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STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2016

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A N A C T

RELATING TO HEALTH AND SAFETY -- RHODE ISLAND BEHAVIORAL HEALTH
CARE REFORM ACT OF 2016

Introduced By: Senators Nesselbush, Miller, P Fogarty, Pichardo, and Pearson

Date Introduced: March 08, 2016

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 2016

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 2016."

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 costs and effectiveness,
17 spending on behavioral health is a small percentage of all health care spending and is thus often
18 neglected 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 2016 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. --** (a) For the purposes of this chapter, the following terms shall
19 have the following meanings:

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

22 (2) "Behavioral health functioning" means and is intended to refer to mental health
23 conditions, substance abuse disorders, and health-related behaviors and is not intended to expand
24 the scope of covered services or benefits beyond those required in the federal parity law, also
25 known as the Mental Health Parity and Addiction Equity Act of 2008, Pub. L. 110-343.

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

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

32 (5) "Behavioral health services" means treatment and services offered by a behavioral
33 health provider for the purpose of affecting behavioral health.

34 (6) "Services to treat health-related behaviors" means medically necessary treatment

1 offered by a behavioral health provider for the purpose of improving or preventing a specific,
2 diagnosable medical condition.

3 (b) 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 § 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
14 and 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 patient 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 their 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(4), 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 § 338A of the
5 Public Health Service Act, 42 U.S.C. § 2541, who desire to serve the health care needs of
6 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) "Board" means the health professional loan repayment board.

10 (2) "Commissioner" means the commissioner of postsecondary education.

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

13 (4) "Division" means the Rhode Island division of higher education assistance.

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 § 338A of the Public Health Service Act, 42 U.S.C. § 2541,
17 licensed in the state who has entered into a contract with the board to serve medically
18 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 contact 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 § 23-17.12-14 and shall be cause for the imposition of penalties under that section.

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

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

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

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

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

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

1 hospitals, including practicing physicians, and other health care providers in the same specialty as
2 would typically treat the services subject to the criteria as follows:

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

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

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

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

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

34 (6) Utilization review agents whose annualized data reported to the department

1 demonstrate that the utilization review agent will review fewer than five hundred (500) such
2 requests for authorization may request a variance from the requirements of this section.

3 [\(7\) Medically acceptable screening criteria and review procedures for behavioral health](#)
4 [services by behavioral health providers shall be certified by the director of the department of](#)
5 [health as materially equivalent to criteria and procedures applied to primary care services and](#)
6 [providers as identified by the director.](#)

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

9 **23-17.13-3. Certification of health plans.** -- (a) Certification process.

10 (1) Certification.

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

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

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

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

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

31 (i) Allowable charge;

32 (ii) Capitation;

33 (iii) Co-payments;

34 (iv) Co-insurance;

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

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

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

- 31 (i) Coverage provisions, benefits, and any restriction or limitations on health care
32 services, including but not limited to, any exclusions as follows: by category of service, and if
33 applicable, by specific service, by technology, procedure, medication, provider or treatment
34 modality, diagnosis and condition, the latter three (3) of which shall be listed by name.

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

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

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

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

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

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

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

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

33 (9) Health plans must disclose to prospective and current enrollees the existence of
34 financial arrangements for capitated or other risk sharing arrangements that exist with providers

1 in a manner described in paragraphs (i), (ii), and (iii):

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

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

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

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

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

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

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

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

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

25 (i) Physician services;

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

27 (iii) Other professional services;

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

30 (v) Health education;

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

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

34 (i) The ratio of the number of complaints received to the total number of covered

1 persons, reported by category, listed in paragraphs (b)(15)(i) -- (vi);

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

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

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

8 (17) Plans must demonstrate that:

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

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

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

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

21 (c) Issuance of certification.

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

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

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

34 (4) All health plans shall be required to establish a mechanism under which local

1 individual subscribers to the plan provide input into the plan's procedures and processes regarding
2 the delivery of health care services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 [practice in integrated primary care settings that have been determined by the department of](#)
2 [health;](#)

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

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

7 **23-17.17-3. Establishment of health care quality performance measurement and**

8 **reporting program.** -- The director of health is authorized and directed to develop a state health

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

21 **23-17.17-9. Health care quality and value database.** -- (a) The director shall establish

22 and maintain a unified health care quality and value database, [including information about](#)
23 [behavioral health services](#) to:

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

- 33 (9) Encourage evidence-based practices in health care, [including behavioral health](#).

34 (b) The program authorized by this section shall include a consumer health care quality

1 and value information system designed to make available to consumers transparent health care
2 price information, quality information and such other information as the director determines is
3 necessary to empower individuals, including uninsured individuals, to make economically sound
4 and medically appropriate decisions.

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

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

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

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

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

1 **23-17.17-10. Reporting requirements for the health care database.** -- (a) Insurers,
2 health care providers, health care facilities and governmental agencies shall file reports, data,
3 schedules, statistics or other information determined by the director to be necessary to carry out
4 the purposes of this chapter. The reports required by this chapter shall be accepted by the director
5 in any certification commission for health care information technology ("CCHIT") certified form.

6 Such information may include:

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

8 (2) information relating to hospital finance; and

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

12 ~~(3)~~(4) any other information relating to health care costs, prices, quality, utilization, or
13 resources required to be filed by the director.

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

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

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

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

1 active treatment for an acute medical [or behavioral health](#) condition at the time the patient's
2 physician [or behavioral health provider](#) terminates his, her, or its physician [or behavioral health](#)
3 [provider](#) contract with the health plan until the active treatment is concluded or, if earlier, one
4 year after the termination; and, with respect to the patient, during the active treatment period the
5 physician [or behavioral health provider](#) shall be subject to all the terms and conditions of the
6 terminated physician [or behavioral health provider](#) contract, including but not limited to, all
7 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 § 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 § 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 § 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 1002(1), to the extent that the plan provides health benefits to employees or their dependents
20 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 § 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 § 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. § 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. § 4980B, other
4 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. § 1161 et seq., other than section 609 of that act, 29 U.S.C. § 1169; or
- 7 (iii) Title XXII of the United States Public Health Service Act, 42 U.S.C. § 300bb-1 et
8 seq.;
- 9 (5) "Creditable coverage" has the same meaning as defined in the United States Public
10 Health Service Act, section 2701(c), 42 U.S.C. § 300gg(c), as added by P.L. 104-191;
- 11 (6) "Church plan" has the meaning given that term under section 3(33) of the Employee
12 Retirement Income Security Act of 1974, 29 U.S.C. § 1002(33);
- 13 (7) "Director" means the director of the department of business regulation;
- 14 (8) "Employee" has the meaning given that term under section 3(6) of the Employee
15 Retirement Income Security Act of 1974, 29 U.S.C. § 1002(6);
- 16 (9) "Employer" has the meaning given that term under section 3(5) of the Employee
17 Retirement Income Security Act of 1974, 29 U.S.C. § 1002(5), except that the term includes only
18 employers of two (2) or more employees;
- 19 (10) "Enrollment date" means, with respect to an individual covered under a group health
20 plan or health insurance coverage, the date of enrollment of the individual in the plan or coverage
21 or, if earlier, the first day of the waiting period for the enrollment;
- 22 (11) "Governmental plan" has the meaning given that term under section 3(32) of the
23 Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002(32), and includes any
24 governmental plan established or maintained for its employees by the government of the United
25 States, the government of any state or political subdivision of the state, or by any agency or
26 instrumentality of government;
- 27 (12) "Group health insurance coverage" means, in connection with a group health plan,
28 health insurance coverage offered in connection with that plan;
- 29 (13) "Group health plan" means an employee welfare benefits plan as defined in section
30 3(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002(1), to the extent
31 that the plan provides medical care and including items and services paid for as medical care to
32 employees or their dependents as defined under the terms of the plan directly or through
33 insurance, reimbursement or otherwise;
- 34 (14) "Health insurance carrier" or "carrier" means any entity subject to the insurance

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

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

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

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

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

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

19 (D) Workers' compensation or similar insurance;

20 (E) Automobile medical payment insurance;

21 (F) Credit-only insurance;

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

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

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

29 (A) Limited scope dental or vision benefits;

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

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

34 (iv) "Health insurance coverage" does not include the following "noncoordinated,

1 excepted benefits" if the benefits are provided under a separate policy, certificate, or contract of
2 insurance, there is no coordination between the provision of the benefits and any exclusion of
3 benefits under any group health plan maintained by the same plan sponsor, and the benefits are
4 paid with respect to an event without regard to whether benefits are provided with respect to the
5 event under any group health plan maintained by the same plan sponsor:

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

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

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

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

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

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

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

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

17 (i) Health status;

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

20 (iii) Claims experience;

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

22 (v) Medical history;

23 (vi) Genetic information;

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

26 (viii) Disability;

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

34 (19) "Large group market" means the health insurance market under which individuals

1 obtain health insurance coverage (directly or through any arrangement) on behalf of themselves
2 (and their dependents) through a group health plan maintained by a large employer;

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

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

6 (ii) A special enrollment period;

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

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

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

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

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

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

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

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

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

32 (27) "Waiting period" means, with respect to a group health plan and an individual who
33 is a potential participant or beneficiary in the plan, the period that must pass with respect to the
34 individual before the individual is eligible to be covered for benefits under the terms of the plan.

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

3 **27-19-1. Definitions.** -- As used in this chapter:

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

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

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

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

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

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

28 (7) "Grandfathered health plan" means any group health plan or health insurance
29 coverage subject to 42 USC § 18011;

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

32 (9) "Group health plan" means an employee welfare benefit plan as defined 29 USC §
33 1002(1), to the extent that the plan provides health benefits to employees or their dependents
34 directly or through insurance, reimbursement, or otherwise;

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

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

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

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

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

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

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

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

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

31 (iii) Liability insurance, including general liability insurance and automobile liability
32 insurance.

33 (iv) Workers' compensation or similar insurance.

34 (v) Automobile medical payment insurance.

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

7 (B) The following benefits if they are provided under a separate policy, certificate or

8 contract of insurance or are otherwise not an integral part of the plan:

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

14 (C) The following benefits if the benefits are provided under a separate policy, certificate

15 or contract of insurance, there is no coordination between the provision of the benefits and any

16 exclusion of benefits under any group health plan maintained by the same plan sponsor, and the

17 benefits are paid with respect to an event without regard to whether benefits are provided with

18 respect to such an event under any group health plan maintained by the same plan sponsor:

- 19 (i) Coverage only for a specified disease or illness.
- 20 (ii) Hospital indemnity or other fixed indemnity insurance.

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

- 22 (i) Medicare supplement health insurance as defined under section 1882(g)(1) of the
- 23 federal Social Security Act.
- 24 (ii) Coverage supplemental to the coverage provided under chapter 55 of title 10, United
- 25 States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)).
- 26 (iii) Similar supplemental coverage provided to coverage under a group health plan.

27 (17) "Nonprofit hospital service corporation" means any corporation organized pursuant

28 to this chapter for the purpose of establishing, maintaining, and operating a nonprofit hospital

29 service plan;

30 (18) "Nonprofit hospital service plan" means a plan by which specified hospital care is to

31 be provided to subscribers to the plan by a contracting hospital;

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

33 § 42-14.5-1 of the General Law;

34 (20) "Rescission" means a cancellation or discontinuance of coverage that has retroactive

1 effect for reasons unrelated to timely payment of required premiums or contribution to costs of
2 coverage; and

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

6 **27-19-5.2. Patient responsibility -- Administrative requirements. --** For health benefit
7 contracts issued, renewed, or delivered on or after April 1, 2002, the following shall apply:

8 (1) The amount of copayments for physician office visits and hospital emergency room
9 visits shall be printed on the subscriber identification cards issued to insureds. [The amount of](#)
10 [copayments of behavioral health office visits shall be equal to those for non-preventive primary](#)
11 [care office visits.](#) (2) A schedule of all applicable copayments, by product or by group, in paper or
12 electronic format, or both, shall be published, updated, and distributed to participating providers.

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

15 SECTION 14. Sections 27-20-1, 27-20-3 and 27-20-5.3 of the General Laws in Chapter
16 27-20 entitled "Nonprofit Medical Service Corporations" are hereby amended to read as follows:

17 **27-20-1. Definitions. --** As used in this chapter:

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

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

31 (3) "Certified registered nurse practitioners" is an expanded role utilizing independent
32 knowledge of physical assessment and management of health care and illnesses. The practice
33 includes collaboration with other licensed health care professionals including, but not limited to,
34 physicians, pharmacists, podiatrists, dentists, and nurses;

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

3 (5) "Counselor in mental health" means a person who has been licensed pursuant to § 5-
4 63.2-9.

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

7 (7) "Grandfathered health plan" means any group health plan or health insurance
8 coverage subject to 42 USC § 18011.

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

11 (9) "Group health plan" means an employee welfare benefit plan as defined in 29 USC §
12 1002(1) to the extent that the plan provides health benefits to employees or their dependents
13 directly or through insurance, reimbursement, or otherwise.

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

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

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

26 (13) "Health care provider" or "provider" means a health care professional or a health
27 care facility.

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

30 (15) "Health insurance carrier" means a person, firm, corporation or other entity subject
31 to the jurisdiction of the commissioner under this chapter, and includes a nonprofit medical
32 service corporation. Such term does not include a group health plan.

33 (16) "Health plan" or "health benefit plan" means health insurance coverage and a group
34 health plan, including coverage provided through an association plan if it covers Rhode Island

1 residents. Except to the extent specifically provided by the federal Affordable Care Act, the term
2 "health plan" shall not include a group health plan to the extent state regulation of the health plan
3 is pre-empted under section 514 of the federal Employee Retirement Income Security Act of
4 1974. The term also shall not include:

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

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

8 (iii) Liability insurance, including general liability insurance and automobile liability
9 insurance.

10 (iv) Workers' compensation or similar insurance.

11 (v) Automobile medical payment insurance.

12 (vi) Credit-only insurance.

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

14 (viii) Other similar insurance coverage,

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

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

20 (i) Limited scope dental or vision benefits.

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

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

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

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

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

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

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

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

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

4 (17) "Licensed midwife" means any midwife licensed under § 23-13-9;

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

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

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

18 (21) "Office of the health insurance commissioner" means the agency established under
19 § 42-14.5-1 of the General laws.

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

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

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

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

32 **27-20-3. Qualifications of directors.** -- A majority of the directors of a nonprofit
33 medical service corporation, other than a corporation organized pursuant to the provisions of
34 chapter 19 of this title, must at all times be doctors of medicine [or behavioral health providers](#)

1 duly licensed to practice under the laws of this state. The directors of any nonprofit medical
2 service corporation formed after January 1, 1964 shall consist of an equal number of
3 representatives of the public, doctors of medicine [or behavioral health providers](#) duly licensed to
4 practice under the laws of this state, and subscribers.

5 **27-20-5.3. Patient responsibility -- Administrative requirements.** -- For health benefit
6 contracts issued, renewed, or delivered on or after April 1, 2002, the following shall apply:

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

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

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

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

17 **27-20.9-3. Pay-for-performance guidelines.** -- A health insurer shall not require a
18 physician [or behavioral health provider](#), as a condition of contracting, to participate in any
19 financial or reimbursement incentive program, commonly referred to as pay-for-performance
20 programs unless such program meets the principles and guidelines for pay-for-performance
21 programs endorsed by the national quality forum and adopted by the AQA Alliance or the
22 hospital quality alliance, or similar principles and guidelines for pay-for-performance programs
23 approved by the office of the health insurance commissioner. [Any pay-for-performance program](#)
24 [offered to a primary care physician, or a program certified by the health insurance commissioner](#)
25 [to be equivalent, shall be made available for behavioral health providers.](#)

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

29 **27-38.2-1. Coverage for the treatment of mental health and substance use disorders..**

30 **--** (a) A group health plan and an individual or group health insurance plan shall provide coverage
31 for the treatment of mental health, ~~and~~ substance-use disorders [and health-related behaviors](#) under
32 the same terms and conditions as that coverage is provided for other illnesses and diseases [and in](#)
33 [particular, for illnesses and diseases commonly treated by primary care providers.](#)

34 (b) Coverage for the treatment of mental health and substance-use disorders shall not

1 impose any annual or lifetime dollar limitation.

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

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

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

15 (f) Medication-assisted therapy, including methadone maintenance services, for the
16 treatment of substance-use disorders, opioid overdoses, and chronic addiction is included within
17 the appropriate classification based on the site of the service.

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

20 **27-38.2-2. Definitions.** -- For the purposes of this chapter, the following words and terms
21 have the following meanings:

22 (1) "Financial requirements" means deductibles, copayments, coinsurance, or out-of-
23 pocket maximums.

24 (2) "Group health plan" means an employee welfare benefit plan as defined in 29 USC
25 1002(1) to the extent that the plan provides health benefits to employees or their dependents
26 directly or through insurance, reimbursement, or otherwise. For purposes of this chapter, a group
27 health plan shall not include a plan that provides health benefits directly to employees or their
28 dependents, except in the case of a plan provided by the state or an instrumentality of the state.

29 (3) "Health insurance plan" means health insurance coverage offered, delivered, issued
30 for delivery, or renewed by a health insurer.

31 (4) "Health insurers" means all persons, firms, corporations, or other organizations
32 offering and assuring health services on a prepaid or primarily expense-incurred basis, including
33 but not limited to, policies of accident or sickness insurance, as defined by chapter 18 of this title;
34 nonprofit hospital or medical service plans, whether organized under chapter 19 or 20 of this title

1 or under any public law or by special act of the general assembly; health maintenance
2 organizations, or any other entity that insures or reimburses for diagnostic, therapeutic, or
3 preventive services to a determined population on the basis of a periodic premium. Provided, this
4 chapter does not apply to insurance coverage providing benefits for:

- 5 (i) Hospital confinement indemnity;
- 6 (ii) Disability income;
- 7 (iii) Accident only;
- 8 (iv) Long-term care;
- 9 (v) Medicare supplement;
- 10 (vi) Limited benefit health;
- 11 (vii) Specific disease indemnity;
- 12 (viii) Sickness or bodily injury or death by accident or both; and
- 13 (ix) Other limited benefit policies.

14 (5) "Mental health or substance use disorder" means any mental disorder and substance
15 use disorder that is listed in the most recent revised publication or the most updated volume of
16 either the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the
17 American Psychiatric Association or the International Classification of Disease Manual (ICO)
18 published by the World Health Organization; [or any health-related behavior identified by the](#)
19 [director of health as having a significant effect on health, illness, disease, or functioning and that](#)
20 [substantially limits the life activities of the person with the illness](#) provided, that tobacco and
21 caffeine are excluded from the definition of "substance" for the purposes of this chapter.

22 (6) "Non-quantitative treatment limitations" means: (i) Medical management standards;
23 (ii) Formulary design and protocols; (iii) Network tier design; (iv) Standards for provider
24 admission to participate in a network; (v) Reimbursement rates and methods for determining
25 usual, customary, and reasonable charges; and (vi) Other criteria that limit scope or duration of
26 coverage for services in the treatment of mental health and substance use disorders, including
27 restrictions based on geographic location, facility type, and provider specialty.

28 (7) "Quantitative treatment limitations" means numerical limits on coverage for the
29 treatment of mental health and substance use disorders based on the frequency of treatment,
30 number of visits, days of coverage, days in a waiting period, or other similar limits on the scope
31 or duration of treatment.

32 **27-38.2-3. Medical necessity and appropriateness of treatment.** -- (a) Upon request of
33 the reimbursing health insurers, all providers of treatment of mental illness shall furnish medical
34 records or other necessary data which substantiates that initial or continued treatment is at all

1 times medically necessary and appropriate. When the provider cannot establish the medical
2 necessity and/or appropriateness of the treatment modality being provided, neither the health
3 insurer nor the patient shall be obligated to reimburse for that period or type of care that was not
4 established. The exception to the preceding can only be made if the patient has been informed of
5 the provisions of this subsection and has agreed in writing to continue to receive treatment at his
6 or her own expense.

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

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

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

16 **27-41-2. Definitions.** -- As used in this chapter:

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

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

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

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

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

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

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

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

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

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

23 (k) "Grandfathered health plan" means any group health plan or health insurance
24 coverage subject to 42 USC § 18011.

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

27 (m) "Group health plan" means an employee welfare benefit plan as defined in 29 USC §
28 1002(1), to the extent that the plan provides health benefits to employees or their dependents
29 directly or through insurance, reimbursement, or otherwise.

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

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

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

8 (q) "Health care provider" or "provider" means a health care professional or a health care
9 facility.

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

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

17 (t) "Health maintenance organization" means a single public or private organization
18 which:

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

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

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

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

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

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

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

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

3 (ii) Through arrangements with individual licensed midwives or one or more groups of
4 licensed midwives organized on a group practice or individual practice basis.

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

6 (v) "Material modification" means only systemic changes to the information filed under
7 § 27-41-3.

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

10 (x) "Office of the health insurance commissioner" means the agency established under §
11 42-14.5-1 of the general laws.

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

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

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

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

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

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

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

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

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

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

34 [\(gg\) "Behavioral health provider" means a mental health counselor, marriage and family](#)

1 [therapist, social worker, psychologist, advanced practice psychiatric nurse, and/or psychiatrist](#)
2 [licensed by the department of health under relevant law and regulation.](#)

3 **27-41-26.1. Patient responsibility -- Administrative requirements.** -- For health
4 benefit contracts issued, renewed, or delivered in this state the following shall apply:

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

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

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

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

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

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

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

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

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

- 33 (1) Has been actively in existence for at least five (5) years;
34 (2) Has been formed and maintained in good faith for purposes other than obtaining

1 insurance;

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

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

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

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

10 (7) Has a constitution and bylaws; and

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

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

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

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

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

29 (i) A group health plan;

30 (ii) A health benefit plan;

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

33 (iv) Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., (Medicaid), other
34 than coverage consisting solely of benefits under 42 U.S.C. § 1396s (the program for distribution

1 of pediatric vaccines);

2 (v) 10 U.S.C. § 1071 et seq., (medical and dental care for members and certain former
3 members of the uniformed services, and for their dependents)(Civilian Health and Medical
4 Program of the Uniformed Services)(CHAMPUS). For purposes of 10 U.S.C. § 1071 et seq.,
5 "uniformed services" means the armed forces and the commissioned corps of the National
6 Oceanic and Atmospheric Administration and of the Public Health Service;

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

8 (vii) A state health benefits risk pool;

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

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

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

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

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

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

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

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

1 hours per week. Any retiree under contract with any independently incorporated fire district is
2 also included in the definition of eligible employee, as well as any former employee of an
3 employer who retired before normal retirement age, as defined by 42 U.S.C. 18002(a)(2)(c) while
4 the employer participates in the early retiree reinsurance program defined by that chapter. Persons
5 covered under a health benefit plan pursuant to the Consolidated Omnibus Budget Reconciliation
6 Act of 1986 shall not be considered "eligible employees" for purposes of minimum participation
7 requirements pursuant to § 27-50-7(d)(9).

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

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

13 (p) "Family composition" means:

- 14 (1) Enrollee;
- 15 (2) Enrollee, spouse and children;
- 16 (3) Enrollee and spouse; or
- 17 (4) Enrollee and children.

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

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

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

31 (2) For purposes of this chapter:

32 (i) Any plan, fund, or program that would not be, but for PHSA Section 2721(e), 42
33 U.S.C. § 300gg(e), as added by P.L. 104-191, an employee welfare benefit plan and that is
34 established or maintained by a partnership, to the extent that the plan, fund or program provides

1 medical care, including items and services paid for as medical care, to present or former partners
2 in the partnership, or to their dependents, as defined under the terms of the plan, fund or program,
3 directly or through insurance, reimbursement or otherwise, shall be treated, subject to paragraph
4 (ii) of this subdivision, as an employee welfare benefit plan that is a group health plan;

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

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

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

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

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

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

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

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

25 (iii) Liability insurance, including general liability insurance and automobile liability
26 insurance;

27 (iv) Workers' compensation or similar insurance;

28 (v) Automobile medical payment insurance;

29 (vi) Credit-only insurance;

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

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

34 (3) "Health benefit plan" does not include the following benefits if they are provided

1 under a separate policy, certificate, or contract of insurance or are otherwise not an integral part
2 of the plan:

3 (i) Limited scope dental or vision benefits;

4 (ii) Benefits for long-term care, nursing home care, home health care, community-based
5 care, or any combination of those; or

6 (iii) Other similar, limited benefits specified in federal regulations issued pursuant to
7 Pub. L. No. 104-191.

8 (4) "Health benefit plan" does not include the following benefits if the benefits are
9 provided under a separate policy, certificate or contract of insurance, there is no coordination
10 between the provision of the benefits and any exclusion of benefits under any group health plan
11 maintained by the same plan sponsor, and the benefits are paid with respect to an event without
12 regard to whether benefits are provided with respect to such an event under any group health plan
13 maintained by the same plan sponsor:

14 (i) Coverage only for a specified disease or illness; or

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

16 (5) "Health benefit plan" does not include the following if offered as a separate policy,
17 certificate, or contract of insurance:

18 (i) Medicare supplemental health insurance as defined under § 1882(g)(1) of the Social
19 Security Act, 42 U.S.C. § 1395ss(g)(1);

20 (ii) Coverage supplemental to the coverage provided under 10 U.S.C. § 1071 et seq.; or

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

22 (6) A carrier offering policies or certificates of specified disease, hospital confinement
23 indemnity, or limited benefit health insurance shall comply with the following:

24 (i) The carrier files on or before March 1 of each year a certification with the director
25 that contains the statement and information described in paragraph (ii) of this subdivision;

26 (ii) The certification required in paragraph (i) of this subdivision shall contain the
27 following:

28 (A) A statement from the carrier certifying that policies or certificates described in this
29 paragraph are being offered and marketed as supplemental health insurance and not as a substitute
30 for hospital or medical expense insurance or major medical expense insurance; and

31 (B) A summary description of each policy or certificate described in this paragraph,
32 including the average annual premium rates (or range of premium rates in cases where premiums
33 vary by age or other factors) charged for those policies and certificates in this state; and

34 (iii) In the case of a policy or certificate that is described in this paragraph and that is

1 offered for the first time in this state on or after July 13, 2000, the carrier shall file with the
2 director the information and statement required in paragraph (ii) of this subdivision at least thirty
3 (30) days prior to the date the policy or certificate is issued or delivered in this state.

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

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

7 (1) Health status;

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

10 (3) Claims experience;

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

12 (5) Medical history;

13 (6) Genetic information;

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

16 (8) Disability.

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

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

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

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

25 (B) The individual lost creditable coverage as a result of cessation of employer
26 contribution, termination of employment or eligibility, reduction in the number of hours of
27 employment, involuntary termination of creditable coverage, or death of a spouse, divorce or
28 legal separation, or the individual and/or dependents are determined to be eligible for RItCare
29 under chapter 5.1 of title 40 or chapter 12.3 of title 42 or for RItShare under chapter 8.4 of title
30 40; and

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

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

1 (iii) If the individual is employed by an employer which offers multiple health benefit
2 plans and the individual elects a different plan during an open enrollment period;

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

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

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

10 (vii) Who meets the requirements for special enrollment pursuant to § 27-50-7 or 27-50-
11 8.

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

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

16 (1) The diagnosis, care, mitigation, treatment, or prevention of disease, or amounts paid
17 for the purpose of affecting any structure or function of the body;

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

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

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

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

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

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

33 (2) "Preexisting condition" does not mean a condition for which medical advice,
34 diagnosis, care, or treatment was recommended or received for the first time while the covered

1 person held creditable coverage and that was a covered benefit under the health benefit plan,
2 provided that the prior creditable coverage was continuous to a date not more than ninety (90)
3 days prior to the enrollment date of the new coverage.

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

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

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

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

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

17 (hh) "Risk adjustment mechanism" means the mechanism established pursuant to § 27-
18 50-16.

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

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

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

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

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

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

15 (nn) "Health insurance commissioner" or "commissioner" means that individual
16 appointed pursuant to § 42-14.5-1 of the general laws and afforded those powers and duties as set
17 forth in §§ 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 § 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 § 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 its 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 § 27-41-1, and nonprofit
23 hospital or medical service corporations as defined by chapters 19 and 20 of title 27, to make
24 facility-specific data and other medical service-specific data available in reasonably consistent
25 formats to patients regarding quality and costs. This information would help consumers make
26 informed choices regarding the facilities and/or clinicians or physician practices at which to seek
27 care. Among the items considered would be the unique health services and other public goods
28 provided by facilities and/or clinicians or physician practices in establishing the most appropriate
29 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 § 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 §§ 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 18.5 of title 27 and the small employer
10 health insurance market as defined in chapter 50 of title 27 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 § 27-50-3, carriers offering coverage
34 in the individual market in Rhode Island, health insurance brokers, and members of the general

1 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 its 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 who would contribute to the streamlining of health care administration and who 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 health care 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 §§ 27-18-48.1,
31 27-18-60, 27-18-62, 27-18-64, similar provisions in chapters 19, 20 and 41, of title 27, and §§ 27-
32 18-3(c), 27-38.2-1 et seq., or others as determined by the commissioner, on the cost of health
33 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 be limited to:

11 (1) Utilization review;

12 (2) Contracting; and

13 (3) Licensing and regulation.

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

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

25 (q) To encourage the fair treatment of behavioral health providers by health insurers
26 through consideration of the extent to which policies, procedures, practices, actions or inaction of
27 a health insurer affect behavioral health providers in a manner not commensurate to their effects
28 on primary care providers in determination that the interests of consumers are, or are likely to be,
29 adversely affected by any policy, practice, action or inaction of a health insurer; in consideration
30 of the approval or denial of any regulatory request, application or filing made by a health insurer
31 or of any other circumstances that exist such that the interests of the state's health insurance
32 consumers may be adversely affected. In particular, to enforce the Federal Mental Health Parity
33 Act of 1996, Pub. L. 104-204, and the Federal Mental Health Parity and Addiction Equity Act of
34 2008, Pub. L. 110-343, including its provisions regarding parity in payments and financing of

1 behavioral health services.

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

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

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

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

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

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

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

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

23 (t) Establish and promote policies that:

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

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

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

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

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

34 (1) Efforts by health insurers to develop benefit design and payment policies that enhance

1 the affordability of their products, encourage more efficient use of the state's existing health care
2 resources; promote appropriate and cost effective acquisition of new health care technology and
3 expansion of the existing health care infrastructure; advance the development and use of high
4 quality health care services (e.g., centers of excellence); and prioritize the use of limited
5 resources;

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

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

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

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

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

33 (3) Whether the insurer includes incentives for behavioral health providers of step-down
34 and diversion behavioral health services from hospital levels of care based on specific clinical and

1 [financial outcomes of such care:](#)

2 [\(4\) Whether the insurer includes incentives for behavioral health providers that are](#)
3 [certified by the health insurance commissioner to be equivalent to those offered to primary care](#)
4 [providers; and](#)

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

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

9 **42-14.6-4. Promotion of the patient-centered medical home.** -- (a) Care coordination
10 payments.

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

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

29 (3) The care coordination payment system shall be in place through July 1, 2016. Its
30 continuation beyond that point shall depend on results of the evaluation reports filed pursuant to §
31 42-14.6-6.

32 (4) Examination of other payment reforms. - By January 1, 2013, the commissioner and
33 the secretary shall direct the collaborative to consider additional payment reforms to be
34 implemented to support patient-centered medical homes including, but not limited to, payment

1 structures (to medical home or other providers) that:

2 (i) Reward high-quality, low-cost providers;

3 (ii) Create enrollee incentives to receive care from high-quality, low-cost providers;

4 (iii) Foster collaboration among providers to reduce cost shifting from one part of the
5 health continuum to another; and

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

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

13 (6) Inclusion of behavioral health. By January 1, 2017, the commissioner and the
14 secretary shall direct the collaborative to consider additional reforms to be implemented to
15 promote the inclusion of behavioral health in patient-centered medical homes including, but not
16 limited to, applying payment structures described in subsection (a)(4) of this section to behavioral
17 health providers, and projects to evaluate the benefits of different forms of collaboration, on-site
18 availability, and joint treatment planning for patients served in patient-centered medical homes.

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

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

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EXPLANATION
BY THE LEGISLATIVE COUNCIL
OF

A N A C T

RELATING TO HEALTH AND SAFETY -- RHODE ISLAND BEHAVIORAL HEALTH
CARE REFORM ACT OF 2016

1 This act would establish the "Rhode Island Behavioral Health Care Reform Act of 2016."
2 Its purpose would be to ensure appropriate use of health care resources to manage behavioral
3 health care services and to promote the delivery of such services to people who need them, and
4 includes routine screening of children for behavioral health matters. The act would direct various
5 parties, 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.

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