

2014 -- S 2769

=====  
LC005119  
=====

STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2014

—————  
A N A C T

RELATING TO HEALTH AND SAFETY -- RHODE ISLAND BEHAVIORAL HEALTH  
CARE REFORM ACT OF 2014

Introduced By: Senators Nesselbush, Miller, Sheehan, Sosnowski, and Paiva Weed

Date Introduced: March 13, 2014

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

1 SECTION 1. Title 42 of the General Laws entitled "STATE AFFAIRS AND  
2 GOVERNMENT" is hereby amended by adding thereto the following chapter:

3 CHAPTER 14.7

4 RHODE ISLAND BEHAVIORAL HEALTH CARE REFORM ACT OF 2014

5 **42-14.7-1. Short title.** -- This act shall be known and may be cited as the "Rhode Island  
6 Behavioral Health Care Reform Act of 2014."

7 **42-14.7-2. Legislative findings.** -- The general assembly finds and declares that:

8 (1) Mental health and substance abuse problems affect one out of every four (4) Rhode  
9 Islanders every year.

10 (2) Health-related behaviors such as diet, exercise, tobacco use, and compliance with  
11 medical treatment affect even more Rhode Islanders every year.

12 (3) The resulting costs, both financial and in impairment, loss of productivity and  
13 suffering, cause a significant burden on the state and its citizens.

14 (4) Health care reform efforts can only succeed if a comprehensive approach is taken that  
15 includes the role of behavior and behavioral health in health and health care.

16 (5) Despite its significant potential impact on health care cost and effectiveness, spending  
17 on behavioral health is a small percentage of all health care spending and is thus often neglected  
18 in health care reform, improvement, or cost-containment efforts.

1 (6) As is true for citizens of all states, half of Rhode Islanders with mental health,  
2 substance abuse, or health-related behavioral problems receive no treatment at all, and of those  
3 who do receive treatment, a large majority receives treatment that does not meet national  
4 guidelines for effectiveness, resulting in significant avoidable personal suffering and waste of  
5 health care funds.

6 (7) "Stigma", as defined by the United States Surgeon General, includes a lack of  
7 understanding and a lack of proportional attention to behavioral health, which impedes effective  
8 management of behavioral health and other health care resources to address health-related  
9 behaviors and behavioral health cost-effectively.

10 (8) Tragedies such as the shootings in Newtown, Connecticut, have heightened attention  
11 to the need for better regulation, management and delivery of behavioral health services.

12 (9) Therefore, it is in the best interest of the state to ensure the most appropriate use of  
13 health care resources to more effectively manage behavioral health services to protect the welfare  
14 of its citizens.

15 **42-14.7-3. Purpose.** -- The purpose of the behavioral health care reform act of 2014 is to  
16 ensure appropriate use of health care resources to manage the contribution of behavioral health  
17 and behavioral health services to the affordability and effectiveness of health care.

18 **42-14.7-4. Definitions.** -- For the purposes of this chapter, the following terms shall have  
19 the following meanings:

20 (1) "Behavioral health" means mental health, substance abuse, and health-related  
21 behavior.

22 (2) "Health-related behavior" means behavior that creates risks for diseases, illnesses, or  
23 conditions or that can be modified to reduce health risks, such as diet, exercise, tobacco use, and  
24 compliance with medical treatment.

25 (3) "Behavioral health provider" means mental health counselor, marriage and family  
26 therapist, social worker, psychologist, advanced practice psychiatric nurse, and/or psychiatrist  
27 licensed by the department of health under relevant law and regulation.

28 (4) "Behavioral health services" means treatment and services offered by a behavioral  
29 health provider for the purpose of affecting behavioral health.

30 (5) "Services to treat health-related behaviors" means medically necessary treatment  
31 offered by a behavioral health provider for the purpose of improving or preventing a specific,  
32 diagnosable medical condition.

33 (6) "Behavioral health functioning" means and is intended to refer to mental health  
34 conditions, substance abuse disorders, and health-related behaviors and is not intended to expand

1 [the scope of covered services or benefits beyond those required in the federal parity law, also](#)  
2 [known as the Mental Health Parity and Addiction Equity Act of 2008, Pub. L. 110-343.](#)

3 [\(7\) Where behavioral health providers or behavioral health services are to be regulated](#)  
4 [with reference to equivalent provisions addressing primary care providers or primary care](#)  
5 [services, it is understood that behavioral health providers are not to be considered as primary care](#)  
6 [providers themselves but as independent professional members of the primary care team, whether](#)  
7 [practicing on-site or in coordination with primary care practices, in recognition of the fact that](#)  
8 [behavioral health services are critical for achieving the best possible cost-effectiveness of primary](#)  
9 [care services.](#)

10 SECTION 2. Sections 23-1-1, 23-1-2, 23-1-36, 23-1-43 and 23-1-44 of the General Laws  
11 in Chapter 23-1 entitled "Department of Health" are hereby amended to read as follows:

12 **23-1-1. General functions of department.** -- The department of health shall take  
13 cognizance of the interests of life and health among the peoples of the state; shall make  
14 investigations into the causes of disease, the prevalence of epidemics and endemics among the  
15 people, the sources of mortality, the effect of localities, employments, [and individual behaviors,](#)  
16 and all other conditions and circumstances on the public health, and do all in its power to  
17 ascertain the causes and the best means for the prevention and control of diseases or conditions  
18 detrimental to the public health, and adopt proper and expedient measures to prevent and control  
19 diseases and conditions detrimental to the public health in the state. It shall publish and circulate,  
20 from time to time, information that the director may deem to be important and useful for diffusion  
21 among the people of the state, and shall investigate and give advice in relation to those subjects  
22 relating to public health that may be referred to it by the general assembly or by the governor  
23 when the general assembly is not in session, or when requested by any city or town. The  
24 department shall adopt and promulgate rules and regulations that it deems necessary, not  
25 inconsistent with law, to carry out the purposes of this section; provided, however, that the  
26 department shall not require all nonprofit volunteer ambulance, rescue service, and volunteer fire  
27 departments to have two (2) or more certified emergency medical technicians manning  
28 ambulances or rescue vehicles.

29 **23-1-2. Inquiries to local authorities and physicians.** -- The director of health shall  
30 make inquiry, from time to time, of the city and town clerks and practicing physicians [and](#)  
31 [behavioral health providers,](#) in relation to the prevalence of any disease, or knowledge of any  
32 known or generally believed source of disease or causes of general ill health, and also in relation  
33 to acts for the promotion and protection of the public health, and also in relation to diseases  
34 among domestic animals in their several cities and towns; and those city and town clerks and

1 practicing physicians shall give information, in reply to the inquiries, of those facts and  
2 circumstances that have come to their knowledge.

3 ~~23-1-36. Director's duties regarding health education, alcohol, and substance abuse~~  
4 ~~programs~~ Director's duties regarding health education, mental health, alcohol, and  
5 substance abuse programs. -- The director shall establish health education, [mental health](#),  
6 alcohol, and substance abuse programs for students in grades kindergarten through twelve (12), in  
7 accordance with section 35-4-18. The director shall make an annual report to the governor and the  
8 general assembly on the administration of the program.

9 23-1-43. Minority population health promotion. -- The director of health shall  
10 establish a minority population health promotion program to provide health information,  
11 education, [health-related behavior change](#) and risk reduction activities to reduce the risk of  
12 premature death from preventable disease in minority populations.

13 ~~23-1-44. Routine childhood and adult immunization vaccines~~ Routine childhood and  
14 adult immunization vaccines and behavioral health prevention services. -- (a) The  
15 department of health shall include in the department's immunization program those vaccines for  
16 routine childhood immunization as recommended by the Advisory Committee for Immunization  
17 Practices (ACIP) and the Academy of Pediatrics (AAP), and for adult influenza immunization as  
18 recommended by the ACIP, to the extent permitted by available funds. The childhood  
19 immunization program includes administrative and quality assurance services and KIDSNET, a  
20 confidential, computerized child health information system that is used to manage statewide  
21 immunizations, as well as other public health preventive services, for all children in Rhode Island  
22 from birth through age 18. [The department of health shall include in the department's behavioral](#)  
23 [health prevention program those behavioral health screening or prevention services meeting the](#)  
24 [United States Centers for Medicaid and Medicare Services definition of preventive services in the](#)  
25 [Patient Protection and Affordable Care Act, Pub. L. 111-148, as amended by the Federal Health](#)  
26 [Care and Education Reconciliation Act of 2010, Pub. L. 111-152, as both may be amended from](#)  
27 [time to time, and regulations adopted thereunder.](#)

28 (b) The director of the department of health shall appoint an advisory committee that will  
29 be convened after the ACIP [or the United States Preventive Services Task Force \(USPSTF\)](#)  
30 makes a recommendation regarding adult immunization [or adult behavioral health screening or](#)  
31 [prevention](#). The committee will review the ACIP [or USPSTF](#) recommendations for the state,  
32 assess the vaccine [or service](#) cost and feasibility, and advise the director of health and the office  
33 of the health insurance commissioner regarding insurers and providers acting on the ACIP [or](#)  
34 [USPSTF](#) adult immunization, [behavioral health screening or prevention services](#)

1 recommendation. All recommendations will be posted on the department of health website. The  
2 advisory committee membership shall include, but not be limited to, a primary care provider,  
3 pharmacist, representatives of the nursing home industry, the home health care industry, a  
4 licensed psychologist, a licensed social worker, a licensed mental health counselor, a licensed  
5 marriage and family therapist, a licensed nurse or advanced practice nurse, a patient advocate, a  
6 member of the general public and major insurers.

7 SECTION 3. Chapter 23-13 of the General Laws entitled "Maternal and Child Health  
8 Services for Children with Special Health Care Needs" is hereby amended by adding thereto the  
9 following section:

10 **23-13-27. Routine childhood behavioral health screening.** -- (a) The physician  
11 attending any patient younger than twenty-one (21) years of age shall cause that child to be  
12 subject to health screening services for psychiatric disorders, psychological, interpersonal, and  
13 any other conditions for which there is a medical benefit to the early detection and treatment of  
14 the disorder or condition, and an assessment for developmental risk. The department of health  
15 shall promulgate regulations pertaining to behavioral health screenings, diagnostic and treatment  
16 services as accepted medical practice shall indicate. The provisions of this section shall not apply  
17 if the parents of the child up to the age of eighteen (18) years of age or the young adult between  
18 the ages of eighteen (18) and twenty-one (21) years of age objects to the screening on the grounds  
19 that those tests conflict with his or her religious tenets and practices.

20 (b) In addition, the department of health is authorized to establish by regulation a  
21 reasonable fee structure for the behavioral health screening and disease control program services,  
22 which includes, but is not limited to, screening, diagnostic, and treatment services. The program  
23 services shall be a covered benefit and be reimbursable by all health insurers, as defined in § 27-  
24 38.2-2(1), providing health insurance coverage in Rhode Island except for supplemental policies  
25 which only provide coverage for specific diseases, hospital indemnity, Medicare supplements, or  
26 other supplemental policies. The department of human services shall pay for the program services  
27 where the patient is eligible for medical assistance under the provisions of chapter 8 of title 40.

28 SECTION 4. Sections 23-14.1-1 and 23-14.1-2 of the General Laws in Chapter 23-14.1  
29 entitled "Health Professional Loan Repayment Program" are hereby amended to read as follows:

30 **23-14.1-1. Legislative findings.** -- The general assembly finds that:

31 (1) It is the right of every citizen of the state to have ready access to quality health care;  
32 and

33 (2) Health care facilities serving the poor, including community health centers  
34 throughout the state, are experiencing increasing difficulty in attracting and retaining physicians

1 and other health professionals to administer to the needy populations they serve. Therefore, it is  
2 the general assembly's intent to provide incentives, in the form of loan repayment, to physicians,  
3 dentists, dental hygienists, nurse practitioners, certified nurse midwives, physician assistants,  
4 [behavioral health providers](#), and any other eligible health care professional under section 338A of  
5 the Public Health Service Act, 42 U.S.C. section 254I, who desire to serve the health care needs  
6 of medically underserved individuals in Rhode Island.

7 **23-14.1-2. Definitions.** -- For the purpose of this chapter, the following words and terms  
8 have the following meanings unless the context clearly requires otherwise:

9 (1) "Authority" means the higher education assistance authority.

10 (2) "Board" means the health professional loan repayment board.

11 (3) "Community health center" means a health care facility as defined and licensed under  
12 chapter 17 of this title.

13 (4) "Director" means the director of the higher education assistance authority.

14 (5) "Eligible health professional" means a physician, dentist, dental hygienist, nurse  
15 practitioner, certified nurse midwife, physician assistant, [behavioral health providers](#), or any other  
16 eligible health care professional under section 338A of the Public Health Service Act, 42 U.S.C.  
17 section 254I, licensed in the state who has entered into a contract with the board to serve  
18 medically underserved populations.

19 (6) "Loan repayment" means an amount of money to be repaid to satisfy loan obligations  
20 incurred to obtain a degree or certification in an eligible health profession as defined in  
21 subdivision (5).

22 SECTION 5. Section 23-17.12-9 of the General Laws in Chapter 23-17.12 entitled  
23 "Health Care Services - Utilization Review Act" is hereby amended to read as follows:

24 **23-17.12-9. Review agency requirement for adverse determination and internal**  
25 **appeals.** -- (a) The adverse determination and appeals process of the review agent shall conform  
26 to the following:

27 (1) Notification of a prospective adverse determination by the review agent shall be  
28 mailed or otherwise communicated to the provider of record and to the patient or other  
29 appropriate individual as follows:

30 (i) Within fifteen (15) business days of receipt of all the information necessary to  
31 complete a review of non-urgent and/or non-emergent services;

32 (ii) Within seventy-two (72) hours of receipt of all the information necessary to complete  
33 a review of urgent and/or emergent services; and

34 (iii) Prior to the expected date of service.

1 (2) Notification of a concurrent adverse determination shall be mailed or otherwise  
2 communicated to the patient and to the provider of record period as follows:

3 (i) To the provider(s) prior to the end of the current certified period; and

4 (ii) To the patient within one business day of making the adverse determination.

5 (3) Notification of a retrospective adverse determination shall be mailed or otherwise  
6 communicated to the patient and to the provider of record within thirty (30) business days of  
7 receipt of a request for payment with all supporting documentation for the covered benefit being  
8 reviewed.

9 (4) A utilization review agency shall not retrospectively deny authorization for health  
10 care services provided to a covered person when an authorization has been obtained for that  
11 service from the review agent unless the approval was based upon inaccurate information  
12 material to the review or the health care services were not provided consistent with the provider's  
13 submitted plan of care and/or any restrictions included in the prior approval granted by the review  
14 agent.

15 (5) Any notice of an adverse determination shall include:

16 (i) The principal reasons for the adverse determination, to include explicit documentation  
17 of the criteria not met and/or the clinical rationale utilized by the agency's clinical reviewer in  
18 making the adverse determination. The criteria shall be in accordance with the agency criteria  
19 noted in subsection 23-17.12-9(d) and shall be made available within the first level appeal  
20 timeframe if requested unless otherwise provided as part of the adverse determination notification  
21 process;

22 (ii) The procedures to initiate an appeal of the adverse determination, including the name  
23 and telephone number of the person to contract with regard to an appeal;

24 (iii) The necessary contact information to complete the two-way direct communication  
25 defined in subdivision 23-17.12-9(a)(7); and

26 (iv) The information noted in subdivision 23-27.12-9(a)(5)(i)(ii)(iii) for all verbal  
27 notifications followed by written notification to the patient and provider(s).

28 (6) All initial retrospective adverse determinations of a health care service that had been  
29 ordered by a physician, dentist or other practitioner shall be made, documented and signed  
30 consistent with the regulatory requirements which shall be developed by the department with the  
31 input of review agents, providers and other affected parties.

32 (7) A level one appeal decision of an adverse determination shall not be made until an  
33 appropriately qualified and licensed review physician, dentist or other practitioner has spoken to,  
34 or otherwise provided for, an equivalent two-way direct communication with the patient's

1 attending physician, dentist, other practitioner, other designated or qualified professional or  
2 provider responsible for treatment of the patient concerning the medical care, with the exception  
3 of the following:

4 (i) When the attending provider is not reasonably available;

5 (ii) When the attending provider chooses not to speak with agency staff;

6 (iii) When the attending provider has negotiated an agreement with the review agent for  
7 alternative care; and/or

8 (iv) When the attending provider requests a peer to peer communication prior to the  
9 adverse determination, the review agency shall then comply with subdivision 23-17.12-9(c)(1) in  
10 responding to such a request. Such requests shall be on the case specific basis unless otherwise  
11 arranged for in advance by the provider.

12 (8) All initial, prospective and concurrent adverse determinations of a health care service  
13 that had been ordered by a physician, dentist or other practitioner shall be made, documented and  
14 signed by a licensed practitioner with the same licensure status as the ordering practitioner or a  
15 licensed physician or dentist. This does not prohibit appropriately qualified review agency staff  
16 from engaging in discussions with the attending provider, the attending provider's designee or  
17 appropriate health care facility and office personnel regarding alternative service and treatment  
18 options. Such a discussion shall not constitute an adverse determination provided though that any  
19 change to the provider's original order and/or any decision for an alternative level of care must be  
20 made and/or appropriately consented to by the attending provider or the provider's designee  
21 responsible for treating the patient.

22 (9) The requirement that, upon written request made by or on behalf of a patient, any  
23 adverse determination and/or appeal shall include the written evaluation and findings of the  
24 reviewing physician, dentist or other practitioner. The review agent is required to accept a verbal  
25 request made by or on behalf of a patient for any information where a provider or patient can  
26 demonstrate that a timely response is urgent.

27 (b) The review agent shall conform to the following for the appeal of an adverse  
28 determination:

29 (1) The review agent shall maintain and make available a written description of the  
30 appeal procedure by which either the patient or the provider of record may seek review of  
31 determinations not to authorize a health care service. The process established by each review  
32 agent may include a reasonable period within which an appeal must be filed to be considered and  
33 that period shall not be less than sixty (60) days.

34 (2) The review agent shall notify, in writing, the patient and provider of record of its



1 decision on the appeal as soon as practical, but in no case later than fifteen (15) or twenty-one  
2 (21) business days if verbal notice is given within fifteen (15) business days after receiving the  
3 required documentation on the appeal.

4 (3) The review agent shall also provide for an expedited appeals process for emergency  
5 or life threatening situations. Each review agent shall complete the adjudication of expedited  
6 appeals within two (2) business days of the date the appeal is filed and all information necessary  
7 to complete the appeal is received by the review agent.

8 (4) All first level appeals of determinations not to authorize a health care service that had  
9 been ordered by a physician, dentist, or other practitioner shall be made, documented, and signed  
10 by a licensed practitioner with the same licensure status as the ordering practitioner or a licensed  
11 physician or a licensed dentist.

12 (5) All second level appeal decisions shall be made, signed, and documented by a  
13 licensed practitioner in the same or a similar general specialty as typically manages the medical  
14 condition, procedure, or treatment under discussion.

15 (6) The review agent shall maintain records of written appeals and their resolution, and  
16 shall provide reports as requested by the department.

17 (c) The review agency must conform to the following requirements when making its  
18 adverse determination and appeal decisions:

19 (1) The review agent must assure that the licensed practitioner or licensed physician is  
20 reasonably available to review the case as required under subdivision 23-17.12-9(a)(7) and shall  
21 conform to the following:

22 (i) Each agency peer reviewer shall have access to and review all necessary information  
23 as requested by the agency and/or submitted by the provider(s) and/or patients;

24 (ii) Each agency shall provide accurate peer review contact information to the provider at  
25 the time of service, if requested, and/or prior to such service, if requested. This contact  
26 information must provide a mechanism for direct communication with the agency's peer  
27 reviewer;

28 (iii) Agency peer reviewers shall respond to the provider's request for a two-way direct  
29 communication defined in subdivision 23-17.12-9(a)(7)(iv) as follows:

30 (A) For a prospective review of non-urgent and non-emergent health care services, a  
31 response within one business day of the request for a peer discussion;

32 (B) For concurrent and prospective reviews of urgent and emergent health care services,  
33 a response within a reasonable period of time of the request for a peer discussion; and

34 (C) For retrospective reviews, prior to the first level appeal decision.

1 (iv) The review agency will have met the requirements of a two-way direct  
2 communication, when requested and/or as required prior to the first level of appeal, when it has  
3 made two (2) reasonable attempts to contact the attending provider directly.

4 (v) Repeated violations of this section shall be deemed to be substantial violations  
5 pursuant to section 23-17.12-14 and shall be cause for the imposition of penalties under that  
6 section.

7 (2) No reviewer at any level under this section shall be compensated or paid a bonus or  
8 incentive based on making or upholding an adverse determination.

9 (3) No reviewer under this section who has been involved in prior reviews of the case  
10 under appeal or who has participated in the direct care of the patient may participate as the sole  
11 reviewer in reviewing a case under appeal; provided, however, that when new information has  
12 been made available at the first level of appeal, then the review may be conducted by the same  
13 reviewer who made the initial adverse determination.

14 (4) A review agent is only entitled to review information or data relevant to the  
15 utilization review process. A review agent may not disclose or publish individual medical records  
16 or any confidential medical information obtained in the performance of utilization review  
17 activities. A review agent shall be considered a third party health insurer for the purposes of  
18 section 5-37.3-6(b)(6) of this state and shall be required to maintain the security procedures  
19 mandated in section 5-37.3-4(c).

20 (5) Notwithstanding any other provision of law, the review agent, the department, and all  
21 other parties privy to information which is the subject of this chapter shall comply with all state  
22 and federal confidentiality laws, including, but not limited to, chapter 37.3 of title 5  
23 (Confidentiality of Health Care Communications and Information Act) and specifically section 5-  
24 37.3-4(c), which requires limitation on the distribution of information which is the subject of this  
25 chapter on a "need to know" basis, and section 40.1-5-26.

26 (6) The department may, in response to a complaint that is provided in written form to  
27 the review agent, review an appeal regarding any adverse determination, and may request  
28 information of the review agent, provider or patient regarding the status, outcome or rationale  
29 regarding the decision.

30 (d) The requirement that each review agent shall utilize and provide upon request, by  
31 Rhode Island licensed hospitals and the Rhode Island Medical Society, [the Rhode Island](#)  
32 [Psychiatric Society, the Rhode Island Psychological Association, and the National Association of](#)  
33 [Social Workers, Rhode Island chapter](#), in either electronic or paper format, written medically  
34 acceptable screening criteria and review procedures which are established and periodically

1 evaluated and updated with appropriate consultation with Rhode Island licensed physicians,  
2 hospitals, including practicing physicians, and other health care providers in the same specialty as  
3 would typically treat the services subject to the criteria as follows:

4 (1) Utilization review agents shall consult with no fewer than five (5) Rhode Island  
5 licensed physicians or other health care providers. Further, in instances where the screening  
6 criteria and review procedures are applicable to inpatients and/or outpatients of hospitals, the  
7 medical director of each licensed hospital in Rhode Island shall also be consulted. Utilization  
8 review agents who utilize screening criteria and review procedures provided by another entity  
9 may satisfy the requirements of this section if the utilization review agent demonstrates to the  
10 satisfaction of the director that the entity furnishing the screening criteria and review procedures  
11 has complied with the requirements of this section.

12 (2) Utilization review agents seeking initial certification shall conduct the consultation  
13 for all screening and review criteria to be utilized. Utilization review agents who have been  
14 certified for one year or longer shall be required to conduct the consultation on a periodic basis  
15 for the utilization review agent's highest volume services subject to utilization review during the  
16 prior year; services subject to the highest volume of adverse determinations during the prior year;  
17 and for any additional services identified by the director.

18 (3) Utilization review agents shall not include in the consultations as required under  
19 paragraph (1) of this subdivision, any physicians or other health services providers who have  
20 financial relationships with the utilization review agent other than financial relationships for  
21 provisions of direct patient care to utilization review agent enrollees and reasonable compensation  
22 for consultation as required by paragraph (1) of this subdivision.

23 (4) All documentation regarding required consultations, including comments and/or  
24 recommendations provided by the health care providers involved in the review of the screening  
25 criteria, as well as the utilization review agent's action plan or comments on any  
26 recommendations, shall be in writing and shall be furnished to the department on request. The  
27 documentation shall also be provided on request to any licensed health care provider at a nominal  
28 cost that is sufficient to cover the utilization review agent's reasonable costs of copying and  
29 mailing.

30 (5) Utilization review agents may utilize non-Rhode Island licensed physicians or other  
31 health care providers to provide the consultation as required under paragraph (1) of this  
32 subdivision, when the utilization review agent can demonstrate to the satisfaction of the director  
33 that the related services are not currently provided in Rhode Island or that another substantial  
34 reason requires such approach.

1 (6) Utilization review agents whose annualized data reported to the department  
2 demonstrate that the utilization review agent will review fewer than five hundred (500) such  
3 requests for authorization may request a variance from the requirements of this section.

4 (7) Medically acceptable screening criteria and review procedures for behavioral health  
5 services by behavioral health providers shall be certified by the director of the department of  
6 health as materially equivalent to criteria and procedures applied to primary care services and  
7 providers as identified by the director.

8 SECTION 6. Section 23-17.13-3 of the General Laws in Chapter 23-17.13 entitled  
9 "Health Care Accessibility and Quality Assurance Act" is hereby amended to read as follows:

10 **23-17.13-3. Certification of health plans.** -- (a) Certification process.

11 (1) Certification.

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

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

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

21 (3) Cost of certification. - The total cost of obtaining and maintaining certification under  
22 this title and compliance with the requirements of the applicable rules and regulations are borne  
23 by the entities so certified and shall be one hundred and fifty percent (150%) of the total salaries  
24 paid to the certifying personnel of the department engaged in those certifications less any salary  
25 reimbursements and shall be paid to the director to and for the use of the department. That  
26 assessment shall be in addition to any taxes and fees otherwise payable to the state.

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

32 (i) Allowable charge;

33 (ii) Capitation;

34 (iii) Co-payments;

- 1 (iv) Co-insurance;
- 2 (v) Credentialing;
- 3 (vi) Formulary;
- 4 (vii) Grace period;
- 5 (viii) Indemnity insurance;
- 6 (ix) In-patient care;
- 7 (x) Maximum lifetime cap;
- 8 (xi) Medical necessity;
- 9 (xii) Out-of-network;
- 10 (xiii) Out-patient;
- 11 (xiv) Pre-existing conditions;
- 12 (xv) Point of service;
- 13 (xvi) Risk sharing;
- 14 (xvii) Second opinion;
- 15 (xviii) Provider network;
- 16 (xix) Urgent care.

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

23 (1) Prospective and current enrollees in health plans must be provided information as to  
24 the terms and conditions of the plan consistent with the rules and regulations promulgated under  
25 chapter 12.3 of title 42 so that they can make informed decisions about accepting and utilizing the  
26 health care services of the health plan. This must be standardized so that customers can compare  
27 the attributes of the plans, and all information required by this paragraph shall be updated at  
28 intervals determined by the director. Of those items required under this section, the director shall  
29 also determine which items shall be routinely distributed to prospective and current enrollees as  
30 listed in this subsection and which items may be made available upon request. The items to be  
31 disclosed are:

32 (i) Coverage provisions, benefits, and any restriction or limitations on health care  
33 services, including but not limited to, any exclusions as follows: by category of service, and if  
34 applicable, by specific service, by technology, procedure, medication, provider or treatment

1 modality, diagnosis and condition, the latter three (3) of which shall be listed by name.

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

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

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

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

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

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

23 (7) A summary of prior authorization or other review requirements including  
24 preauthorization review, concurrent review, post-service review, post-payment review and any  
25 procedure that may lead the patient to be denied coverage for or not be provided a particular  
26 service.

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

34 (9) Health plans must disclose to prospective and current enrollees the existence of

1 financial arrangements for capitated or other risk sharing arrangements that exist with providers  
2 in a manner described in paragraphs (i), (ii), and (iii):

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

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

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

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

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

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

21 (13) Summary of criteria used to authorize treatment.

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

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

26 (i) Physician services;

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

28 (iii) Other professional services;

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

31 (v) Health education;

32 (vi) Substance abuse services and mental health services.

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

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

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

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

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

9 (17) Plans must demonstrate that:

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

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

15 (18) A comprehensive list of participating providers listed by office location, specialty if  
16 applicable, and other information as determined by the director, updated annually.

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

22 (c) Issuance of certification.

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

25 (2) A health care plan will meet the requirements of certification, subsection (b) by  
26 providing information required in subsection (b) to any state or federal agency in conformance  
27 with any other applicable state or federal law, or in conformity with standards adopted by an  
28 accrediting organization provided that the director determines that the information is substantially  
29 similar to the previously mentioned requirements and is presented in a format that provides a  
30 meaningful comparison between health plans.

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



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

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

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

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

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

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

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

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

28 (ii) The provider of covered services lack of affiliation with, or admitting privileges at a  
29 hospital, if that lack of affiliation is due solely to the provider's type of license.

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

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

33 (10) Plans shall not be allowed to include clauses in physician or other provider contracts  
34 that allow for the plan to terminate the contract "without cause"; provided, however, cause shall

1 include lack of need due to economic considerations.

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

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

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

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

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

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

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

17 (d) Network adequacy standards shall include and be governed by the following, in  
18 consideration of the requirements of the Patient Protection and Affordable Care Act, Pub. L. 111-  
19 148, as amended by the Federal Health Care and Education Reconciliation Act of 2010, Pub. L.  
20 111-152, as both may be amended from time to time, including, but not limited to, federal  
21 regulations regarding establishment of exchanges and qualified health plans, and exchange  
22 standards for employers as it relates to qualified health plans:

23 (1) Health plans offered by issuers shall provide timely access, based on referral from the  
24 enrollee's attending or primary care physician, to at least one hospital in-network for each of the  
25 following services: child outpatient services treating health-related behaviors, and adult outpatient  
26 services treating health-related behaviors.

27 (2) Of the primary care practices that health plans contract within each county of Rhode  
28 Island, at least ten percent (10%) shall offer integrated behavioral health, mental health and  
29 substance abuse services for their patients. Incentives included in health plans' contracts with  
30 primary care practices, or alternative incentives certified by the health insurance commissioner to  
31 be equivalent, shall be offered to behavioral health providers offering services on-site in primary  
32 care practices. Health plans shall include sufficient incentives for behavioral health providers to  
33 offer services on-site in primary care practices to enable at least ten percent (10%) of primary  
34 care practices, geographically distributed throughout the state of Rhode Island, to hire or contract

1 [with behavioral health providers who meet standards for training, qualification, and preparation to](#)  
2 [practice in integrated primary care settings that have been determined by the department of](#)  
3 [health;](#)

4 [\(3\) Health plans offered by issuers shall include providers of step-down and diversion](#)  
5 [behavioral health services from hospital levels of care.](#)

6 SECTION 7. Sections 23-17.17-3, 23-17.17-9 and 23-17.17-10 of the General Laws in  
7 Chapter 23-17.17 entitled "Health Care Quality Program" are hereby amended to read as follows:

8 **23-17.17-3. Establishment of health care quality performance measurement and**  
9 **reporting program.** -- The director of health is authorized and directed to develop a state health

10 care quality performance measurement and reporting program. The health care quality  
11 performance measurement and reporting program shall include quality performance measures and  
12 reporting for health care facilities licensed in Rhode Island. The program shall be phased in over  
13 a multi-year period and shall begin with the establishment of a program of quality performance  
14 measurement and reporting for hospitals. In subsequent years, quality performance measurement  
15 and reporting requirements will be established for other types of health care facilities such as  
16 nursing facilities, home nursing care providers, other licensed facilities, and licensed health care  
17 providers, [including behavioral health providers](#), as determined by the director of health. Prior to  
18 developing and implementing a quality performance measurement and reporting program for  
19 hospitals or any other health care facility or health care provider, the director shall seek public  
20 comment regarding the type of performance measures to be used and the methods and format for  
21 collecting the data.

22 **23-17.17-9. Health care quality and value database.** -- (a) The director shall establish  
23 and maintain a unified health care quality and value database, [including information about](#)  
24 [behavioral health services](#), to:

- 25 (1) Determine the capacity and distribution of existing resources;
- 26 (2) Identify health care needs and inform health care policy;
- 27 (3) Evaluate the effectiveness of intervention programs on improving patient outcomes;
- 28 (4) Compare costs between various treatment settings and approaches;
- 29 (5) Provide information to consumers and purchasers of health care;
- 30 (6) Improve the quality and affordability of patient health care and health care coverage;
- 31 (7) Strengthen primary care [and behavioral health](#) infrastructure;
- 32 (8) Strengthen chronic disease management, [including management of health-related](#)  
33 [behaviors](#);
- 34 (9) Encourage evidence-based practices in health care, [including behavioral health](#).

1 (b) The program authorized by this section shall include a consumer health care quality  
2 and value information system designed to make available to consumers transparent health care  
3 price information, quality information and such other information as the director determines is  
4 necessary to empower individuals, including uninsured individuals, to make economically sound  
5 and medically appropriate decisions.

6 (c) The health care quality steering committee shall serve as the working group to advise  
7 the director on the development and implementation of the consumer health care quality and  
8 value information system.

9 (d) The director, in collaboration with the health insurance commissioner, may require  
10 an insurer covering at least five percent (5%) of the lives covered in the insured market in this  
11 state to file with the director a consumer health care price and quality information plan in  
12 accordance with regulations adopted by the director pursuant to this section.

13 (e) The director shall adopt such regulations as are necessary to carry out the purposes of  
14 this section and this chapter. The regulations may permit the gradual implementation of the  
15 consumer health care quality and value information system over time, beginning with health care  
16 price and quality information that the director determines is most needed by consumers or that  
17 can be most practically provided to the consumer in an understandable manner. The regulations  
18 shall permit insurers to use security measures designed to allow subscribers access to price and  
19 other information without disclosing trade secrets to individuals and entities who are not  
20 subscribers. The regulations shall avoid unnecessary duplication of efforts relating to price and  
21 quality reporting by insurers, health care providers, health care facilities, and others, including  
22 activities undertaken by hospitals pursuant to their reporting obligations under this chapter and  
23 other chapters of the general laws.

24 (f) Requirements for reporting to the health care quality database enumerated in this  
25 section and subsequent sections of this chapter shall not apply to insurance coverage providing  
26 benefits for:

- 27 (1) Hospital confinement indemnity;
- 28 (2) Disability income;
- 29 (3) Accident only;
- 30 (4) Long-term care;
- 31 (5) Medicare supplement;
- 32 (6) Limited benefit health;
- 33 (7) Specified disease indemnity;
- 34 (8) Sickness or bodily injury or death by accident or both; or

1 (9) Other limited benefit policies.

2 **23-17.17-10. Reporting requirements for the health care database.** -- (a) Insurers,  
3 health care providers, health care facilities and governmental agencies shall file reports, data,  
4 schedules, statistics or other information determined by the director to be necessary to carry out  
5 the purposes of this chapter. The reports required by this chapter shall be accepted by the director  
6 in any certification commission for health care information technology ("CCHIT") certified form.  
7 Such information may include:

8 (1) health insurance claims and enrollment information used by health insurers;

9 (2) information relating to hospital finance; ~~and~~

10 [\(3\) information relating to behavioral health conditions and treatments based on valid and](#)  
11 [reliable standardized measures of specific behavioral health disorders, conditions, symptoms,](#)  
12 [risks, or health-related behaviors and services; and](#)

13 ~~(3)~~(4) any other information relating to health care costs, prices, quality, utilization, or  
14 resources required to be filed by the director.

15 (b) The comprehensive health care information system shall not collect any data that  
16 contains direct personal identifiers. For the purposes of this section "direct personal identifiers"  
17 includes information relating to an individual that contains primary or obvious identifiers, such as  
18 the individual's name, street address, e-mail address, telephone number and social security  
19 number. All data submitted to the director pursuant to this chapter shall be protected by the  
20 removal of all personal identifiers and the assignment by the insurer to each subscriber record of a  
21 unique identifier not linked to any personally identifiable information.

22 SECTION 8. Section 23-17.18-1 of the General Laws in Chapter 23-17.18 entitled  
23 "Health Plan Modification Act" is hereby amended to read as follows:

24 **23-17.18-1. Modification of health plans.** -- (a) A health plan may materially modify the  
25 terms of a participating agreement it maintains with a physician [or behavioral health provider](#)  
26 only if the plan disseminates in writing by mail to the physician [or behavioral health provider](#) the  
27 contents of the proposed modification and an explanation, in nontechnical terms, of the  
28 modification's impact.

29 (b) The health plan shall provide the physician [or behavioral health provider](#) an  
30 opportunity to amend or terminate the physician [or provider](#) contract with the health plan within  
31 sixty (60) days of receipt of the notice of modification. Any termination of a physician [or](#)  
32 [provider](#) contract made pursuant to this section shall be effective fifteen (15) calendar days from  
33 the mailing of the notice of termination in writing by mail to the health plan. The termination  
34 shall not affect the method of payment or reduce the amount of reimbursement to the physician [or](#)

1 [behavioral health provider](#) by the health plan for any patient in active treatment for an acute  
2 medical [or behavioral health](#) condition at the time the patient's physician [or behavioral health](#)  
3 [provider](#) terminates his, her, or its physician [or provider](#) contract with the health plan until the  
4 active treatment is concluded or, if earlier, one year after the termination; and, with respect to the  
5 patient, during the active treatment period the physician [or behavioral health provider](#) shall be  
6 subject to all the terms and conditions of the terminated physician [or provider](#) contract, including  
7 but not limited to, all reimbursement provisions which limit the patient's liability.

8 (c) Nothing in this section shall apply to accident-only, specified disease, hospital  
9 indemnity, Medicare supplement, long-term care, disability income, or other limited benefit  
10 health insurance policies.

11 SECTION 9. Sections 23-17.22-2 and 23-17.22-3 of the General Laws in Chapter 23-  
12 17.22 entitled "Healthy Rhode Island Reform Act of 2008" are hereby amended to read as  
13 follows:

14 **23-17.22-2. Establishment of the healthy Rhode Island strategic plan.** -- (a) The  
15 director of health in consultation with the health care planning and accountability advisory  
16 council established pursuant to chapter 81 of title 23, shall be responsible for the development  
17 and implementation of a five (5) year strategic plan that charts the course for a healthy Rhode  
18 Island.

19 (b) The director and the health care planning and accountability advisory council shall  
20 engage a broad range of health care providers, health insurance plans, professional organizations,  
21 community and nonprofit groups, consumers, businesses, school districts, and state and local  
22 government in developing and implementing the healthy Rhode Island five (5) year strategic plan.

23 (c) (1) The healthy Rhode Island strategic plan shall include:

24 (i) A description of the course charted to a healthy Rhode Island (the healthy Rhode  
25 Island model), which includes patient self-management, emphasis on primary care [and behavioral](#)  
26 [health, particularly health-related behaviors](#), community initiatives, and health system and  
27 information technology reform, to be used uniformly statewide by private insurers, third party  
28 administrators, and public programs;

29 (ii) A description of prevention programs and how these programs are integrated into  
30 communities, with chronic care management, [health-related behavior changes](#), and the healthy  
31 Rhode Island model;

32 (iii) A plan to develop and implement reimbursement systems aligned with the goal of  
33 managing the care for individuals with or at risk for conditions in order to improve outcomes and  
34 the quality of care;

1 (iv) The involvement of public and private groups, health care professionals, insurers,  
2 third party administrators, associations, and firms to facilitate and assure the sustainability of a  
3 new system of care;

4 (v) The involvement of community and consumer groups to facilitate and assure the  
5 sustainability of health services supporting healthy behaviors and good patient self-management  
6 for the prevention and management of chronic conditions;

7 (vi) Alignment of any information technology needs with other health care information  
8 technology initiatives;

9 (vii) The use and development of outcome measures and reporting requirements, aligned  
10 with outcome measures established by the director under this section, to assess and evaluate the  
11 healthy Rhode Island model system of chronic care management;

12 (viii) Target timelines for inclusion of specific chronic conditions to be included in the  
13 chronic care infrastructure and for statewide implementation of the healthy Rhode Island model;

14 (ix) Identification of resource needs for implementation and sustaining the healthy  
15 Rhode Island model and strategies to meet the identified needs; and

16 (x) A strategy for ensuring statewide participation no later than January 1, 2010 by all  
17 health insurers, third-party administrators, health care professionals, health care facilities as  
18 defined in section 23-17-2 of the Rhode Island general laws, and consumers in the healthy Rhode  
19 Island chronic care management plan, including common outcome measures, best practices and  
20 protocols, data reporting requirements, payment methodologies, and other standards.

21 (2) The strategic plan shall be reviewed biennially and amended as necessary to reflect  
22 changes in priorities. Amendments to the plan shall be reported to the general assembly in the  
23 report established under subsection (d) of this section.

24 (d) (1) The director shall report to the general assembly annually on the status of  
25 implementation of the Rhode Island blueprint for health. The report shall include the number of  
26 participating insurers, health care facilities, health care professionals and patients; the progress for  
27 achieving statewide participation in the chronic care management plan, including the measures  
28 established under subsection (c) of this section; the expenditures and savings for the period; the  
29 results of health care professional and patient satisfaction surveys; the progress toward creation  
30 and implementation of privacy and security protocols; and other information as requested by the  
31 committees. The surveys shall be developed in collaboration with the health care planning and  
32 accountability advisory council.

33 (2) If statewide participation in the healthy Rhode Island model for health is not  
34 achieved by January 1, 2010, the director shall evaluate the healthy Rhode Island model for

1 health and recommend to the general assembly changes necessary to create alternative measures  
2 to ensure statewide participation by all health insurers, third-party administrators, health care  
3 facilities, and health care professionals.

4 **23-17.22-3. Healthy Rhode Island chronic care management program.** -- (a) The  
5 director shall create criteria for the healthy Rhode Island chronic care management program as  
6 provided for in this section.

7 (b) The director shall include a broad range of chronic conditions in the healthy Rhode  
8 Island chronic care management program.

9 (c) The healthy Rhode Island chronic care management program shall be designed to  
10 include:

11 (1) A method involving the health care [or behavioral health care](#) professional in  
12 identifying eligible patients, including the use of a chronic care information system established  
13 pursuant to this section, an enrollment process which provides incentives and strategies for  
14 maximum patient participation, and a standard statewide health [and behavioral health](#) risk  
15 assessment for each individual;

16 (2) The process for coordinating care among health care professionals, including a  
17 process for ensuring that each patient has a designated primary care physician;

18 (3) The methods of increasing communications among health care professionals and  
19 patients, including patient education, self-management, [health-related behavior change](#), and  
20 follow-up plans;

21 (4) The educational, wellness, and clinical management protocols and tools used by the  
22 care management organization, including management guideline materials for health care  
23 professionals to assist in patient-specific recommendations;

24 (5) Process and outcome measures to provide performance feedback for health [and](#)  
25 [behavioral health](#) care professionals and information on the quality of care, including patient  
26 satisfaction and health status outcomes;

27 (6) Payment methodologies to align reimbursements and create financial incentives and  
28 rewards for health [and behavioral health](#) care professionals to establish management systems for  
29 chronic conditions, to improve health outcomes, and to improve the quality of care, including  
30 case management fees, pay for performance, payment for technical support and data entry  
31 associated with patient registries, the cost of staff coordination within a medical [or behavioral](#)  
32 [health](#) practice, and any reduction in a health [or behavioral health](#) care professional's productivity;

33 (7) Payment methodologies to any care management organization implementing a  
34 chronic care management program which would put the care management organization's fee at



1 risk if the management is not successful in reducing costs; and

2 (8) A requirement that the data on enrollees in any chronic care management program  
3 implemented pursuant to this section be shared, to the extent allowable under federal law, and in a  
4 format that does not provide any patient-identifiable information, with the director in order to  
5 inform the health care reform initiatives.

6 (d) No later than January 1, 2009 the secretary of health and human services shall ensure  
7 access to a healthy Rhode Island chronic care management program consistent with the program  
8 criteria developed by the director under this section for appropriate persons receiving any type of  
9 medical assistance benefits through the department of human services, the department of mental  
10 health, retardation and hospitals, the department of children, youth and families, or the  
11 department of elderly affairs with such chronic care management program to be available to all  
12 such persons by July 1, 2009. Any contract to provide medical assistance benefits may allow the  
13 entity to subcontract some chronic care management services to other entities if it is cost-  
14 effective, efficient, or in the best interests of the individuals enrolled in the program.

15 (e) No later than January 1, 2009 the director of administration shall ensure access to a  
16 healthy Rhode Island chronic care management program, consistent with program criteria  
17 developed by the director under this section, for appropriate state employees and their dependents  
18 who receive medical coverage through the health benefit plan for state employees.

19 (f) No later than January 1, 2010 the director, in collaboration with the health insurance  
20 commissioner, shall require statewide participation by all health insurers, third-party  
21 administrators, health care professionals, health care facilities and other professionals, in the  
22 healthy Rhode Island chronic care management plan, including common outcome measures, best  
23 practices and protocols, data reporting requirements, payment methodologies, and other  
24 standards.

25 (g) The director shall ensure that the healthy Rhode Island chronic care management  
26 program is modified over time to comply with the healthy Rhode Island strategic plan established  
27 under this chapter.

28 SECTION 10. Section 27-18-1.1 of the General Laws in Chapter 27-18 entitled  
29 "Accident and Sickness Insurance Policies" is hereby amended to read as follows:

30 **27-18-1.1. Definitions.** -- As used in this chapter:

31 (1) "Adverse benefit determination" means any of the following: a denial, reduction, or  
32 termination of, or a failure to provide or make payment (in whole or in part) for, a benefit,  
33 including any such denial, reduction, termination, or failure to provide or make payment that is  
34 based on a determination of an individual's eligibility to participate in a plan or to receive

1 coverage under a plan, and including, with respect to group health plans, a denial, reduction, or  
2 termination of, or a failure to provide or make payment (in whole or in part) for, a benefit  
3 resulting from the application of any utilization review, as well as a failure to cover an item or  
4 service for which benefits are otherwise provided because it is determined to be experimental or  
5 investigational or not medically necessary or appropriate. The term also includes a rescission of  
6 coverage determination.

7 (2) "Affordable Care Act" means the federal Patient Protection and Affordable Care Act  
8 of 2010, as amended by the federal Health Care and Education Reconciliation Act of 2010, and  
9 federal regulations adopted thereunder.

10 (3) "Commissioner" or "health insurance commissioner" means that individual appointed  
11 pursuant to section 42-14.5-1 of the general laws.

12 (4) "Essential health benefits" shall have the meaning set forth in section 1302(b) of the  
13 federal Affordable Care Act,

14 (5) "Grandfathered health plan" means any group health plan or health insurance  
15 coverage subject to 42 USC section 18011.

16 (6) "Group health insurance coverage" means, in connection with a group health plan,  
17 health insurance coverage offered in connection with such plan.

18 (7) "Group health plan" means an employee welfare benefit plan, as defined in 29 USC  
19 section 1002(1), to the extent that the plan provides health benefits to employees or their  
20 dependents directly or through insurance, reimbursement, or otherwise.

21 (8) "Health benefits" or "covered benefits" means coverage or benefits for the diagnosis,  
22 cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting  
23 any structure or function of the body [or behavioral health functioning](#) including coverage or  
24 benefits for transportation primarily for and essential thereto, and including medical services as  
25 defined in R.I. Gen. Laws section 27-19-17;

26 (9) "Health care facility" means an institution providing health care services or a health  
27 care setting, including, but not limited to, hospitals and other licensed inpatient centers,  
28 ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers,  
29 diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health  
30 settings.

31 (10) "Health care professional" means a physician or other health care practitioner  
32 licensed, accredited or certified to perform specified health care services consistent with state  
33 law.

34 (11) "Health care provider" or "provider" means a health care professional or a health

1 care facility.

2 (12) "Health care services" means services for the diagnosis, prevention, treatment, cure  
3 or relief of a health condition, illness, injury or disease.

4 (13) "Health insurance carrier" means a person, firm, corporation or other entity subject  
5 to the jurisdiction of the commissioner under this chapter. Such term does not include a group  
6 health plan.

7 (14) "Health plan" or "health benefit plan" means health insurance coverage and a group  
8 health plan, including coverage provided through an association plan if it covers Rhode Island  
9 residents. Except to the extent specifically provided by the federal Affordable Care Act, the term  
10 "health plan" shall not include a group health plan to the extent state regulation of the health plan  
11 is pre-empted under section 514 of the federal Employee Retirement Income Security Act of  
12 1974. The term also shall not include:

13 (A) (i) Coverage only for accident, or disability income insurance, or any combination  
14 thereof.

15 (ii) Coverage issued as a supplement to liability insurance.

16 (iii) Liability insurance, including general liability insurance and automobile liability  
17 insurance.

18 (iv) Workers' compensation or similar insurance.

19 (v) Automobile medical payment insurance.

20 (vi) Credit-only insurance.

21 (vii) Coverage for on-site medical clinics.

22 (viii) Other similar insurance coverage, specified in federal regulations issued pursuant  
23 to Pub. L. No. 104-191, the federal health insurance portability and accountability act of 1996  
24 ("HIPAA"), under which benefits for medical care are secondary or incidental to other insurance  
25 benefits.

26 (B) The following benefits if they are provided under a separate policy, certificate or  
27 contract of insurance or are otherwise not an integral part of the plan:

28 (i) Limited scope dental or vision benefits.

29 (ii) Benefits for long-term care, nursing home care, home health care, community-based  
30 care, or any combination thereof.

31 (iii) Other excepted benefits specified in federal regulations issued pursuant to federal  
32 Pub. L. No. 104-191 ("HIPAA").

33 (C) The following benefits if the benefits are provided under a separate policy, certificate  
34 or contract of insurance, there is no coordination between the provision of the benefits and any

1 exclusion of benefits under any group health plan maintained by the same plan sponsor, and the  
2 benefits are paid with respect to an event without regard to whether benefits are provided with  
3 respect to such an event under any group health plan maintained by the same plan sponsor:

4 (i) Coverage only for a specified disease or illness.

5 (ii) Hospital indemnity or other fixed indemnity insurance.

6 (D) The following if offered as a separate policy, certificate or contract of insurance:

7 (i) Medicare supplement health insurance as defined under section 1882(g)(1) of the  
8 federal Social Security Act.

9 (ii) Coverage supplemental to the coverage provided under chapter 55 of title 10, United  
10 States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)).

11 (iii) Similar supplemental coverage provided to coverage under a group health plan.

12 (15) "Office of the health insurance commissioner" means the agency established under  
13 section 42-14.5-1 of the General laws.

14 (16) "Rescission" means a cancellation or discontinuance of coverage that has retroactive  
15 effect for reasons unrelated to timely payment of required premiums or contribution to costs of  
16 coverage.

17 SECTION 11. Section 27-18.5-8 of the General Laws in Chapter 27-18.5 entitled  
18 "Individual Health Insurance Coverage" is hereby amended to read as follows:

19 **27-18.5-8. Wellness health benefit plan.** -- All carriers that offer health insurance in the  
20 individual market shall actively market and offer the wellness health direct benefit plan to eligible  
21 individuals. The wellness health direct benefit plan shall be determined by regulation  
22 promulgated by the office of the health insurance commissioner (OHIC). The OHIC shall develop  
23 the criteria for the direct wellness health benefit plan, including, but not limited to, benefit levels,  
24 cost sharing levels, exclusions and limitations in accordance with the following:

25 (1) Form and utilize an advisory committee in accordance with subsection 27-50-10(5).

26 (2) Set a target for the average annualized individual premium rate for the direct  
27 wellness health benefit plan to be less than ten percent (10%) of the average annual statewide  
28 wage, dependent upon the availability of reinsurance funds, as reported by the Rhode Island  
29 department of labor and training, in their report entitled "Quarterly Census of Rhode Island  
30 Employment and Wages." In the event that this report is no longer available, or the OHIC  
31 determines that it is no longer appropriate for the determination of maximum annualized  
32 premium, an alternative method shall be adopted in regulation by the OHIC. The maximum  
33 annualized individual premium rate shall be determined no later than August 1st of each year, to  
34 be applied to the subsequent calendar year premiums rates.

1 (3) Ensure that the direct wellness health benefit plan creates appropriate incentives for  
2 employers, providers, health plans and consumers to, among other things:

3 (i) Focus on primary care, [behavioral health care](#), prevention and wellness;

4 (ii) Actively manage the chronically ill population, [including health-related behavior](#);

5 (iii) Use the least cost, most appropriate setting; and

6 (iv) Use evidence based, quality care.

7 (4) The plan shall be made available in accordance with title 27, chapter 18.5 as required  
8 by regulation on or before May 1, 2007.

9 SECTION 12. Section 27-18.6-2 of the General Laws in Chapter 27-18.6 entitled "Large  
10 Group Health Insurance Coverage" is hereby amended to read as follows:

11 **27-18.6-2. Definitions.** -- The following words and phrases as used in this chapter have  
12 the following meanings unless a different meaning is required by the context:

13 (1) "Affiliation period" means a period which, under the terms of the health insurance  
14 coverage offered by a health maintenance organization, must expire before the health insurance  
15 coverage becomes effective. The health maintenance organization is not required to provide  
16 health care services or benefits during the period and no premium shall be charged to the  
17 participant or beneficiary for any coverage during the period;

18 (2) "Beneficiary" has the meaning given that term under section 3(8) of the Employee  
19 Retirement Security Act of 1974, 29 U.S.C. section 1002(8);

20 (3) "Bona fide association" means, with respect to health insurance coverage in this state,  
21 an association which:

22 (i) Has been actively in existence for at least five (5) years;

23 (ii) Has been formed and maintained in good faith for purposes other than obtaining  
24 insurance;

25 (iii) Does not condition membership in the association on any health status-relating  
26 factor relating to an individual (including an employee of an employer or a dependent of an  
27 employee);

28 (iv) Makes health insurance coverage offered through the association available to all  
29 members regardless of any health status-related factor relating to the members (or individuals  
30 eligible for coverage through a member);

31 (v) Does not make health insurance coverage offered through the association available  
32 other than in connection with a member of the association;

33 (vi) Is composed of persons having a common interest or calling;

34 (vii) Has a constitution and bylaws; and

- 1 (viii) Meets any additional requirements that the director may prescribe by regulation;
- 2 (4) "COBRA continuation provision" means any of the following:
- 3 (i) Section 4980(B) of the Internal Revenue Code of 1986, 26 U.S.C. section 4980B,  
4 other than the subsection (f)(1) of that section insofar as it relates to pediatric vaccines;
- 5 (ii) Part 6 of subtitle B of title 1 of the Employee Retirement Income Security Act of  
6 1974, 29 U.S.C. section 1161 et seq., other than section 609 of that act, 29 U.S.C. section 1169;  
7 or
- 8 (iii) Title XXII of the United States Public Health Service Act, 42 U.S.C. section 300bb-  
9 1 et seq.;
- 10 (5) "Creditable coverage" has the same meaning as defined in the United States Public  
11 Health Service Act, section 2701(c), 42 U.S.C. section 300gg(c), as added by P.L. 104-191;
- 12 (6) "Church plan" has the meaning given that term under section 3(33) of the Employee  
13 Retirement Income Security Act of 1974, 29 U.S.C. section 1002(33);
- 14 (7) "Director" means the director of the department of business regulation;
- 15 (8) "Employee" has the meaning given that term under section 3(6) of the Employee  
16 Retirement Income Security Act of 1974, 29 U.S.C. section 1002(6);
- 17 (9) "Employer" has the meaning given that term under section 3(5) of the Employee  
18 Retirement Income Security Act of 1974, 29 U.S.C. section 1002(5), except that the term includes  
19 only employers of two (2) or more employees;
- 20 (10) "Enrollment date" means, with respect to an individual covered under a group health  
21 plan or health insurance coverage, the date of enrollment of the individual in the plan or coverage  
22 or, if earlier, the first day of the waiting period for the enrollment;
- 23 (11) "Governmental plan" has the meaning given that term under section 3(32) of the  
24 Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1002(32), and includes any  
25 governmental plan established or maintained for its employees by the government of the United  
26 States, the government of any state or political subdivision of the state, or by any agency or  
27 instrumentality of government;
- 28 (12) "Group health insurance coverage" means, in connection with a group health plan,  
29 health insurance coverage offered in connection with that plan;
- 30 (13) "Group health plan" means an employee welfare benefits plan as defined in section  
31 3(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1002(1), to the  
32 extent that the plan provides medical care and including items and services paid for as medical  
33 care to employees or their dependents as defined under the terms of the plan directly or through  
34 insurance, reimbursement or otherwise;

1 (14) "Health insurance carrier" or "carrier" means any entity subject to the insurance  
2 laws and regulations of this state, or subject to the jurisdiction of the director, that contracts or  
3 offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health  
4 care services, including, without limitation, an insurance company offering accident and sickness  
5 insurance, a health maintenance organization, a nonprofit hospital, medical or dental service  
6 corporation, or any other entity providing a plan of health insurance, health benefits, or health  
7 services;

8 (15) (i) "Health insurance coverage" means a policy, contract, certificate, or agreement  
9 offered by a health insurance carrier to provide, deliver, arrange for, pay for, or reimburse any of  
10 the costs of health care services. Health insurance coverage does include short-term and  
11 catastrophic health insurance policies, and a policy that pays on a cost-incurred basis, except as  
12 otherwise specifically exempted in this definition;

13 (ii) "Health insurance coverage" does not include one or more, or any combination of,  
14 the following "excepted benefits":

15 (A) Coverage only for accident, or disability income insurance, or any combination of  
16 those;

17 (B) Coverage issued as a supplement to liability insurance;

18 (C) Liability insurance, including general liability insurance and automobile liability  
19 insurance;

20 (D) Workers' compensation or similar insurance;

21 (E) Automobile medical payment insurance;

22 (F) Credit-only insurance;

23 (G) Coverage for on-site medical clinics; and

24 (H) Other similar insurance coverage, specified in federal regulations issued pursuant to  
25 P.L. 104-191, under which benefits for medical care are secondary or incidental to other  
26 insurance benefits;

27 (iii) "Health insurance coverage" does not include the following "limited, excepted  
28 benefits" if they are provided under a separate policy, certificate of insurance, or are not an  
29 integral part of the plan:

30 (A) Limited scope dental or vision benefits;

31 (B) Benefits for long-term care, nursing home care, home health care, community-based  
32 care, or any combination of those; and

33 (C) Any other similar, limited benefits that are specified in federal regulations issued  
34 pursuant to P.L. 104-191;

1 (iv) "Health insurance coverage" does not include the following "noncoordinated,  
2 excepted benefits" if the benefits are provided under a separate policy, certificate, or contract of  
3 insurance, there is no coordination between the provision of the benefits and any exclusion of  
4 benefits under any group health plan maintained by the same plan sponsor, and the benefits are  
5 paid with respect to an event without regard to whether benefits are provided with respect to the  
6 event under any group health plan maintained by the same plan sponsor:

7 (A) Coverage only for a specified disease or illness; and

8 (B) Hospital indemnity or other fixed indemnity insurance;

9 (v) "Health insurance coverage" does not include the following "supplemental, excepted  
10 benefits" if offered as a separate policy, certificate, or contract of insurance:

11 (A) Medicare supplemental health insurance as defined under section 1882(g)(1) of the  
12 Social Security Act, 42 U.S.C. section 1395ss(g)(1);

13 (B) Coverage supplemental to the coverage provided under 10 U.S.C. section 1071 et  
14 seq.; and

15 (C) Similar supplemental coverage provided to coverage under a group health plan;

16 (16) "Health maintenance organization" ("HMO") means a health maintenance  
17 organization licensed under chapter 41 of this title;

18 (17) "Health status-related factor" means any of the following factors:

19 (i) Health status;

20 (ii) Medical condition, including both physical and mental illnesses, and behaviors  
21 related to health status;

22 (iii) Claims experience;

23 (iv) Receipt of health or behavioral health care;

24 (v) Medical history;

25 (vi) Genetic information;

26 (vii) Evidence of insurability, including contributions arising out of acts of domestic  
27 violence; and

28 (viii) Disability;

29 (18) "Large employer" means, in connection with a group health plan with respect to a  
30 calendar year and a plan year, an employer who employed an average of at least fifty-one (51)  
31 employees on business days during the preceding calendar year and who employs at least two (2)  
32 employees on the first day of the plan year. In the case of an employer which was not in existence  
33 throughout the preceding calendar year, the determination of whether the employer is a large  
34 employer shall be based on the average number of employees that is reasonably expected the



1 employer will employ on business days in the current calendar year;

2 (19) "Large group market" means the health insurance market under which individuals  
3 obtain health insurance coverage (directly or through any arrangement) on behalf of themselves  
4 (and their dependents) through a group health plan maintained by a large employer;

5 (20) "Late enrollee" means, with respect to coverage under a group health plan, a  
6 participant or beneficiary who enrolls under the plan other than during:

7 (i) The first period in which the individual is eligible to enroll under the plan; or

8 (ii) A special enrollment period;

9 (21) "Medical care" means amounts paid for:

10 (i) The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid  
11 for the purpose of affecting any structure or function of the body, or behavioral health  
12 functioning;

13 (ii) Amounts paid for transportation primarily for and essential to medical care referred  
14 to in paragraph (i) of this subdivision; and

15 (iii) Amounts paid for insurance covering medical care referred to in paragraphs (i) and  
16 (ii) of this subdivision;

17 (22) "Network plan" means health insurance coverage offered by a health insurance  
18 carrier under which the financing and delivery of medical care including items and services paid  
19 for as medical care are provided, in whole or in part, through a defined set of providers under  
20 contract with the carrier;

21 (23) "Participant" has the meaning given such term under section 3(7) of the Employee  
22 Retirement Income Security Act of 1974, 29 U.S.C. section 1002(7);

23 (24) "Placed for adoption" means, in connection with any placement for adoption of a  
24 child with any person, the assumption and retention by that person of a legal obligation for total  
25 or partial support of the child in anticipation of adoption of the child. The child's placement with  
26 the person terminates upon the termination of the legal obligation;

27 (25) "Plan sponsor" has the meaning given that term under section 3(16)(B) of the  
28 Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1002(16)(B). "Plan  
29 sponsor" also includes any bona fide association, as defined in this section;

30 (26) "Preexisting condition exclusion" means, with respect to health insurance coverage,  
31 a limitation or exclusion of benefits relating to a condition based on the fact that the condition  
32 was present before the date of enrollment for the coverage, whether or not any medical advice,  
33 diagnosis, care or treatment was recommended or received before the date; and

34 (27) "Waiting period" means, with respect to a group health plan and an individual who

1 is a potential participant or beneficiary in the plan, the period that must pass with respect to the  
2 individual before the individual is eligible to be covered for benefits under the terms of the plan.

3 SECTION 13. Sections 27-19-1 and 27-19-5.2 of the General Laws in Chapter 27-19  
4 entitled "Nonprofit Hospital Service Corporations" are hereby amended to read as follows:

5 **27-19-1. Definitions.** -- As used in this chapter:

6 (1) "Contracting hospital" means an eligible hospital which has contracted with a  
7 nonprofit hospital service corporation to render hospital care to subscribers to the nonprofit  
8 hospital service plan operated by the corporation;

9 (2) "Adverse benefit determination" means any of the following: a denial, reduction, or  
10 termination of, or a failure to provide or make payment (in whole or in part) for, a benefit,  
11 including any such denial, reduction, termination, or failure to provide or make payment that is  
12 based on a determination of an individual's eligibility to participate in a plan or to receive  
13 coverage under a plan, and including, with respect to group health plans, a denial, reduction, or  
14 termination of, or a failure to provide or make payment (in whole or in part) for, a benefit  
15 resulting from the application of any utilization review, as well as a failure to cover an item or  
16 service for which benefits are otherwise provided because it is determined to be experimental or  
17 investigational or not medically necessary or appropriate. The term also includes a rescission of  
18 coverage determination.

19 (3) "Affordable Care Act" means the federal Patient Protection and Affordable Care Act  
20 of 2010, as amended by the federal Health Care and Education Reconciliation Act of 2010, and  
21 federal regulations adopted thereunder;

22 (4) "Commissioner" or "health insurance commissioner" means that individual appointed  
23 pursuant to section 42-14.5-1 of the General laws;

24 (5) "Eligible hospital" is one which is maintained either by the state or by any of its  
25 political subdivisions or by a corporation organized for hospital purposes under the laws of this  
26 state or of any other state or of the United States, which is designated as an eligible hospital by a  
27 majority of the directors of the nonprofit hospital service corporation;

28 (6) "Essential health benefits" shall have the meaning set forth in section 1302(b) of the  
29 federal Affordable Care Act.

30 (7) "Grandfathered health plan" means any group health plan or health insurance  
31 coverage subject to 42 USC section 18011;

32 (8) "Group health insurance coverage" means, in connection with a group health plan,  
33 health insurance coverage offered in connection with such plan;

34 (9) "Group health plan" means an employee welfare benefit plan as defined 29 USC

1 section 1002(1), to the extent that the plan provides health benefits to employees or their  
2 dependents directly or through insurance, reimbursement, or otherwise;

3 (10) "Health benefits" or "covered benefits" means coverage or benefits for the  
4 diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose  
5 of affecting any structure or function of the body, [or behavioral health functioning](#) including  
6 coverage or benefits for transportation primarily for and essential thereto, and including medical  
7 services as defined in R.I. Gen. Laws section 27-19-17;

8 (11) "Health care facility" means an institution providing health care services or a health  
9 care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory  
10 surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic,  
11 laboratory and imaging centers, and rehabilitation and other therapeutic health settings;

12 (12) "Health care professional" means a physician or other health care practitioner  
13 licensed, accredited or certified to perform specified health care services consistent with state  
14 law;

15 (13) "Health care provider" or "provider" means a health care professional or a health  
16 care facility;

17 (14) "Health care services" means services for the diagnosis, prevention, treatment, cure  
18 or relief of a health condition, illness, injury or disease;

19 (15) "Health insurance carrier" means a person, firm, corporation or other entity subject  
20 to the jurisdiction of the commissioner under this chapter, and includes nonprofit hospital service  
21 corporations. Such term does not include a group health plan. The use of this term shall not be  
22 construed to subject a nonprofit hospital service corporation to the insurance laws of this state  
23 other than as set forth in R.I. Gen. Laws section 27-19-2;

24 (16) "Health plan" or "health benefit plan" means health insurance coverage and a group  
25 health plan, including coverage provided through an association plan if it covers Rhode Island  
26 residents. Except to the extent specifically provided by the federal Affordable Care Act, the term  
27 "health plan" shall not include a group health plan to the extent state regulation of the health plan  
28 is pre-empted under section 514 of the federal Employee Retirement Income Security Act of  
29 1974. The term also shall not include:

30 (A) (i) Coverage only for accident, or disability income insurance, or any combination  
31 thereof.

32 (ii) Coverage issued as a supplement to liability insurance.

33 (iii) Liability insurance, including general liability insurance and automobile liability  
34 insurance.

- 1 (iv) Workers' compensation or similar insurance.
- 2 (v) Automobile medical payment insurance.
- 3 (vi) Credit-only insurance.
- 4 (vii) Coverage for on-site medical clinics.
- 5 (viii) Other similar insurance coverage, specified in federal regulations issued pursuant  
6 to federal Pub. L. No. 104-191, the federal health insurance portability and accountability act of  
7 1996 ("HIPAA"), under which benefits for medical care are secondary or incidental to other  
8 insurance benefits.

9 (B) The following benefits if they are provided under a separate policy, certificate or  
10 contract of insurance or are otherwise not an integral part of the plan:

- 11 (i) Limited scope dental or vision benefits.
- 12 (ii) Benefits for long-term care, nursing home care, home health care, community-based  
13 care, or any combination thereof.
- 14 (iii) Other excepted benefits specified in federal regulations issued pursuant to federal  
15 Pub. L. No. 104-191 ("HIPAA").

16 (C) The following benefits if the benefits are provided under a separate policy, certificate  
17 or contract of insurance, there is no coordination between the provision of the benefits and any  
18 exclusion of benefits under any group health plan maintained by the same plan sponsor, and the  
19 benefits are paid with respect to an event without regard to whether benefits are provided with  
20 respect to such an event under any group health plan maintained by the same plan sponsor:

- 21 (i) Coverage only for a specified disease or illness.
- 22 (ii) Hospital indemnity or other fixed indemnity insurance.
- 23 (D) The following if offered as a separate policy, certificate or contract of insurance:
- 24 (i) Medicare supplement health insurance as defined under section 1882(g)(1) of the  
25 federal Social Security Act.
- 26 (ii) Coverage supplemental to the coverage provided under chapter 55 of title 10, United  
27 States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)).
- 28 (iii) Similar supplemental coverage provided to coverage under a group health plan.

29 (17) "Nonprofit hospital service corporation" means any corporation organized pursuant  
30 to this chapter for the purpose of establishing, maintaining, and operating a nonprofit hospital  
31 service plan;

32 (18) "Nonprofit hospital service plan" means a plan by which specified hospital care is to  
33 be provided to subscribers to the plan by a contracting hospital;

34 (19) "Office of the health insurance commissioner" means the agency established under

1 section 42-14.5-1 of the General Law;

2 (20) "Rescission" means a cancellation or discontinuance of coverage that has retroactive  
3 effect for reasons unrelated to timely payment of required premiums or contribution to costs of  
4 coverage; and

5 (21) "Subscribers" mean those persons, whether or not residents of this state, who have  
6 contracted with a nonprofit hospital service corporation for hospital care pursuant to a nonprofit  
7 hospital service plan operated by the corporation.

8 **27-19-5.2. Patient responsibility -- Administrative requirements. --** For health benefit  
9 contracts issued, renewed, or delivered on or after April 1, 2002, the following shall apply:

10 (1) The amount of copayments for physician office visits and hospital emergency room  
11 visits shall be printed on the subscriber identification cards issued to insureds. [The amount of](#)  
12 [copayments of behavioral health office visits shall be equal to those for non-preventive primary](#)  
13 [care office visits.](#)

14 (2) A schedule of all applicable copayments, by product or by group, in paper or  
15 electronic format, or both, shall be published, updated, and distributed to participating providers.

16 (3) Notification shall be provided to subscribers on an annual basis regarding their  
17 responsibility for copayments and deductibles.

18 SECTION 14. Sections 27-20-1, 27-20-3 and 27-20-5.3 of the General Laws in Chapter  
19 27-20 entitled "Nonprofit Medical Service Corporations" are hereby amended to read as follows:

20 **27-20-1. Definitions. --** As used in this chapter:

21 (1) "Adverse benefit determination" means any of the following: a denial, reduction, or  
22 termination of, or a failure to provide or make payment (in whole or in part) for, a benefit,  
23 including any such denial, reduction, termination, or failure to provide or make payment that is  
24 based on a determination of a an individual's eligibility to participate in a plan or to receive  
25 coverage under a plan, and including, with respect to group health plans, a denial, reduction, or  
26 termination of, or a failure to provide or make payment (in whole or in part) for, a benefit  
27 resulting from the application of any utilization review, as well as a failure to cover an item or  
28 service for which benefits are otherwise provided because it is determined to be experimental or  
29 investigational or not medically necessary or appropriate. The term also includes a rescission of  
30 coverage determination.

31 (2) "Affordable Care Act" means the federal Patient Protection and Affordable Care Act  
32 of 2010, as amended by the federal Health Care and Education Reconciliation Act of 2010, and  
33 federal regulations adopted thereunder;

34 (3) "Certified registered nurse practitioners" is an expanded role utilizing independent

1 knowledge of physical assessment and management of health care and illnesses. The practice  
2 includes collaboration with other licensed health care professionals including, but not limited to,  
3 physicians, pharmacists, podiatrists, dentists, and nurses;

4 (4) "Commissioner" or "health insurance commissioner" means that individual appointed  
5 pursuant to section 42-14.5-1 of the General laws.

6 (5) "Counselor in mental health" means a person who has been licensed pursuant to  
7 section 5-63.2-9.

8 (6) "Essential health benefits" shall have the meaning set forth in section 1302(b) of the  
9 federal Affordable Care Act.

10 (7) "Grandfathered health plan" means any group health plan or health insurance  
11 coverage subject to 42 USC section 18011.

12 (8) "Group health insurance coverage" means, in connection with a group health plan,  
13 health insurance coverage offered in connection with such plan.

14 (9) "Group health plan" means an employee welfare benefit plan as defined in 29 USC  
15 section 1002(1) to the extent that the plan provides health benefits to employees or their  
16 dependents directly or through insurance, reimbursement, or otherwise.

17 (10) "Health benefits" or "covered benefits" means coverage or benefits for the  
18 diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose  
19 of affecting any structure or function of the body [or behavioral health functioning](#) including  
20 coverage or benefits for transportation primarily for and essential thereto, and including medical  
21 services as defined in R.I. Gen. Laws section 27-19-17;

22 (11) "Health care facility" means an institution providing health care services or a health  
23 care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory  
24 surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic,  
25 laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

26 (12) "Health care professional" means a physician or other health care practitioner  
27 licensed, accredited or certified to perform specified health care services consistent with state  
28 law.

29 (13) "Health care provider" or "provider" means a health care professional or a health  
30 care facility.

31 (14) "Health care services" means services for the diagnosis, prevention, treatment, cure  
32 or relief of a health condition, illness, injury or disease.

33 (15) "Health insurance carrier" means a person, firm, corporation or other entity subject  
34 to the jurisdiction of the commissioner under this chapter, and includes a nonprofit medical

1 service corporation. Such term does not include a group health plan.

2 (16) "Health plan" or "health benefit plan" means health insurance coverage and a group  
3 health plan, including coverage provided through an association plan if it covers Rhode Island  
4 residents. Except to the extent specifically provided by the federal Affordable Care Act, the term  
5 "health plan" shall not include a group health plan to the extent state regulation of the health plan  
6 is pre-empted under section 514 of the federal Employee Retirement Income Security Act of  
7 1974. The term also shall not include:

8 (A) (i) Coverage only for accident, or disability income insurance, or any combination  
9 thereof.

10 (ii) Coverage issued as a supplement to liability insurance.

11 (iii) Liability insurance, including general liability insurance and automobile liability  
12 insurance.

13 (iv) Workers' compensation or similar insurance.

14 (v) Automobile medical payment insurance.

15 (vi) Credit-only insurance.

16 (vii) Coverage for on-site medical clinics.

17 (viii) Other similar insurance coverage,

18 specified in federal regulations issued pursuant to Federal Pub. L. No. 104-191, the  
19 federal health insurance portability and accountability act of 1996 ("HIPAA"), under which  
20 benefits for medical care are secondary or incidental to other insurance benefits.

21 (B) The following benefits if they are provided under a separate policy, certificate or  
22 contract of insurance or are otherwise not an integral part of the plan:

23 (i) Limited scope dental or vision benefits.

24 (ii) Benefits for long-term care, nursing home care, home health care, community-based  
25 care, or any combination thereof.

26 (iii) Other excepted benefits specified in federal regulations issued pursuant to federal  
27 Pub. L. No. 104-191 ("HIPAA").

28 (C) The following benefits if the benefits are provided under a separate policy, certificate  
29 or contract of insurance, there is no coordination between the provision of the benefits and any  
30 exclusion of benefits under any group health plan maintained by the same plan sponsor, and the  
31 benefits are paid with respect to an event without regard to whether benefits are provided with  
32 respect to such an event under any group health plan maintained by the same plan sponsor:

33 (i) Coverage only for a specified disease or illness.

34 (ii) Hospital indemnity or other fixed indemnity insurance.

1 (D) The following if offered as a separate policy, certificate or contract of insurance:

2 (i) Medicare supplement health insurance as defined under section 1882(g)(1) of the  
3 federal Social Security Act.

4 (ii) Coverage supplemental to the coverage provided under chapter 55 of title 10, United  
5 States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)).

6 (iii) Similar supplemental coverage provided to coverage under a group health plan.

7 (17) "Licensed midwife" means any midwife licensed under section 23-13-9;

8 (18) "Medical services" means those professional services rendered by persons duly  
9 licensed under the laws of this state to practice medicine, surgery, chiropractic, podiatry, and  
10 other professional services rendered by a licensed midwife, certified registered nurse  
11 practitioners, and psychiatric and mental health nurse clinical specialists, and appliances, drugs,  
12 medicines, supplies, and nursing care necessary in connection with the services, or the expense  
13 indemnity for the services, appliances, drugs, medicines, supplies, and care, as may be specified  
14 in any nonprofit medical service plan. Medical service shall not be construed to include hospital  
15 services;

16 (19) "Nonprofit medical service corporation" means any corporation organized pursuant  
17 hereto for the purpose of establishing, maintaining, and operating a nonprofit medical service  
18 plan;

19 (20) "Nonprofit medical service plan" means a plan by which specified medical service  
20 is provided to subscribers to the plan by a nonprofit medical service corporation;

21 (21) "Office of the health insurance commissioner" means the agency established under  
22 section 42-14.5-1 of the General laws.

23 (22) "Psychiatric and mental health nurse clinical specialist" is an expanded role utilizing  
24 independent knowledge and management of mental health and illnesses. The practice includes  
25 collaboration with other licensed health care professionals, including, but not limited to,  
26 psychiatrists, psychologists, physicians, pharmacists, and nurses;

27 (23) "Rescission" means a cancellation or discontinuance of coverage that has retroactive  
28 effect for reasons unrelated to timely payment of required premiums or contribution to costs of  
29 coverage.

30 (24) "Subscribers" means those persons or groups of persons who contract with a  
31 nonprofit medical service corporation for medical service pursuant to a nonprofit medical service  
32 plan; and

33 (25) "Therapist in marriage and family practice" means a person who has been licensed  
34 pursuant to section 5-63.2-10.



1           **27-20-3. Qualifications of directors.** -- A majority of the directors of a nonprofit  
2 medical service corporation, other than a corporation organized pursuant to the provisions of  
3 chapter 19 of this title, must at all times be doctors of medicine [or behavioral health providers](#)  
4 duly licensed to practice under the laws of this state. The directors of any nonprofit medical  
5 service corporation formed after January 1, 1964 shall consist of an equal number of  
6 representatives of the public, doctors of medicine [or behavioral health providers](#) duly licensed to  
7 practice under the laws of this state, and subscribers.

8           **27-20-5.3. Patient responsibility -- Administrative requirements.** -- For health benefit  
9 contracts issued, renewed, or delivered on or after April 1, 2002, the following shall apply:

10           (1) The amount of copayments for physician office visits and hospital emergency room  
11 visits shall be printed on the subscriber identification cards issued to insureds. [The amount of](#)  
12 [copayments for behavioral health office visits shall be equal to those for non-preventive primary](#)  
13 [care office visits.](#)

14           (2) A schedule of all applicable copayments, by product or by group, in paper or  
15 electronic format, or both, shall be published, updated, and distributed to participating providers.

16           (3) On an annual basis, notification shall be provided to subscribers regarding their  
17 responsibility for copayments and deductibles.

18           SECTION 15. Section 27-20.9-3 of the General Laws in Chapter 27-20.9 entitled  
19 "Contract With Health Care Providers" is hereby amended to read as follows:

20           **27-20.9-3. Pay-for-performance guidelines.** -- A health insurer shall not require a  
21 physician [or behavioral health provider](#), as a condition of contracting, to participate in any  
22 financial or reimbursement incentive program, commonly referred to as pay-for-performance  
23 programs unless such program meets the principles and guidelines for pay-for-performance  
24 programs endorsed by the national quality forum and adopted by the AQA Alliance or the  
25 hospital quality alliance, or similar principles and guidelines for pay-for-performance programs  
26 approved by the office of the health insurance commissioner. [Any pay-for-performance program](#)  
27 [offered to a primary care physician, or a program certified by the health insurance commissioner](#)  
28 [to be equivalent, shall be made available for behavioral health providers.](#)

29           SECTION 16. Sections 27-38.2-1, 27-38.2-2, 27-38.2-3 and 27-38.2-4 of the General  
30 Laws in Chapter 27-38.2 entitled "Insurance Coverage for Mental Illness and Substance Abuse"  
31 are hereby amended to read as follows:

32           **27-38.2-1. Mental illness coverage.** -- Every health care insurer that delivers or issues  
33 for delivery or renews in this state a contract, plan, or policy except contracts providing  
34 supplemental coverage to Medicare or other governmental programs, shall provide coverage for

1 the medical treatment of mental illness, ~~and~~ substance abuse, and health-related behaviors under  
2 the same terms and conditions as that coverage is provided for other illnesses and diseases and in  
3 particular, for illnesses and diseases commonly treated by primary care providers. Insurance  
4 coverage offered pursuant to this statute must include the same durational limits, amount limits,  
5 deductibles, and co-insurance factors for mental illness as for other illnesses and diseases and in  
6 particular, for illnesses and diseases commonly treated by primary care providers.

7 **27-38.2-2. Definitions.** -- For the purposes of this chapter, the following words and terms  
8 have the following meanings:

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

- 17 (i) Hospital confinement indemnity;
- 18 (ii) Disability income;
- 19 (iii) Accident only;
- 20 (iv) Long-term care;
- 21 (v) Medicare supplement;
- 22 (vi) Limited benefit health;
- 23 (vii) Specific disease indemnity;
- 24 (viii) Sickness or bodily injury or death by accident or both; and
- 25 (ix) Other limited benefit policies.

26 (2) "Mental illness" means any mental disorder and substance abuse disorder that is  
27 listed in the most recent revised publication or the most updated volume of either the Diagnostic  
28 and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric  
29 Association or the International Classification of Disease Manual (ICD) published by the World  
30 Health Organization or any health-related behavior identified by the director of health as having a  
31 significant effect on health, illness, disease, or functioning and that substantially limits the life  
32 activities of the person with the illness; provided, that tobacco and caffeine are excluded from the  
33 definition of "substance" for the purposes of this chapter. "Mental illness" shall not include: (i)  
34 mental retardation, (ii) learning disorders, (iii) motor skills disorders, (iv) communication

1 disorders, and (v) mental disorders classified as "V" codes. Nothing shall preclude persons with  
2 these conditions from receiving benefits provided under this chapter for any other diagnoses  
3 covered by this chapter.

4 (3) "Mental illness coverage" means inpatient hospitalization, partial hospitalization  
5 provided in a hospital or any other licensed facility, intensive out patient services, outpatient  
6 services, [services provided by a behavioral health provider in a medical facility or practice](#), and  
7 community residential care services for substance abuse treatment. It shall not include methadone  
8 maintenance services or community residential care services for mental illnesses other than  
9 substance abuse disorders.

10 (4) "Outpatient services" means office visits that provide for the treatment of mental  
11 illness and substance abuse.

12 (5) "Community residential care services" mean those facilities as defined and licensed  
13 in accordance with chapter 24 of title 40.1.

14 **27-38.2-3. Medical necessity and appropriateness of treatment.** -- (a) Upon request of  
15 the reimbursing health insurers, all providers of treatment of mental illness shall furnish medical  
16 records or other necessary data which substantiates that initial or continued treatment is at all  
17 times medically necessary and appropriate. When the provider cannot establish the medical  
18 necessity and/or appropriateness of the treatment modality being provided, neither the health  
19 insurer nor the patient shall be obligated to reimburse for that period or type of care that was not  
20 established. The exception to the preceding can only be made if the patient has been informed of  
21 the provisions of this subsection and has agreed in writing to continue to receive treatment at his  
22 or her own expense.

23 (b) The health insurers, when making the determination of medically necessary and  
24 appropriate treatment, must do so in a manner consistent with that used to make the determination  
25 for the treatment of other diseases or injuries covered under the health insurance policy or  
26 agreement [and in particular, for illnesses and diseases commonly treated by primary care](#)  
27 [providers](#).

28 (c) Any subscriber who is aggrieved by a denial of benefits provided under this chapter  
29 may appeal a denial in accordance with the rules and regulations promulgated by the department  
30 of health pursuant to chapter 17.12 of title 23.

31 **27-38.2-4. Limitations of coverage.** -- (a) The health care benefits outlined in this  
32 chapter apply only to services delivered within the state of Rhode Island; provided, that all health  
33 insurers shall be required to provide coverage for those benefits mandated by this chapter outside  
34 of the state of Rhode Island where it can be established through a pre-authorization process that

1 the required services are not available in the state of Rhode Island from a provider in the health  
2 insurer's network.

3 (b) For the purposes of this chapter, outpatient services, with the exception of outpatient  
4 medication visits, shall be provided for ~~up to thirty (30)~~ as many visits in any calendar year as are  
5 determined to meet the medical necessity criteria; outpatient services for substance abuse  
6 treatment shall be provided for up to ~~up to thirty (30)~~ as many in any calendar year as are  
7 determined to meet the medical necessity criteria; community residential care services for  
8 substance abuse treatment shall be provided for up to thirty (30) days in any calendar year; and  
9 detoxification benefits shall be provided for up to five (5) detoxification occurrences or thirty (30)  
10 days in any calendar year, whichever comes first.

11 SECTION 17. Sections 27-41-2 and 27-41-26.1 of the General Laws in Chapter 27-41  
12 entitled "Health Maintenance Organizations" are hereby amended to read as follows:

13 **27-41-2. Definitions.** -- As used in this chapter:

14 (a) "Adverse benefit determination" means any of the following: a denial, reduction, or  
15 termination of, or a failure to provide or make payment (in whole or in part) for, a benefit,  
16 including any such denial, reduction, termination, or failure to provide or make payment that is  
17 based on a determination of a an individual's eligibility to participate in a plan or to receive  
18 coverage under a plan, and including, with respect to group health plans, a denial, reduction, or  
19 termination of, or a failure to provide or make payment (in whole or in part) for, a benefit  
20 resulting from the application of any utilization review, as well as a failure to cover an item or  
21 service for which benefits are otherwise provided because it is determined to be experimental or  
22 investigational or not medically necessary or appropriate. The term also includes a rescission of  
23 coverage determination.

24 (b) "Affordable Care Act" means the federal Patient Protection and Affordable Care act  
25 of 2010, as amended by the federal Health Care and Education Reconciliation Act of 2010, and  
26 federal regulations adopted thereunder;

27 (c) "Commissioner" or "health insurance commissioner" means that individual appointed  
28 pursuant to section 42-14.5-1 of the general laws.

29 (d) "Covered health services" means the services that a health maintenance organization  
30 contracts with enrollees and enrolled groups to provide or make available to an enrolled  
31 participant.

32 (e) "Director" means the director of the department of business regulation or his or her  
33 duly appointed agents.

34 (f) "Employee" means any person who has entered into the employment of or works

1 under a contract of service or apprenticeship with any employer. It shall not include a person who  
2 has been employed for less than thirty (30) days by his or her employer, nor shall it include a  
3 person who works less than an average of thirty (30) hours per week. For the purposes of this  
4 chapter, the term "employee" means a person employed by an "employer" as defined in  
5 subsection (d) of this section. Except as otherwise provided in this chapter the terms "employee"  
6 and "employer" are to be defined according to the rules and regulations of the department of labor  
7 and training.

8 (g) "Employer" means any person, partnership, association, trust, estate, or corporation,  
9 whether foreign or domestic, or the legal representative, trustee in bankruptcy, receiver, or trustee  
10 of a receiver, or the legal representative of a deceased person, including the state of Rhode Island  
11 and each city and town in the state, which has in its employ one or more individuals during any  
12 calendar year. For the purposes of this section, the term "employer" refers only to an employer  
13 with persons employed within the state of Rhode Island.

14 (h) "Enrollee" means an individual who has been enrolled in a health maintenance  
15 organization.

16 (i) "Essential health benefits" shall have the meaning set forth in section 1302(b) of the  
17 federal Affordable Care Act.

18 (j) "Evidence of coverage" means any certificate, agreement, or contract issued to an  
19 enrollee setting out the coverage to which the enrollee is entitled.

20 (k) "Grandfathered health plan" means any group health plan or health insurance  
21 coverage subject to 42 USC section 18011.

22 (l) "Group health insurance coverage" means, in connection with a group health plan,  
23 health insurance coverage offered in connection with such plan.

24 (m) "Group health plan" means an employee welfare benefit plan as defined in 29 USC  
25 section 1002(1), to the extent that the plan provides health benefits to employees or their  
26 dependents directly or through insurance, reimbursement, or otherwise.

27 (n) "Health benefits" or "covered benefits" means coverage or benefits for the diagnosis,  
28 cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting  
29 any structure or function of the body [or behavioral health functioning](#) including coverage or  
30 benefits for transportation primarily for and essential thereto, and including medical services as  
31 defined in R.I. Gen. Laws section 27-19-17;

32 (o) "Health care facility" means an institution providing health care services or a health  
33 care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory  
34 surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic,

1 laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

2 (p) "Health care professional" means a physician or other health care practitioner  
3 licensed, accredited or certified to perform specified health care services consistent with state  
4 law.

5 (q) "Health care provider" or "provider" means a health care professional or a health care  
6 facility.

7 (r) "Health care services" means any services included in the furnishing to any individual  
8 of medical, podiatric, or dental care, or hospitalization, or incident to the furnishing of that care or  
9 hospitalization, and the furnishing to any person of any and all other services for the purpose of  
10 preventing, alleviating, curing, or healing human illness, injury, or physical disability.

11 (s) "Health insurance carrier" means a person, firm, corporation or other entity subject to  
12 the jurisdiction of the commissioner under this chapter, and includes a health maintenance  
13 organization. Such term does not include a group health plan.

14 (t) "Health maintenance organization" means a single public or private organization  
15 which:

16 (1) Provides or makes available to enrolled participants health care services, including at  
17 least the following basic health care services: usual physician services, hospitalization, laboratory,  
18 x-ray, emergency, and preventive services, and out of area coverage, and the services of licensed  
19 midwives;

20 (2) Is compensated, except for copayments, for the provision of the basic health care  
21 services listed in subdivision (1) of this subsection to enrolled participants on a predetermined  
22 periodic rate basis; and

23 (3) (i) Provides physicians' services primarily:

24 (A) Directly through physicians who are either employees or partners of the  
25 organization; or

26 (B) Through arrangements with individual physicians or one or more groups of  
27 physicians organized on a group practice or individual practice basis;

28 (ii) "Health maintenance organization" does not include prepaid plans offered by entities  
29 regulated under chapter 1, 2, 19, or 20 of this title that do not meet the criteria above and do not  
30 purport to be health maintenance organizations;

31 (4) Provides the services of licensed midwives primarily:

32 (i) Directly through licensed midwives who are either employees or partners of the  
33 organization; or

34 (ii) Through arrangements with individual licensed midwives or one or more groups of

1 licensed midwives organized on a group practice or individual practice basis.

2 (u) "Licensed midwife" means any midwife licensed pursuant to section 23-13-9.

3 (v) "Material modification" means only systemic changes to the information filed under  
4 section 27-41-3.

5 (w) "Net worth", for the purposes of this chapter, means the excess of total admitted  
6 assets over total liabilities.

7 (x) "Office of the health insurance commissioner" means the agency established under  
8 section 42-14.5-1 of the general laws.

9 (y) "Physician" includes podiatrist as defined in chapter 29 of title 5.

10 (z) "Private organization" means a legal corporation with a policy making and governing  
11 body.

12 (aa) "Provider" means any physician, hospital, licensed midwife, or other person who is  
13 licensed or authorized in this state to furnish health care services.

14 (bb) "Public organization" means an instrumentality of government.

15 (cc) "Rescission" means a cancellation or discontinuance of coverage that has retroactive  
16 effect for reasons unrelated to timely payment of required premiums or contribution to costs of  
17 coverage.

18 (dd) "Risk based capital ("RBC") instructions" means the risk based capital report  
19 including risk based capital instructions adopted by the National Association of Insurance  
20 Commissioners ("NAIC"), as these risk based capital instructions are amended by the NAIC in  
21 accordance with the procedures adopted by the NAIC.

22 (ee) "Total adjusted capital" means the sum of:

23 (1) A health maintenance organization's statutory capital and surplus (i.e. net worth) as  
24 determined in accordance with the statutory accounting applicable to the annual financial  
25 statements required to be filed under section 27-41-9; and

26 (2) Any other items, if any, that the RBC instructions provide.

27 (ff) "Uncovered expenditures" means the costs of health care services that are covered by  
28 a health maintenance organization, but that are not guaranteed, insured, or assumed by a person or  
29 organization other than the health maintenance organization. Expenditures to a provider that  
30 agrees not to bill enrollees under any circumstances are excluded from this definition.

31 (gg) "Behavioral health provider" means mental health counselor, marriage and family  
32 therapist, social worker, psychologist, advanced practice psychiatric nurse, and/or psychiatrist  
33 licensed by the department of health under relevant law and regulation.

34 **27-41-26.1. Patient responsibility -- Administrative requirements. --** For health

1 benefit contracts issued, renewed, or delivered in this state the following shall apply:

2 (1) The amount of copayments for physician office visits and hospital emergency room  
3 visits shall be printed on the subscriber identification cards issued to the insured. [The amount of](#)  
4 [copayments for behavioral health office visits shall be equal to those for non-preventive primary](#)  
5 [care office visits.](#)

6 (2) A schedule of all applicable copayments, by product or by group, in paper or  
7 electronic format, or both, shall be published, updated, and distributed to participating providers.

8 (3) On an annual basis, notification shall be provided to subscribers regarding their  
9 responsibility for copayments and deductibles.

10 SECTION 18. Sections 27-50-3 and 27-50-10 of the General Laws in Chapter 27-50  
11 entitled "Small Employer Health Insurance Availability Act" are hereby amended to read as  
12 follows:

13 **27-50-3. Definitions. [Effective December 31, 2010.]** -- (a) "Actuarial certification"  
14 means a written statement signed by a member of the American Academy of Actuaries or other  
15 individual acceptable to the director that a small employer carrier is in compliance with the  
16 provisions of section 27-50-5, based upon the person's examination and including a review of the  
17 appropriate records and the actuarial assumptions and methods used by the small employer carrier  
18 in establishing premium rates for applicable health benefit plans.

19 (b) "Adjusted community rating" means a method used to develop a carrier's premium  
20 which spreads financial risk across the carrier's entire small group population in accordance with  
21 the requirements in section 27-50-5.

22 (c) "Affiliate" or "affiliated" means any entity or person who directly or indirectly  
23 through one or more intermediaries controls or is controlled by, or is under common control with,  
24 a specified entity or person.

25 (d) "Affiliation period" means a period of time that must expire before health insurance  
26 coverage provided by a carrier becomes effective, and during which the carrier is not required to  
27 provide benefits.

28 (e) "Bona fide association" means, with respect to health benefit plans offered in this  
29 state, an association which:

30 (1) Has been actively in existence for at least five (5) years;

31 (2) Has been formed and maintained in good faith for purposes other than obtaining  
32 insurance;

33 (3) Does not condition membership in the association on any health-status related factor  
34 relating to an individual (including an employee of an employer or a dependent of an employee);



1 (4) Makes health insurance coverage offered through the association available to all  
2 members regardless of any health status-related factor relating to those members (or individuals  
3 eligible for coverage through a member);

4 (5) Does not make health insurance coverage offered through the association available  
5 other than in connection with a member of the association;

6 (6) Is composed of persons having a common interest or calling;

7 (7) Has a constitution and bylaws; and

8 (8) Meets any additional requirements that the director may prescribe by regulation.

9 (f) "Carrier" or "small employer carrier" means all entities licensed, or required to be  
10 licensed, in this state that offer health benefit plans covering eligible employees of one or more  
11 small employers pursuant to this chapter. For the purposes of this chapter, carrier includes an  
12 insurance company, a nonprofit hospital or medical service corporation, a fraternal benefit  
13 society, a health maintenance organization as defined in chapter 41 of this title or as defined in  
14 chapter 62 of title 42, or any other entity subject to state insurance regulation that provides  
15 medical care as defined in subsection (y) that is paid or financed for a small employer by such  
16 entity on the basis of a periodic premium, paid directly or through an association, trust, or other  
17 intermediary, and issued, renewed, or delivered within or without Rhode Island to a small  
18 employer pursuant to the laws of this or any other jurisdiction, including a certificate issued to an  
19 eligible employee which evidences coverage under a policy or contract issued to a trust or  
20 association.

21 (g) "Church plan" has the meaning given this term under section 3(33) of the Employee  
22 Retirement Income Security Act of 1974 [29 U.S.C. section 1002(33)].

23 (h) "Control" is defined in the same manner as in chapter 35 of this title.

24 (i) (1) "Creditable coverage" means, with respect to an individual, health benefits or  
25 coverage provided under any of the following:

26 (i) A group health plan;

27 (ii) A health benefit plan;

28 (iii) Part A or part B of Title XVIII of the Social Security Act, 42 U.S.C. section 1395c  
29 et seq., or 42 U.S.C. section 1395j et seq., (Medicare);

30 (iv) Title XIX of the Social Security Act, 42 U.S.C. section 1396 et seq., (Medicaid),  
31 other than coverage consisting solely of benefits under 42 U.S.C. section 1396s (the program for  
32 distribution of pediatric vaccines);

33 (v) 10 U.S.C. section 1071 et seq., (medical and dental care for members and certain  
34 former members of the uniformed services, and for their dependents)(Civilian Health and

1 Medical Program of the Uniformed Services)(CHAMPUS). For purposes of 10 U.S.C. section  
2 1071 et seq., "uniformed services" means the armed forces and the commissioned corps of the  
3 National Oceanic and Atmospheric Administration and of the Public Health Service;

4 (vi) A medical care program of the Indian Health Service or of a tribal organization;

5 (vii) A state health benefits risk pool;

6 (viii) A health plan offered under 5 U.S.C. section 8901 et seq., (Federal Employees  
7 Health Benefits Program (FEHBP));

8 (ix) A public health plan, which for purposes of this chapter, means a plan established or  
9 maintained by a state, county, or other political subdivision of a state that provides health  
10 insurance coverage to individuals enrolled in the plan; or

11 (x) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. section  
12 2504(e)).

13 (2) A period of creditable coverage shall not be counted, with respect to enrollment of an  
14 individual under a group health plan, if, after the period and before the enrollment date, the  
15 individual experiences a significant break in coverage.

16 (j) "Dependent" means a spouse, child under the age twenty-six (26) years, and an  
17 unmarried child of any age who is financially dependent upon, the parent and is medically  
18 determined to have a physical or mental impairment which can be expected to result in death or  
19 which has lasted or can be expected to last for a continuous period of not less than twelve (12)  
20 months.

21 (k) "Director" means the director of the department of business regulation.

22 (l) [Deleted by P.L. 2006, ch. 258, section 2, and P.L. 2006, ch. 296, section 2.]

23 (m) "Eligible employee" means an employee who works on a full-time basis with a  
24 normal work week of thirty (30) or more hours, except that at the employer's sole discretion, the  
25 term shall also include an employee who works on a full-time basis with a normal work week of  
26 anywhere between at least seventeen and one-half (17.5) and thirty (30) hours, so long as this  
27 eligibility criterion is applied uniformly among all of the employer's employees and without  
28 regard to any health status-related factor. The term includes a self-employed individual, a sole  
29 proprietor, a partner of a partnership, and may include an independent contractor, if the self-  
30 employed individual, sole proprietor, partner, or independent contractor is included as an  
31 employee under a health benefit plan of a small employer, but does not include an employee who  
32 works on a temporary or substitute basis or who works less than seventeen and one-half (17.5)  
33 hours per week. Any retiree under contract with any independently incorporated fire district is  
34 also included in the definition of eligible employee, as well as any former employee of an

1 employer who retired before normal retirement age, as defined by 42 U.S.C. 18002(a)(2)(c) while  
2 the employer participates in the early retiree reinsurance program defined by that chapter. Persons  
3 covered under a health benefit plan pursuant to the Consolidated Omnibus Budget Reconciliation  
4 Act of 1986 shall not be considered "eligible employees" for purposes of minimum participation  
5 requirements pursuant to section 27-50-7(d)(9).

6 (n) "Enrollment date" means the first day of coverage or, if there is a waiting period, the  
7 first day of the waiting period, whichever is earlier.

8 (o) "Established geographic service area" means a geographic area, as approved by the  
9 director and based on the carrier's certificate of authority to transact insurance in this state, within  
10 which the carrier is authorized to provide coverage.

11 (p) "Family composition" means:

12 (1) Enrollee;

13 (2) Enrollee, spouse and children;

14 (3) Enrollee and spouse; or

15 (4) Enrollee and children.

16 (q) "Genetic information" means information about genes, gene products, and inherited  
17 characteristics that may derive from the individual or a family member. This includes information  
18 regarding carrier status and information derived from laboratory tests that identify mutations in  
19 specific genes or chromosomes, physical medical examinations, family histories, and direct  
20 analysis of genes or chromosomes.

21 (r) "Governmental plan" has the meaning given the term under section 3(32) of the  
22 Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1002(32), and any federal  
23 governmental plan.

24 (s) (1) "Group health plan" means an employee welfare benefit plan as defined in section  
25 3(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1002(1), to the  
26 extent that the plan provides medical care, as defined in subsection (y) of this section, and  
27 including items and services paid for as medical care to employees or their dependents as defined  
28 under the terms of the plan directly or through insurance, reimbursement, or otherwise.

29 (2) For purposes of this chapter:

30 (i) Any plan, fund, or program that would not be, but for PHSA Section 2721(e), 42  
31 U.S.C. section 300gg(e), as added by P.L. 104-191, an employee welfare benefit plan and that is  
32 established or maintained by a partnership, to the extent that the plan, fund or program provides  
33 medical care, including items and services paid for as medical care, to present or former partners  
34 in the partnership, or to their dependents, as defined under the terms of the plan, fund or program,

1 directly or through insurance, reimbursement or otherwise, shall be treated, subject to paragraph  
2 (ii) of this subdivision, as an employee welfare benefit plan that is a group health plan;

3 (ii) In the case of a group health plan, the term "employer" also includes the partnership  
4 in relation to any partner; and

5 (iii) In the case of a group health plan, the term "participant" also includes an individual  
6 who is, or may become, eligible to receive a benefit under the plan, or the individual's beneficiary  
7 who is, or may become, eligible to receive a benefit under the plan, if:

8 (A) In connection with a group health plan maintained by a partnership, the individual is  
9 a partner in relation to the partnership; or

10 (B) In connection with a group health plan maintained by a self-employed individual,  
11 under which one or more employees are participants, the individual is the self-employed  
12 individual.

13 (t) (1) "Health benefit plan" means any hospital or medical policy or certificate, major  
14 medical expense insurance, hospital or medical service corporation subscriber contract, or health  
15 maintenance organization subscriber contract. Health benefit plan includes short-term and  
16 catastrophic health insurance policies, and a policy that pays on a cost-incurred basis, except as  
17 otherwise specifically exempted in this definition.

18 (2) "Health benefit plan" does not include one or more, or any combination of, the  
19 following:

20 (i) Coverage only for accident or disability income insurance, or any combination of  
21 those;

22 (ii) Coverage issued as a supplement to liability insurance;

23 (iii) Liability insurance, including general liability insurance and automobile liability  
24 insurance;

25 (iv) Workers' compensation or similar insurance;

26 (v) Automobile medical payment insurance;

27 (vi) Credit-only insurance;

28 (vii) Coverage for on-site medical clinics; and

29 (viii) Other similar insurance coverage, specified in federal regulations issued pursuant  
30 to Pub. L. No. 104-191, under which benefits for medical care are secondary or incidental to other  
31 insurance benefits.

32 (3) "Health benefit plan" does not include the following benefits if they are provided  
33 under a separate policy, certificate, or contract of insurance or are otherwise not an integral part  
34 of the plan:

- 1 (i) Limited scope dental or vision benefits;
- 2 (ii) Benefits for long-term care, nursing home care, home health care, community-based  
3 care, or any combination of those; or
- 4 (iii) Other similar, limited benefits specified in federal regulations issued pursuant to  
5 Pub. L. No. 104-191.
- 6 (4) "Health benefit plan" does not include the following benefits if the benefits are  
7 provided under a separate policy, certificate or contract of insurance, there is no coordination  
8 between the provision of the benefits and any exclusion of benefits under any group health plan  
9 maintained by the same plan sponsor, and the benefits are paid with respect to an event without  
10 regard to whether benefits are provided with respect to such an event under any group health plan  
11 maintained by the same plan sponsor:
- 12 (i) Coverage only for a specified disease or illness; or
- 13 (ii) Hospital indemnity or other fixed indemnity insurance.
- 14 (5) "Health benefit plan" does not include the following if offered as a separate policy,  
15 certificate, or contract of insurance:
- 16 (i) Medicare supplemental health insurance as defined under section 1882(g)(1) of the  
17 Social Security Act, 42 U.S.C. section 1395ss(g)(1);
- 18 (ii) Coverage supplemental to the coverage provided under 10 U.S.C. section 1071 et  
19 seq.; or
- 20 (iii) Similar supplemental coverage provided to coverage under a group health plan.
- 21 (6) A carrier offering policies or certificates of specified disease, hospital confinement  
22 indemnity, or limited benefit health insurance shall comply with the following:
- 23 (i) The carrier files on or before March 1 of each year a certification with the director  
24 that contains the statement and information described in paragraph (ii) of this subdivision;
- 25 (ii) The certification required in paragraph (i) of this subdivision shall contain the  
26 following:
- 27 (A) A statement from the carrier certifying that policies or certificates described in this  
28 paragraph are being offered and marketed as supplemental health insurance and not as a substitute  
29 for hospital or medical expense insurance or major medical expense insurance; and
- 30 (B) A summary description of each policy or certificate described in this paragraph,  
31 including the average annual premium rates (or range of premium rates in cases where premiums  
32 vary by age or other factors) charged for those policies and certificates in this state; and
- 33 (iii) In the case of a policy or certificate that is described in this paragraph and that is  
34 offered for the first time in this state on or after July 13, 2000, the carrier shall file with the

1 director the information and statement required in paragraph (ii) of this subdivision at least thirty  
2 (30) days prior to the date the policy or certificate is issued or delivered in this state.

3 (u) "Health maintenance organization" or "HMO" means a health maintenance  
4 organization licensed under chapter 41 of this title.

5 (v) "Health status-related factor" means any of the following factors:

6 (1) Health status;

7 (2) Medical condition, including both physical and mental illnesses, and behaviors  
8 related to health status;

9 (3) Claims experience;

10 (4) Receipt of health or behavioral health care;

11 (5) Medical history;

12 (6) Genetic information;

13 (7) Evidence of insurability, including conditions arising out of acts of domestic  
14 violence; or

15 (8) Disability.

16 (w) (1) "Late enrollee" means an eligible employee or dependent who requests  
17 enrollment in a health benefit plan of a small employer following the initial enrollment period  
18 during which the individual is entitled to enroll under the terms of the health benefit plan,  
19 provided that the initial enrollment period is a period of at least thirty (30) days.

20 (2) "Late enrollee" does not mean an eligible employee or dependent:

21 (i) Who meets each of the following provisions:

22 (A) The individual was covered under creditable coverage at the time of the initial  
23 enrollment;

24 (B) The individual lost creditable coverage as a result of cessation of employer  
25 contribution, termination of employment or eligibility, reduction in the number of hours of  
26 employment, involuntary termination of creditable coverage, or death of a spouse, divorce or  
27 legal separation, or the individual and/or dependents are determined to be eligible for RItCare  
28 under chapter 5.1 of title 40 or chapter 12.3 of title 42 or for RItShare under chapter 8.4 of title  
29 40; and

30 (C) The individual requests enrollment within thirty (30) days after termination of the  
31 creditable coverage or the change in conditions that gave rise to the termination of coverage;

32 (ii) If, where provided for in contract or where otherwise provided in state law, the  
33 individual enrolls during the specified bona fide open enrollment period;

34 (iii) If the individual is employed by an employer which offers multiple health benefit

1 plans and the individual elects a different plan during an open enrollment period;

2 (iv) If a court has ordered coverage be provided for a spouse or minor or dependent child  
3 under a covered employee's health benefit plan and a request for enrollment is made within thirty  
4 (30) days after issuance of the court order;

5 (v) If the individual changes status from not being an eligible employee to becoming an  
6 eligible employee and requests enrollment within thirty (30) days after the change in status;

7 (vi) If the individual had coverage under a COBRA continuation provision and the  
8 coverage under that provision has been exhausted; or

9 (vii) Who meets the requirements for special enrollment pursuant to section 27-50-7 or  
10 27-50-8.

11 (x) "Limited benefit health insurance" means that form of coverage that pays stated  
12 predetermined amounts for specific services or treatments or pays a stated predetermined amount  
13 per day or confinement for one or more named conditions, named diseases or accidental injury.

14 (y) "Medical care" means amounts paid for:

15 (1) The diagnosis, care, mitigation, treatment, or prevention of disease, or amounts paid  
16 for the purpose of affecting any structure or function of the body [or behavioral health functioning](#);

17 (2) Transportation primarily for and essential to medical care referred to in subdivision  
18 (1); and

19 (3) Insurance covering medical care referred to in subdivisions (1) and (2) of this  
20 subsection.

21 (z) "Network plan" means a health benefit plan issued by a carrier under which the  
22 financing and delivery of medical care, including items and services paid for as medical care, are  
23 provided, in whole or in part, through a defined set of providers under contract with the carrier.

24 (aa) "Person" means an individual, a corporation, a partnership, an association, a joint  
25 venture, a joint stock company, a trust, an unincorporated organization, any similar entity, or any  
26 combination of the foregoing.

27 (bb) "Plan sponsor" has the meaning given this term under section 3(16)(B) of the  
28 Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1002(16)(B).

29 (cc) (1) "Preexisting condition" means a condition, regardless of the cause of the  
30 condition, for which medical advice, diagnosis, care, or treatment was recommended or received  
31 during the six (6) months immediately preceding the enrollment date of the coverage.

32 (2) "Preexisting condition" does not mean a condition for which medical advice,  
33 diagnosis, care, or treatment was recommended or received for the first time while the covered  
34 person held creditable coverage and that was a covered benefit under the health benefit plan,

1 provided that the prior creditable coverage was continuous to a date not more than ninety (90)  
2 days prior to the enrollment date of the new coverage.

3 (3) Genetic information shall not be treated as a condition under subdivision (1) of this  
4 subsection for which a preexisting condition exclusion may be imposed in the absence of a  
5 diagnosis of the condition related to the information.

6 (dd) "Premium" means all moneys paid by a small employer and eligible employees as a  
7 condition of receiving coverage from a small employer carrier, including any fees or other  
8 contributions associated with the health benefit plan.

9 (ee) "Producer" means any insurance producer licensed under chapter 2.4 of this title.

10 (ff) "Rating period" means the calendar period for which premium rates established by a  
11 small employer carrier are assumed to be in effect.

12 (gg) "Restricted network provision" means any provision of a health benefit plan that  
13 conditions the payment of benefits, in whole or in part, on the use of health care providers that  
14 have entered into a contractual arrangement with the carrier pursuant to provide health care  
15 services to covered individuals.

16 (hh) "Risk adjustment mechanism" means the mechanism established pursuant to section  
17 27-50-16.

18 (ii) "Self-employed individual" means an individual or sole proprietor who derives a  
19 substantial portion of his or her income from a trade or business through which the individual or  
20 sole proprietor has attempted to earn taxable income and for which he or she has filed the  
21 appropriate Internal Revenue Service Form 1040, Schedule C or F, for the previous taxable year.

22 (jj) "Significant break in coverage" means a period of ninety (90) consecutive days  
23 during all of which the individual does not have any creditable coverage, except that neither a  
24 waiting period nor an affiliation period is taken into account in determining a significant break in  
25 coverage.

26 (kk) "Small employer" means, except for its use in section 27-50-7, any person, firm,  
27 corporation, partnership, association, political subdivision, or self-employed individual that is  
28 actively engaged in business including, but not limited to, a business or a corporation organized  
29 under the Rhode Island Non-Profit Corporation Act, chapter 6 of title 7, or a similar act of  
30 another state that, on at least fifty percent (50%) of its working days during the preceding  
31 calendar quarter, employed no more than fifty (50) eligible employees, with a normal work week  
32 of thirty (30) or more hours, the majority of whom were employed within this state, and is not  
33 formed primarily for purposes of buying health insurance and in which a bona fide employer-  
34 employee relationship exists. In determining the number of eligible employees, companies that



1 are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation  
2 by this state, shall be considered one employer. Subsequent to the issuance of a health benefit  
3 plan to a small employer and for the purpose of determining continued eligibility, the size of a  
4 small employer shall be determined annually. Except as otherwise specifically provided,  
5 provisions of this chapter that apply to a small employer shall continue to apply at least until the  
6 plan anniversary following the date the small employer no longer meets the requirements of this  
7 definition. The term small employer includes a self-employed individual.

8 (ll) "Waiting period" means, with respect to a group health plan and an individual who  
9 is a potential enrollee in the plan, the period that must pass with respect to the individual before  
10 the individual is eligible to be covered for benefits under the terms of the plan. For purposes of  
11 calculating periods of creditable coverage pursuant to subsection (j)(2) of this section, a waiting  
12 period shall not be considered a gap in coverage.

13 (mm) "Wellness health benefit plan" means a plan developed pursuant to section 27-50-  
14 10.

15 (nn) "Health insurance commissioner" or "commissioner" means that individual  
16 appointed pursuant to section 42-14.5-1 of the general laws and afforded those powers and duties  
17 as set forth in sections 42-14.5-2 and 42-14.5-3 of title 42.

18 (oo) "Low-wage firm" means those with average wages that fall within the bottom  
19 quartile of all Rhode Island employers.

20 (pp) "Wellness health benefit plan" means the health benefit plan offered by each small  
21 employer carrier pursuant to section 27-50-7.

22 (qq) "Commissioner" means the health insurance commissioner.

23 **27-50-10. Wellness health benefit plan.** -- (a) No provision contained in this chapter  
24 prohibits the sale of health benefit plans which differ from the wellness health benefit plans  
25 provided for in this section.

26 (b) The wellness health benefit plan shall be determined by regulations promulgated by  
27 the office of health insurance commissioner (OHIC). The OHIC shall develop the criteria for the  
28 wellness health benefit plan, including, but not limited to, benefit levels, cost-sharing levels,  
29 exclusions, and limitations, in accordance with the following:

30 (1) (i) The OHIC shall form an advisory committee to include representatives of  
31 employers, health insurance brokers, local chambers of commerce, and consumers who pay  
32 directly for individual health insurance coverage.

33 (ii) The advisory committee shall make recommendations to the OHIC concerning the  
34 following:

1 (A) The wellness health benefit plan requirements document. This document shall be  
2 disseminated to all Rhode Island small group and individual market health plans for responses,  
3 and shall include, at a minimum, the benefit limitations and maximum cost sharing levels for the  
4 wellness health benefit plan. If the wellness health benefit product requirements document is not  
5 created by November 1, 2006, it will be determined by regulations promulgated by the OHIC.

6 (B) The wellness health benefit plan design. The health plans shall bring proposed  
7 wellness health plan designs to the advisory committee for review on or before January 1, 2007.  
8 The advisory committee shall review these proposed designs and provide recommendations to the  
9 health plans and the commissioner regarding the final wellness plan design to be approved by the  
10 commissioner in accordance with subsection 27-50-5(h)(4), and as specified in regulations  
11 promulgated by the commissioner on or before March 1, 2007.

12 (2) Set a target for the average annualized individual premium rate for the wellness  
13 health benefit plan to be less than ten percent (10%) of the average annual statewide wage, as  
14 reported by the Rhode Island department of labor and training, in their report entitled "Quarterly  
15 Census of Rhode Island Employment and Wages." In the event that this report is no longer  
16 available, or the OHIC determines that it is no longer appropriate for the determination of  
17 maximum annualized premium, an alternative method shall be adopted in regulation by the  
18 OHIC. The maximum annualized individual premium rate shall be determined no later than  
19 August 1st of each year, to be applied to the subsequent calendar year premium rates.

20 (3) Ensure that the wellness health benefit plan creates appropriate incentives for  
21 employers, providers, health plans and consumers to, among other things:

- 22 (i) Focus on primary care, [behavioral health care](#), prevention and wellness;
- 23 (ii) Actively manage the chronically ill population, [including health-related behavior](#);
- 24 (iii) Use the least cost, most appropriate setting; and
- 25 (iv) Use evidence based, quality care.

26 (4) To the extent possible, the health plans may be permitted to utilize existing products  
27 to meet the objectives of this section.

28 (5) The plan shall be made available in accordance with title 27, chapter 50 as required  
29 by regulation on or before May 1, 2007.

30 SECTION 19. Section 27-74-3 of the General Laws in Chapter 27-74 entitled "Discount  
31 Medical Plan Organization Act" is hereby amended to read as follows:

32 **27-74-3. Definitions.** -- As used in this chapter:

33 (1) "Affiliate" means a person that directly, or indirectly through one or more  
34 intermediaries, controls, or is controlled by, or is under common control with, the person

1 specified.

2 (2) "Ancillary services" includes, but is not limited to, audiology, dental, vision, mental  
3 health, substance abuse, chiropractic, and podiatry services.

4 (3) "Commissioner" means the health insurance commissioner.

5 (4) "Control" or "controlled by" or "under common control with" means the possession,  
6 direct or indirect, of the power to direct or cause the direction of the management and policies of  
7 a person, whether through the ownership of voting securities, by contract other than a commercial  
8 contract for goods or nonmanagement services, or otherwise, unless the power is the result of an  
9 official position with or corporate office held by the person. Control shall be presumed to exist if  
10 any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies  
11 representing ten percent (10%) or more of the voting securities of any other person. This  
12 presumption may be rebutted by a showing made in the manner provided by subdivision 27-35-  
13 3(i) that control does not exist in fact. The commissioner may determine, after furnishing all  
14 persons in interest notice and opportunity to be heard and making specific findings of fact to  
15 support the determination, that control exists in fact, notwithstanding the absence of a  
16 presumption to that effect.

17 (5) "Discount medical plan" means a business arrangement or contract in which a person,  
18 in exchange for fees, dues, charges or other consideration, offers access for its members to  
19 providers of medical or ancillary services and the right to receive discounts on medical or  
20 ancillary services provided under the discount medical plan from those providers.

21 (6) "Discount medical plan" does not include a plan that does not charge a membership  
22 or other fee to use the plan's discount medical card.

23 (7) "Discount medical plan organization" means an entity that, in exchange for fees,  
24 dues, charges or other consideration, provides access for discount medical plan members to  
25 providers of medical or ancillary services and the right to receive medical or ancillary services  
26 from those providers at a discount. It is the organization that contracts with providers, provider  
27 networks or other discount medical plan organizations to offer access to medical or ancillary  
28 services at a discount and determines the charge to discount medical plan members.

29 (8) "Facility" means an institution providing medical or ancillary services or a health  
30 care setting.

31 (9) "Facility" includes, but is not limited to:

32 (i) A hospital or other licensed inpatient center;

33 (ii) An ambulatory surgical or treatment center;

34 (iii) A skilled nursing center;

1 (iv) A residential treatment center;

2 (v) A rehabilitation center; and

3 (vi) A diagnostic, laboratory or imaging center.

4 (10) "Health care professional" means a physician or other health care practitioner who  
5 is licensed, accredited or certified to perform specified medical or ancillary services within the  
6 scope of his or her license, accreditation, certification or other appropriate authority and  
7 consistent with state law.

8 (11) "Health carrier" means an entity subject to the insurance laws and regulations of this  
9 state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to  
10 provide, deliver, arrange for, pay for or reimburse any of the costs of health care services,  
11 including a sickness and accident insurance company, a health maintenance organization, a  
12 nonprofit hospital and medical service corporation, or any other entity providing a plan of health  
13 insurance, health benefits or medical or ancillary services.

14 (12) "Marketer" means a person or entity that markets, promotes, sells or distributes a  
15 discount medical plan, including a private label entity that places its name on and markets or  
16 distributes a discount medical plan pursuant to a marketing agreement with a discount medical  
17 plan organization.

18 (13) "Medical services" means any maintenance care of, or preventive care for, the  
19 human body or care, service or treatment of an illness or dysfunction of, or injury to, the human  
20 body [or behavioral health functioning](#).

21 (14) "Medical services" includes, but is not limited to, physician care, [behavioral health](#)  
22 [care](#), inpatient care, hospital surgical services, emergency services, ambulance services,  
23 laboratory services and medical equipment and supplies.

24 (15) "Medical services" does not include pharmacy services or ancillary services.

25 (16) "Member" means any individual who pays fees, dues, charges or other  
26 consideration for the right to receive the benefits of a discount medical plan.

27 (17) "Person" means an individual, a corporation, a partnership, an association, a joint  
28 venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any  
29 combination of the foregoing.

30 (18) "Provider" means any health care professional or facility that has contracted,  
31 directly or indirectly, with a discount medical plan organization to provide medical or ancillary  
32 services to members.

33 (19) "Provider network" means an entity that negotiates directly or indirectly with a  
34 discount medical plan organization on behalf of more than one provider to provide medical or

1 ancillary services to members.

2 SECTION 20. Section 42-14.5-3 of the General Laws in Chapter 42-14.5 entitled "The  
3 Rhode Island Health Care Reform Act of 2004 - Health Insurance Oversight" is hereby amended  
4 to read as follows:

5 **42-14.5-3. Powers and duties [Contingent effective date; see effective dates under**  
6 **this section.] --** 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 section 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,  
19 administrative expenses, reserve requirements, and operations of insurers providing health  
20 insurance in the state, and to prepare or comment on, upon the request of the governor, or  
21 chairpersons of the house or senate finance committees, draft legislation to improve the regulation  
22 of health insurance. In making such recommendations, the commissioner shall recognize that it is  
23 the intent of the legislature that the maximum disclosure be provided regarding the  
24 reasonableness of individual administrative expenditures as well as total administrative costs. The  
25 commissioner shall make recommendations on the levels of reserves including consideration of:  
26 targeted reserve levels; trends in the increase or decrease of reserve levels; and insurer plans for  
27 distributing excess reserves.

28 (c) To establish a consumer/business/labor/medical advisory council to obtain  
29 information and present concerns of consumers, business and medical providers affected by  
30 health insurance decisions. The council shall develop proposals to allow the market for small  
31 business health insurance to be affordable and fairer. The council shall be involved in the  
32 planning and conduct of the quarterly public meetings in accordance with subsection (a) above.  
33 The advisory council shall develop measures to inform small businesses of an insurance  
34 complaint process to ensure that small businesses that experience rate increases in a given year

1 may request and receive a formal review by the department. The advisory council shall assess  
2 views of the health provider community relative to insurance rates of reimbursement, billing and  
3 reimbursement procedures, and the insurers' role in promoting efficient and high quality health  
4 care. The advisory council shall issue an annual report of findings and recommendations to the  
5 governor and the general assembly and present their findings at hearings before the house and  
6 senate finance committees. The advisory council is to be diverse in interests and shall include  
7 representatives of community consumer organizations; small businesses, other than those  
8 involved in the sale of insurance products; and hospital, medical, and other health provider  
9 organizations. Such representatives shall be nominated by their respective organizations. The  
10 advisory council shall be co-chaired by the health insurance commissioner and a community  
11 consumer organization or small business member to be elected by the full advisory council.

12 (d) To establish and provide guidance and assistance to a subcommittee ("The  
13 Professional Provider-Health Plan Work Group") of the advisory council created pursuant to  
14 subsection (c) above, composed of health care providers and Rhode Island licensed health plans.  
15 This subcommittee shall include in its annual report and presentation before the house and senate  
16 finance committees the following information:

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

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

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

22 (4) Methods for health maintenance organizations as defined by section 27-41-1, and  
23 nonprofit hospital or medical service corporations as defined by chapters 27-19 and 27-20, to  
24 make facility-specific data and other medical service-specific data available in reasonably  
25 consistent formats to patients regarding quality and costs. This information would help consumers  
26 make informed choices regarding the facilities and/or clinicians or physician practices at which to  
27 seek care. Among the items considered would be the unique health services and other public  
28 goods provided by facilities and/or clinicians or physician practices in establishing the most  
29 appropriate cost comparisons;

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

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

34 (7) Information related to temporary credentialing of providers seeking to participate in

1 the plan's network and the impact of said activity on health plan accreditation;

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

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

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

6 (f) To provide analysis of the Rhode Island Affordable Health Plan Reinsurance Fund.  
7 The fund shall be used to effectuate the provisions of sections 27-18.5-8 and 27-50-17.

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

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

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

17 (3) The analysis shall include examining the impact on rates in each of the individual and  
18 small employer health insurance markets and the number of insureds in the context of possible  
19 changes to the rating guidelines used for small employer groups, including: community rating  
20 principles; expanding small employer rate bonds beyond the current range; increasing the  
21 employer group size in the small group market; and/or adding rating factors for broker and/or  
22 tobacco use.

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

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

30 (6) The health insurance commissioner shall work with an insurance market merger task  
31 force to assist with the analysis. The task force shall be chaired by the health insurance  
32 commissioner and shall include, but not be limited to, representatives of the general assembly, the  
33 business community, small employer carriers as defined in section 27-50-3, carriers offering  
34 coverage in the individual market in Rhode Island, health insurance brokers and members of the

1 general public.

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

7 (8) The task force shall meet as necessary and include their findings in the annual report  
8 and the commissioner shall include the information in the annual presentation before the house  
9 and senate finance committees.

10 (h) To establish and convene a workgroup representing health care providers and health  
11 insurers for the purpose of coordinating the development of processes, guidelines, and standards  
12 to streamline health care administration that are to be adopted by payors and providers of health  
13 care services operating in the state. This workgroup shall include representatives with expertise  
14 that would contribute to the streamlining of health care administration and that are selected from  
15 hospitals, physician practices, community behavioral health organizations, each health insurer  
16 and other affected entities. The workgroup shall also include at least one designee each from the  
17 Rhode Island Medical Society, Rhode Island Council of Community Mental Health  
18 Organizations, the Rhode Island Health Center Association, and the Hospital Association of  
19 Rhode Island. The workgroup shall consider and make recommendations for:

20 (1) Establishing a consistent standard for electronic eligibility and coverage verification.  
21 Such standard shall:

22 (i) Include standards for eligibility inquiry and response and, wherever possible, be  
23 consistent with the standards adopted by nationally recognized organizations, such as the centers  
24 for Medicare and Medicaid services;

25 (ii) Enable providers and payors to exchange eligibility requests and responses on a  
26 system-to-system basis or using a payor supported web browser;

27 (iii) Provide reasonably detailed information on a consumer's eligibility for health care  
28 coverage, scope of benefits, limitations and exclusions provided under that coverage, cost-sharing  
29 requirements for specific services at the specific time of the inquiry, current deductible amounts,  
30 accumulated or limited benefits, out-of-pocket maximums, any maximum policy amounts, and  
31 other information required for the provider to collect the patient's portion of the bill;

32 (iv) Reflect the necessary limitations imposed on payors by the originator of the  
33 eligibility and benefits information;

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



1 services to patients who are ineligible for insurance coverage in circumstances where a payor  
2 provides eligibility verification based on best information available to the payor at the date of the  
3 request of eligibility.

4 (2) Developing implementation guidelines and promoting adoption of such guidelines  
5 for:

6 (i) The use of the national correct coding initiative code edit policy by payors and  
7 providers in the state;

8 (ii) Publishing any variations from codes and mutually exclusive codes by payors in a  
9 manner that makes for simple retrieval and implementation by providers;

10 (iii) Use of health insurance portability and accountability act standard group codes,  
11 reason codes, and remark codes by payors in electronic remittances sent to providers;

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

13 (v) A standard payor denial review process for providers when they request a  
14 reconsideration of a denial of a claim that results from differences in clinical edits where no  
15 single, common standards body or process exists and multiple conflicting sources are in use by  
16 payors and providers.

17 (vi) Nothing in this section or in the guidelines developed shall inhibit an individual  
18 payor's ability to employ, and not disclose to providers, temporary code edits for the purpose of  
19 detecting and deterring fraudulent billing activities. The guidelines shall require that each payor  
20 disclose to the provider its adjudication decision on a claim that was denied or adjusted based on  
21 the application of such edits and that the provider have access to the payor's review and appeal  
22 process to challenge the payor's adjudication decision.

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

26 (3) Developing and promoting widespread adoption by payors and providers of  
27 guidelines to:

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

31 (ii) Require payors to use common and consistent processes and time frames when  
32 responding to provider requests for medical management approvals. Whenever possible, such  
33 time frames shall be consistent with those established by leading national organizations and be  
34 based upon the acuity of the patient's need for care or treatment. For the purposes of this section,

1 medical management includes prior authorization of services, preauthorization of services,  
2 precertification of services, post service review, medical necessity review, and benefits advisory;

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

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

9 (i) To issue an ANTI-CANCER MEDICATION REPORT. - Not later than June 30,  
10 2014 and annually thereafter, the office of the health insurance commissioner (OHIC) shall  
11 provide the senate committee on health and human services, and the house committee on  
12 corporations, with: (1) Information on the availability in the commercial market of coverage for  
13 anti-cancer medication options; (2) For the state employee's health benefit plan, the costs of  
14 various cancer treatment options; (3) The changes in drug prices over the prior thirty-six (36)  
15 months; and (4) Member utilization and cost-sharing expense.

16 (j) To monitor the adequacy of each health plan's compliance with the provisions of the  
17 federal mental health parity act, including a review of related claims processing and  
18 reimbursement procedures. Findings, recommendations and assessments shall be made available  
19 to the public.

20 (k) To monitor the transition from fee for service and toward global and other alternative  
21 payment methodologies for the payment for healthcare services. Alternative payment  
22 methodologies should be assessed for their likelihood to promote access to affordable health  
23 insurance, health outcomes and performance.

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

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

30 (1) The impact of the current mandated healthcare benefits as defined in sections 27-18-  
31 48.1, 27-18-60, 27-18-62, 27-18-64, similar provisions in title 27, chapters 19, 20 and 41, and  
32 subsection 27-18-3(c), 27-38.2-1 et seq., or others as determined by the commissioner, on the cost  
33 of health insurance for fully insured employers, subject to available resources;

34 (2) Current provider and insurer mandates that are unnecessary and/or duplicative due to

1 the existing standards of care and/or delivery of services in the healthcare system;

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

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

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

11 (1) Utilization review;

12 (2) Contracting; and

13 (3) Licensing and regulation.

14 (o) To protect the interest of consumers by including consideration of behavioral health,  
15 the effects of behavioral health on health insurance consumers, and access to effective behavioral  
16 health services in determination that the interests of consumers are, or are likely to be, adversely  
17 affected by any policy, practice, action or inaction of a health insurer in consideration of the  
18 approval or denial of any regulatory request, application or filing made by a health insurer or of  
19 any other circumstances that exist such that the interests of the state's health insurance consumers  
20 may be adversely affected.

21 (p) To encourage the fair treatment of behavioral health providers by health insurers  
22 through consideration of the extent to which policies, procedures, practices, actions or inaction of  
23 a health insurer affect behavioral health providers in a manner not commensurate to their effects  
24 on primary care providers in determination that the interests of consumers are, or are likely to be,  
25 adversely affected by any policy, practice, action or inaction of a health insurer; in consideration  
26 of the approval or denial of any regulatory request, application or filing made by a health insurer  
27 or of any other circumstances that exist such that the interests of the state's health insurance  
28 consumers may be adversely affected. In particular, to enforce the Federal Mental Health Parity  
29 Act of 1996, Pub. L. 104-204, and the Federal Mental Health Parity and Addiction Equity Act of  
30 2008, Pub. L. 110-343, including its provisions regarding parity in payments and financing of  
31 behavioral health services.

32 (q) When making a determination as described in this section or when acting to  
33 encourage the fair treatment of behavioral health providers, the commissioner may consider  
34 and/or act upon the following issues, either singly or in combination of two (2) or more:

1           (1) The policies, procedures and practices employed by health insurers with respect to  
2 provider reimbursement, claims processing, dispute resolution, and contracting processes;

3           (2) A health insurer's provider rate schedules; and

4           (3) The efforts undertaken by the health insurers to enhance communications with  
5 providers.

6           (r) To improve the efficiency and quality of health care delivery including of behavioral  
7 health care through improved management of the effects of behavioral health care on health and  
8 health care, and increasing access to behavioral health care services through consideration of the  
9 extent to which the policies, procedures, practices, actions or inaction of a health insurer affect  
10 access, efficiency, quality, and impact of behavioral health services on health and health care in a  
11 manner not commensurate to their effects on primary care services and primary care providers in  
12 determination that the decision to approve or deny any regulatory request, application, or filing  
13 made by a health insurer can be made in a manner that will:

14           (1) Improve the quality and efficiency of health care service delivery and outcomes in  
15 Rhode Island;

16           (2) View the health care system as a comprehensive entity; or

17           (3) Encourage and direct insurers towards policies that advance the welfare of the public  
18 through overall efficiency, improved health care quality, and appropriate access;

19           (s) Establish and promote policies that:

20           (1) Promote increased quality and efficiency of health care service delivery and outcomes  
21 in Rhode Island;

22           (2) Encourage health insurers to view the health care system as a comprehensive entity;

23           (3) Encourage and direct insurers towards policies that advance the welfare of the public  
24 through overall efficiency, improved health care quality, and appropriate access; and

25           (4) Promote such action with respect to a health insurer will likely improve the efficiency  
26 and quality of health care delivery and increase access to health care services

27           (t) When making a determination as described in this section or when acting to further the  
28 interests set out in this section, the commissioner may consider and/or act upon the following  
29 issues, either singly or in combination of two (2) or more:

30           (1) Efforts by health insurers to develop benefit design and payment policies that enhance  
31 the affordability of their products, encourage more efficient use of the state's existing health care  
32 resources; promote appropriate and cost effective acquisition of new health care technology and  
33 expansion of the existing health care infrastructure; advance the development and use of high  
34 quality health care services (e.g., centers of excellence); and prioritize the use of limited

1 resources;

2 (2) Improve the availability of stable, predictable, affordable rates for high quality, cost  
3 efficient health insurance products, including coverage of behavioral health services, through  
4 consideration of the extent to which the policies, procedures, practices, actions or inaction of a  
5 health insurer affect whether behavioral health and behavioral health services contribute to the  
6 extent to which the health insurer's products are affordable, and whether the carrier has  
7 implemented effective strategies for management of access, effectiveness, and appropriateness of  
8 behavioral health services to enhance the affordability of its products in the decision to approve  
9 or deny any regulatory request, application, or filing made by a health insurer; and

10 (3) Achieving an economic environment in which health insurance is affordable will  
11 depend in part on improving the performance of the Rhode Island health care system as a whole,  
12 including, but not limited to, improved behavioral health care supply, reduced incidence of  
13 avoidable hospitalizations for behavioral health care-sensitive conditions, and reduced incidence  
14 of emergency room visits for behavioral health care-sensitive conditions.

15 (u) When making a determination whether a health insurance carrier has implemented  
16 effective strategies to enhance the affordability of its products, the commissioner may consider  
17 and/or act upon the following factors, either singly or in combination of two (2) or more:

18 (1) Whether the health insurer offers products that address the underlying cost of health  
19 care by creating appropriate incentives for consumers, employers, providers and the insurer itself  
20 designed to promote efficiency in creating a focus on behavioral health to supplement the focus  
21 on primary care, prevention, and wellness; establish active management procedures for the  
22 chronically ill population, including management of health-related behavior; encourage use of the  
23 least cost, most appropriate settings including behavioral health services for medical conditions as  
24 relevant and for behavioral health conditions; and promoting use of evidence based, quality care,  
25 including for behavioral health services;

26 (2) Whether the insurer employs provider payment strategies for behavioral health  
27 services to enhance cost effective utilization of appropriate services, including adequate financial  
28 support for behavioral health services;

29 (3) Whether the insurer includes incentives for behavioral health providers of step-down  
30 and diversion behavioral health services from hospital levels of care based on specific clinical and  
31 financial outcomes of such care;

32 (4) Whether the insurer includes incentives for behavioral health providers that are  
33 certified by the health insurance commissioner to be equivalent to those offered to primary care  
34 providers; and

1 [\(5\) Whether the proportion of the insurer's medical expense allocated to behavioral health](#)  
2 [care is sufficient to further the interests set out in this section.](#)

3 SECTION 21. Section 42-14.6-4 of the General Laws in Chapter 42-14.6 entitled "Rhode  
4 Island All-Payer Patient-Centered Medical Home Act" is hereby amended to read as follows:

5 **42-14.6-4. Promotion of the patient-centered medical home.** -- (a) Care coordination  
6 payments.

7 (1) The commissioner and the secretary shall convene a patient-centered medical home  
8 collaborative consisting of the entities described in subdivision 42-14.6-3(7). The commissioner  
9 shall require participation in the collaborative by all of the health insurers described above. The  
10 collaborative shall propose, by January 1, 2012, a payment system, to be adopted in whole or in  
11 part by the commissioner and the secretary, that requires all health insurers to make per-person  
12 care coordination payments to patient-centered medical homes, for providing care coordination  
13 services and directly managing on-site or employing care coordinators as part of all health  
14 insurance plans offered in Rhode Island. The collaborative shall provide guidance to the state  
15 health care program as to the appropriate payment system for the state health care program to the  
16 same patient-centered medical homes; the state health care program must justify the reasons for  
17 any departure from this guidance to the collaborative.

18 (2) The care coordination payments under this shall be consistent across insurers and  
19 patient-centered medical homes and shall be in addition to any other incentive payments such as  
20 quality incentive payments. In developing the criteria for care coordination payments, the  
21 commissioner shall consider the feasibility of including the additional time and resources needed  
22 by patients with limited English-language skills, cultural differences, or other barriers to health  
23 care. The commissioner may direct the collaborative to determine a schedule for phasing in care  
24 coordination fees.

25 (3) The care coordination payment system shall be in place through July 1, 2016. Its  
26 continuation beyond that point shall depend on results of the evaluation reports filed pursuant to  
27 section 42-14.6-6.

28 (4) Examination of other payment reforms. - By January 1, 2013, the commissioner and  
29 the secretary shall direct the collaborative to consider additional payment reforms to be  
30 implemented to support patient-centered medical homes including, but not limited to, payment  
31 structures (to medical home or other providers) that:

- 32 (i) Reward high-quality, low-cost providers;
- 33 (ii) Create enrollee incentives to receive care from high-quality, low-cost providers;
- 34 (iii) Foster collaboration among providers to reduce cost shifting from one part of the

1 health continuum to another; and

2 (iv) Create incentives that health care be provided in the least restrictive, most  
3 appropriate setting.

4 (5) The patient-centered medical home collaborative shall examine and make  
5 recommendations to the secretary regarding the designation of patient-centered medical homes, in  
6 order to promote diversity in the size of practices designated, geographic locations of practices  
7 designated and accessibility of the population throughout the state to patient-centered medical  
8 homes.

9 (6) Inclusion of behavioral health. By January 1, 2015, the commissioner and the  
10 secretary shall direct the collaborative to consider additional reforms to be implemented to  
11 promote the inclusion of behavioral health in patient-centered medical homes including, but not  
12 limited to, applying payment structures described in subsection (a)(4) of this section to behavioral  
13 health providers, and projects to evaluate the benefits of different forms of collaboration, on-site  
14 availability, and joint treatment planning for patients served in patient-centered medical homes.

15 (b) The patient-centered medical home collaborative shall propose to the secretary for  
16 adoption, standards for the patient-centered medical home to be used in the payment system. In  
17 developing these standards, the existing standards by the national committee for quality  
18 assurance, or other independent accrediting organizations may be considered where feasible.

19 SECTION 22. This act shall take effect upon passage.

=====  
LC005119  
=====

EXPLANATION  
BY THE LEGISLATIVE COUNCIL  
OF

A N A C T

RELATING TO HEALTH AND SAFETY -- RHODE ISLAND BEHAVIORAL HEALTH  
CARE REFORM ACT OF 2014

\*\*\*

1           This act would establish the "Rhode Island Behavioral Health Care Reform Act of 2014."  
2    Its purpose is to ensure appropriate use of healthcare resources to manage behavioral healthcare  
3    services and to promote the delivery of such services to people who need them, and includes  
4    routine screening of children for behavioral health matters. The act would direct various parties,  
5    including physicians, the director of the department of health, and the health insurance  
6    commissioner to undertake various actions to achieve these goals. It would also provide for  
7    increased insurance coverage for health-related behavioral services.

8           This act would take effect upon passage.

=====  
LC005119  
=====