AN ACT

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

Introduced By: Senators Miller, Goldin, Valverde, Satchell, and Goodwin

Date Introduced: February 25, 2020

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

SECTION 1. The general assembly finds and declares that:

(1) It is necessary to foster greater coordination between patients, healthcare providers, and health insurers to ensure patient health and well-being. Easing administrative burdens imposed on healthcare providers, such as prior authorization requirements, better facilitates quality patient care, allows providers to spend more time on patient care, better enables delivery of healthcare services, and improves timeliness of care.

(2) During the COVID-19 crisis it has become clear that patients and providers benefit substantially from having access to telemedicine services that are covered by health insurers on the same basis as in-person services.

(3) It is essential to facilitate the delivery of telemedicine services as a convenient, easily accessible, and affordable option to both health care providers and patients. Low-cost telephone and other internet-based audio-only and live video technologies are widely available and accessible to health care providers and patients. These technologies enable the delivery of clinically appropriate, medically necessary health care services, including behavioral health care services, to patients in a safe and accessible manner.

(4) There is a need in this state to embrace efforts that will encourage patients, health insurers and healthcare providers to support the use of telemedicine, and that will also encourage all state agencies to evaluate and amend their policies and rules to remove any regulatory barriers
prohibiting the use of telemedicine services or reimbursing for such services on a discriminatory basis relative to in-person services.

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


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

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

(b) To make recommendations to the governor and the house of representatives and senate finance committees regarding health-care insurance and the regulations, rates, services, administrative expenses, reserve requirements, and operations of insurers providing health insurance in the state, and to prepare or comment on, upon the request of the governor or chairpersons of the house or senate finance committees, draft legislation to improve the regulation of health insurance. In making the recommendations, the commissioner shall recognize that it is the intent of the legislature that the maximum disclosure be provided regarding the reasonableness of individual administrative expenditures as well as total administrative costs. The commissioner shall make recommendations on the levels of reserves, including consideration of: targeted reserve levels; trends in the increase or decrease of reserve levels; and insurer plans for distributing excess reserves.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) The health insurance commissioner shall work with an insurance market merger task force to assist with the analysis. The task force shall be chaired by the health insurance commissioner and shall include, but not be limited to, representatives of the general assembly, the business community, small-employer carriers as defined in § 27-50-3, carriers offering coverage in the individual market in Rhode Island, health-insurance brokers, and members of the general public.
(7) For the purposes of conducting this analysis, the commissioner may contract with an outside organization with expertise in fiscal analysis of the private-insurance market. In conducting its study, the organization shall, to the extent possible, obtain and use actual health-plan data. Said data shall be subject to state and federal laws and regulations governing confidentiality of health care and proprietary information.

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

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

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

(i) Include standards for eligibility inquiry and response and, wherever possible, be consistent with the standards adopted by nationally recognized organizations, such as the Centers for Medicare and Medicaid Services;

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

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

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

(v) Recommend a standard or common process to protect all providers from the costs of services to patients who are ineligible for insurance coverage in circumstances where a payor
provides eligibility verification based on best information available to the payor at the date of the
request of eligibility.

(2) Developing implementation guidelines and promoting adoption of the guidelines for:

(i) The use of the National Correct Coding Initiative code-edit policy by payors and
providers in the state;

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

(iii) Use of Health Insurance Portability and Accountability Act standard group codes,
reason codes, and remark codes by payors in electronic remittances sent to providers;

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

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

(vi) Nothing in this section, nor in the guidelines developed, shall inhibit an individual
payor's ability to employ, and not disclose to providers, temporary code edits for the purpose of
detecting and deterring fraudulent billing activities. The guidelines shall require that each payor
disclose to the provider its adjudication decision on a claim that was denied or adjusted based on
the application of such edits and that the provider have access to the payor's review and appeal
process to challenge the payor's adjudication decision.

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

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

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

(ii) Require payors to use common and consistent processes and time frames when
responding to provider requests for medical management approvals. Whenever possible, such time
frames shall be consistent with those established by leading national organizations and be based
upon the acuity of the patient's need for care or treatment. For the purposes of this section, medical
management includes prior authorization of services, preauthorization of services, precertification
of services, post-service review, medical-necessity review, and benefits advisory;
(iii) Develop, maintain, and promote widespread adoption of a single, common website where providers can obtain payors' preauthorization, benefits advisory, and preadmission requirements;

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

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

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

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

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

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

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

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

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

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

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

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

(1) Utilization review;

(2) Contracting; and

(3) Licensing and regulation.

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

(p) To work to ensure the health insurance coverage of behavioral health care under the
same terms and conditions as other health care, and to integrate behavioral health parity
requirements into the office of the health insurance commissioner insurance oversight and health
care transformation efforts.

(q) To work with other state agencies to seek delivery system improvements that enhance
access to a continuum of mental-health and substance-use disorder treatment in the state; and
integrate that treatment with primary and other medical care to the fullest extent possible.

(r) To direct insurers toward policies and practices that address the behavioral health needs
of the public and greater integration of physical and behavioral health care delivery.

(s) The office of the health insurance commissioner shall conduct an analysis of the impact
of the provisions of § 27-38.2-1(i) on health insurance premiums and access in Rhode Island and
submit a report of its findings to the general assembly on or before June 1, 2023.

(t) On or before January 1, 2021, the office of the health insurance commissioner shall
adopt a uniform set of medical criteria for prior authorization and create and disseminate a
standardized electronic or written prior authorization form that shall be used by a health insurer
whenever prior authorization is required by the health insurer.

SECTION 3. Sections 27-81-2, 27-81-3 and 27-81-4 of the General Laws in Chapter 27-81 entitled "The Telemedicine Coverage Act" are hereby amended to read as follows:

27-81-2. Purpose.

The general assembly hereby finds and declares that:

(1) The advancements and continued development of medical and communications technology have had a profound impact on the practice of medicine and offer opportunities for improving the delivery, cost, and accessibility of health care, particularly in the area of telemedicine.

(2) Geography, weather, availability of specialists, transportation, and other factors can create barriers to accessing the appropriate health care, including behavioral health care, and one way to provide, ensure, or enhance access to health care given these barriers is through the appropriate use of technology to allow health-care consumers access to qualified health-care providers.

(3) During the COVID-19 crisis, it has become clear that patients and providers benefit substantially from having access to telemedicine services that are covered by health insurers on the same basis as in-person services.

(4) It is essential to facilitate the delivery of telemedicine services as a convenient, easily accessible, and affordable option to both health care providers and patients. Low-cost telephone and other internet-based audio-only and live video technologies are widely available and accessible to health care providers and patients. These technologies enable the delivery of clinically appropriate, medically necessary health care services, including behavioral health care services, to patients in a safe and accessible manner.

(5) There is a need in this state to embrace efforts that will encourage patients, health insurers and health-care providers to support the use of telemedicine, and that will also encourage all state agencies to evaluate and amend their policies and rules to remove any regulatory barriers prohibiting the use of telemedicine services or reimbursing for such services on a discriminatory basis relative to in-person services.


As used in this chapter:

(1) "Distant site" means a site at which a health-care provider is located while providing health-care services by means of telemedicine.

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

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

(4) "Health-care provider" means a health-care professional or a health-care facility.

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

(6) "Health insurer" means any person, firm, or corporation offering and/or insuring health-care services on a prepaid basis, including, but not limited to, a nonprofit service corporation, a health-maintenance organization, or an entity offering a policy of accident and sickness insurance.

(7) "Health-maintenance organization" means a health-maintenance organization as defined in chapter 41 of this title.

(8) "Nonprofit service corporation" means a nonprofit, hospital-service corporation as defined in chapter 19 of this title, or a nonprofit, medical-service corporation as defined in chapter 20 of this title.

(9) "Originating site" means a site at which a patient is located at the time health-care services are provided to them by means of telemedicine, which can be a patient's home where medically appropriate; provided, however, notwithstanding any other provision of law, health insurers and health-care providers may agree to alternative siting arrangements deemed appropriate by the parties. Patients may receive telemedicine at any location.

(10) "Policy of accident and sickness insurance" means a policy of accident and sickness insurance as defined in chapter 18 of this title.

(11) "Store-and-forward technology" means the technology used to enable the transmission of a patient's medical information from an originating site to the health-care provider at the distant site without the patient being present.

(12) "Telemedicine" means the delivery of clinical health-care services by means of real time audio-only telephone conversation or, two-way electronic audiovisual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health-care delivery, which facilitate the assessment, diagnosis, treatment, and care management of a patient's health care while such patient is at an originating site and the health-care provider is at a distant site, consistent with applicable federal laws and regulations. Telemedicine does not include an audio-only telephone conversation, email message, or facsimile transmission.
between the provider and patient, or an automated computer program used to diagnose and/or treat
ocular or refractive conditions.

27-81-4. Coverage of telemedicine services.

(a) Each health insurer that issues individual or group accident-and-sickness insurance
policies for health-care services and/or provides a health-care plan for health-care services shall
provide coverage for the cost of such covered health-care services provided through telemedicine
services, as provided in this section.

(b) A health insurer shall not exclude a health-care service for coverage solely because the
health-care service is provided through telemedicine and is not provided through in-person
consultation or contact, so long as such health-care services are medically appropriate to be
provided through telemedicine services and, as such, may be subject to the terms and conditions of
a telemedicine agreement between the insurer and the participating health-care provider or provider
group.

All telemedicine services delivered by in-network providers shall be reimbursed at rates
not lower than the same services would have been had they been delivered in-person. Telemedicine
services shall be subject to the same health insurer policies as in-person services, including medical
necessity determinations and appeal rights.

(c) Benefit plans offered by a health insurer may shall not impose a deductible, copayment,
or coinsurance, or other cost sharing requirement for a covered health-care service provided
through telemedicine.

(d) Benefit plans offered by a health insurer shall not require prior authorization for health-
care services provided through telemedicine.

(3)(e) The requirements of this section shall apply to all policies and health plans issued,
reissued, or delivered in the state of Rhode Island on and after January 1, 2018.

(3)(f) This chapter shall not apply to: short-term travel, accident-only, limited or specified
disease; or individual conversion policies or health plans; nor to policies or health plans designed
for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known
as Medicare; or any other similar coverage under state or federal governmental plans.

(g) Health insurers shall establish reasonable requirements for the coverage of telemedicine
services, in accordance with guidance issued by the Office of the Health Insurance Commissioner,
including with respect to documentation and recordkeeping, but may not impose any requirements
more restrictive than those contained in “The Rhode Island Office of Health Insurance
Commissioner and Medicaid Program Instructions During the COVID-19 State of Emergency”
issued March 13, 2020; “Emergency Telemedicine Measures to Address and Stop the Spread of
COVID-19” issued on March 20, 2020; “Rhode Island Office of the Health Insurance Commissioner & Medicaid Program Guidance for Preventive Care Visits During COVID-19 State of Emergency” issued May 7, 2020; and the Telehealth Benefits for Medicare beneficiaries; and any subsequent guidance issued by the Office of the Health Insurance Commissioner or the state Medicaid program. No health insurer shall impose any specific requirements on the technologies used to deliver telemedicine services, including any limitations on audio-only or live video technologies.

(h) The Office of the Health Insurance Commissioner may promulgate rules and regulations consistent with the provisions of this chapter.

(i) Pursuant to § 40-8-17 of the General Laws, the Executive Office of Health and Human Services shall apply for and use its best efforts to obtain any necessary waiver(s), waiver amendment(s) and/or state plan amendment(s) from the Secretary of the United States Department of Health and Human Services, necessary to ensure that individual Medicaid beneficiaries have access to telemedicine services consistent with this chapter. EOHHS may promulgate rules and regulations in accordance with this chapter.

SECTION 4. This act shall take effect upon passage.
EXPLANATION
BY THE LEGISLATIVE COUNCIL
OF
A N A C T
RELATING TO STATE AFFAIRS AND GOVERNMENT -- THE RHODE ISLAND HEALTH CARE REFORM ACT OF 2004--HEALTH INSURANCE OVERSIGHT

***

This act would have the health insurance commissioner adopt a uniform set of medical criteria for prior authorization and create required forms to be used by a health insurer, including telemedicine coverage.

This act would take effect upon passage.

============

LC004557/SUB A

============
AN ACT

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

____________________
LC004557/SUB A
____________________

Presented by