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S T A T E O F R H O D E I S L A N D

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2013

A N A C T

RELATING TO STATE AFFAIRS AND GOVERNMENT - HEALTH INSURANCE OVERSIGHT

Introduced By: Representatives Amore, Handy, Cimini, Ajello, and Valencia

Date Introduced: February 28, 2013

Referred To: House Corporations

It is enacted by the General Assembly as follows:

SECTION 1. The general assembly hereby finds and declares that:

(1) Reducing readmissions, preventing hospital acquired conditions, placing greater emphasis on primary and preventative care, and other improvements, are critical to reducing costs and improving healthcare quality;

(2) That the fee-for-service (FFS) model is a payment mechanism wherein a provider is paid for each individual service rendered to a patient;

(3) That under the fee-for-service reimbursement model, efforts such as reducing readmissions, preventing hospital acquired conditions, and placing greater emphasis on primary and preventative care can result in reduced revenue to hospitals;

(4) That insurers and hospitals are beginning to implement new payment methodologies that better align financial incentives with improved safety, care, and quality;

(5) That the 2011 special senate commission to study cost containment, efficiency, and transparency in the delivery of quality patient care and access by hospitals testimony recommended expediting the full transition away from fee-for-service payment methodologies by 2014; and

(6) That monitoring the market transition away from fee-for-service models and reporting this information to the general assembly is critical to ensuring this transition is taking place and informing any measures the general assembly may elect to consider to further encourage and

accelerate this transition.

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:

42-14.5-3. Powers and duties. [Contingent effective date; see effective dates under this section.] -- 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 section 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 such insurers operate and efforts to bring new health insurers into the Rhode Island market. Notice of not less than ten (10) days of said 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 web site 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 such 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 also 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) above. 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 their 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) above, 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:

(i) 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;

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

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

(iv) Methods for health maintenance organizations as defined by section 27-41-1, and nonprofit hospital or medical service corporations as defined by chapters 27-19 and 27-20, 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/or 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/or clinicians or physician practices in establishing the most appropriate cost comparisons.

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

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

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

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

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

(ix) 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 section 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 sections 27-18.5-8 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 27-18.5 and the small employer health insurance market as defined in chapter 27-50 in accordance with the following:

(i) 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.

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

(iii) 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.

(iv) 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.

(v) 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.

(vi) 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 section 27-50-3, carriers offering coverage in the individual market in Rhode Island, health insurance brokers and members of the

general public.

(vii) 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.

(viii) The task force shall meet as necessary and include their 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 that would contribute to the streamlining of health care administration and that 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 such 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 or 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.

(i) To monitor a transition away from fee-for-service and toward global and other alternative payment methodologies for the payment of healthcare, and to promote access to affordable health insurance, the health insurance commissioner shall:

(1) Annually collect from each health insurer operating in the state of Rhode Island information regarding the number and percentage of their hospital contracts that continue to use fee-for-service payment methodologies and the number and percentage of their hospital contracts that use alternative payment methodologies.

(2) Annually collect from each health insurer operating in the state of Rhode Island any information regarding alternative payment methodologies implemented with hospitals prescribed by the commissioner, including, but not limited to, the type, scope, contractual terms and applicability of the alternative payment methodologies. Information shall be collected in a manner that does not disclose the identity of patients.

(3) Direct hospitals to confirm, or supplement, any information regarding hospital contracts provided by insurers as required in subparagraphs (1) and (2) of this paragraph.

(4) By March 31, 2014 and the same date each subsequent year, submit a report to the general assembly detailing:

(i) The extent that fee-for-service payment methodologies are being phased out;

(ii) The number, percentage, and types of alternative methodologies that have been adopted; and

(iii) Any improvements towards administrative simplification in hospital and insurer payment transactions that can be attributed to the adoption of alternative payment methodologies.

(5) Notwithstanding any other provision of this subsection, the commissioner shall encourage and assist providers with the voluntary adoption of alternative payment methodologies as much as practicable relative to funding and resources available to the office under this chapter.

SECTION 3. This act shall take effect upon passage.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N A C T

RELATING TO STATE AFFAIRS AND GOVERNMENT - HEALTH INSURANCE OVERSIGHT

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This act would require the health insurance commissioner to monitor a transition away from fee-for-services and toward global and other alternative payment methodologies for the payment of healthcare.

This act would take effect upon passage.

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