines that residential or inpatient care, including detoxification and stabilization services, is the most appropriate and least restrictive level of care necessary, that professional shall, within twenty-four (24) hours of admission or at least twenty-four (24) hours prior to the expiration of any previous authorization from the health insurer, submit a treatment plan, including an estimated length of stay and such other information as may be reasonably requested by the health insurer, to the patient's health insurer. The health insurer shall conduct the utilization review in accordance with chapter 18.9 of title 27; provided, that the patient shall be and remain presumptively covered for residential or inpatient services, including detoxification and stabilization services, during the utilization review. On or before March 1, 2021, the senate committee on health and human services, in conjunction with the house committee on corporations, shall conduct a hearing on the impact of this subsection, to include presentations from payors and providers, and other stakeholders at the discretion of the committee chairs. This subsection shall apply only to covered services delivered within the health insurer's provider network. Nothing herein prohibits the group health plan or health insurer from conducting quality of care reviews.

SECTION 5. This act shall take effect on January 1, 2019.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N A C T

RELATING TO HEALTH AND SAFETY -- INSURANCE COVERAGE FOR MENTAL ILLNESS AND SUBSTANCE ABUSE

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This act would provide that patients with mental health and/or substance use disorders are presumptively eligible for emergency admission practices or for continuation of care for clinically appropriate residential or inpatient services. The act would also clarify when it is appropriate for a health care provider to disclose protected health information.

This act would take effect on January 1, 2019.

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