

2016 -- S 2828 SUBSTITUTE A

LC005469/SUB A/2

STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2016

A N A C T

RELATING TO STATE AFFAIRS AND GOVERNMENT - HEALTH INSURANCE  
OVERSIGHT

Introduced By: Senator Gayle L. Goldin

Date Introduced: March 23, 2016

Referred To: Senate Health & Human Services

(by request)

It is enacted by the General Assembly as follows:

1           SECTION 1. Section 42-14.5-3 of the General Laws in Chapter 42-14.5 entitled "The  
2   Rhode Island Health Care Reform Act of 2004 - Health Insurance Oversight" is hereby amended  
3   to read as follows:

4           **42-14.5-3. Powers and duties [Contingent effective date; see effective dates under**  
5   **this section.] --** The health insurance commissioner shall have the following powers and duties:

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

16           (b) To make recommendations to the governor and the house of representatives and  
17   senate finance committees regarding health care insurance and the regulations, rates, services,  
18   administrative expenses, reserve requirements, and operations of insurers providing health

1 insurance in the state, and to prepare or comment on, upon the request of the governor or  
2 chairpersons of the house or senate finance committees, draft legislation to improve the regulation  
3 of health insurance. In making such recommendations, the commissioner shall recognize that it is  
4 the intent of the legislature that the maximum disclosure be provided regarding the  
5 reasonableness of individual administrative expenditures as well as total administrative costs. The  
6 commissioner shall make recommendations on the levels of reserves including consideration of:  
7 targeted reserve levels; trends in the increase or decrease of reserve levels; and insurer plans for  
8 distributing excess reserves.

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

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

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

34 (2) A standardized provider application and credentials verification process, for the

1 purpose of verifying professional qualifications of participating health care providers;

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

3 (4) Methods for health maintenance organizations as defined by § 27-41-1, and nonprofit

4 hospital or medical service corporations as defined by chapters 19 and 20 of title 27, to make

5 facility-specific data and other medical service-specific data available in reasonably consistent

6 formats to patients regarding quality and costs. This information would help consumers make

7 informed choices regarding the facilities and/or clinicians or physician practices at which to seek

8 care. Among the items considered would be the unique health services and other public goods

9 provided by facilities and/or clinicians or physician practices in establishing the most appropriate

10 cost comparisons;

11 (5) All activities related to contractual disclosure to participating providers of the

12 mechanisms for resolving health plan/provider disputes;

13 (6) The uniform process being utilized for confirming, in real time, patient insurance

14 enrollment status, benefits coverage, including co-pays and deductibles;

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

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

17 (8) The feasibility of regular contract renegotiations between plans and the providers in

18 their networks; and

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

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

21 (f) To provide analysis of the Rhode Island Affordable Health Plan Reinsurance Fund.

22 The fund shall be used to effectuate the provisions of §§ 27-18.5-8 and 27-50-17.

23 (g) To analyze the impact of changing the rating guidelines and/or merging the

24 individual health insurance market as defined in chapter 18.5 of title 27 and the small employer

25 health insurance market as defined in chapter 50 of title 27 in accordance with the following:

26 (1) The analysis shall forecast the likely rate increases required to effect the changes

27 recommended pursuant to the preceding subsection (g) in the direct-pay market and small

28 employer health insurance market over the next five (5) years, based on the current rating

29 structure and current products.

30 (2) The analysis shall include examining the impact of merging the individual and small

31 employer markets on premiums charged to individuals and small employer groups.

32 (3) The analysis shall include examining the impact on rates in each of the individual and

33 small employer health insurance markets and the number of insureds in the context of possible

34 changes to the rating guidelines used for small employer groups, including: community rating

1 principles; expanding small employer rate bonds beyond the current range; increasing the  
2 employer group size in the small group market; and/or adding rating factors for broker and/or  
3 tobacco use.

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

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

11 (6) The health insurance commissioner shall work with an insurance market merger task  
12 force to assist with the analysis. The task force shall be chaired by the health insurance  
13 commissioner and shall include, but not be limited to, representatives of the general assembly, the  
14 business community, small employer carriers as defined in § 27-50-3, carriers offering coverage  
15 in the individual market in Rhode Island, health insurance brokers, and members of the general  
16 public.

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

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

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

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

2   Such standard shall:

3           (i) Include standards for eligibility inquiry and response and, wherever possible, be

4   consistent with the standards adopted by nationally recognized organizations, such as the Centers

5   for Medicare and Medicaid Services;

6           (ii) Enable providers and payors to exchange eligibility requests and responses on a

7   system-to-system basis or using a payor-supported web browser;

8           (iii) Provide reasonably detailed information on a consumer's eligibility for health care

9   coverage; scope of benefits; limitations and exclusions provided under that coverage; cost-sharing

10   requirements for specific services at the specific time of the inquiry; current deductible amounts;

11   accumulated or limited benefits; out-of-pocket maximums; any maximum policy amounts; and

12   other information required for the provider to collect the patient's portion of the bill;

13           (iv) Reflect the necessary limitations imposed on payors by the originator of the

14   eligibility and benefits information;

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

16   services to patients who are ineligible for insurance coverage in circumstances where a payor

17   provides eligibility verification based on best information available to the payor at the date of the

18   request of eligibility.

19           (2) Developing implementation guidelines and promoting adoption of such guidelines

20   for:

21           (i) The use of the National Correct Coding Initiative code edit policy by payors and

22   providers in the state;

23           (ii) Publishing any variations from codes and mutually exclusive codes by payors in a

24   manner that makes for simple retrieval and implementation by providers;

25           (iii) Use of health insurance portability and accountability act standard group codes,

26   reason codes, and remark codes by payors in electronic remittances sent to providers;

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

28           (v) A standard payor-denial review process for providers when they request a

29   reconsideration of a denial of a claim that results from differences in clinical edits where no

30   single, common-standards body or process exists and multiple conflicting sources are in use by

31   payors and providers.

32           (vi) Nothing in this section, or in the guidelines developed, shall inhibit an individual

33   payor's ability to employ, and not disclose to providers, temporary code edits for the purpose of

34   detecting and deterring fraudulent billing activities. The guidelines shall require that each payor

1 disclose to the provider its adjudication decision on a claim that was denied or adjusted based on  
2 the application of such edits and that the provider have access to the payor's review and appeal  
3 process to challenge the payor's adjudication decision.

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

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

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

12 (ii) Require payors to use common and consistent processes and time frames when  
13 responding to provider requests for medical management approvals. Whenever possible, such  
14 time frames shall be consistent with those established by leading national organizations and be  
15 based upon the acuity of the patient's need for care or treatment. For the purposes of this section,  
16 medical management includes prior authorization of services, preauthorization of services,  
17 precertification of services, post-service review, medical-necessity review, and benefits advisory;

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

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

24 [\(4\) On or before July 1, 2017, establish guidelines for payors to develop and maintain a](#)  
25 [system that gives patients electronic access to their claims information, pursuant to 45 C.F.R.](#)  
26 [164.524.](#)

27 (i) To issue an ANTI-CANCER MEDICATION REPORT. - Not later than June 30,  
28 2014 and annually thereafter, the office of the health insurance commissioner (OHIC) shall  
29 provide the senate committee on health and human services, and the house committee on  
30 corporations, with: (1) Information on the availability in the commercial market of coverage for  
31 anti-cancer medication options; (2) For the state employee's health benefit plan, the costs of  
32 various cancer treatment options; (3) The changes in drug prices over the prior thirty-six (36)  
33 months; and (4) Member utilization and cost-sharing expense.

34 (j) To monitor the adequacy of each health plan's compliance with the provisions of the

1 federal mental health parity act, including a review of related claims processing and  
2 reimbursement procedures. Findings, recommendations, and assessments shall be made available  
3 to the public.

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

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

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

14 (1) The impact of the current mandated healthcare benefits as defined in §§ 27-18-48.1,  
15 27-18-60, 27-18-62, 27-18-64, similar provisions in chapters 19, 20 and 41, of title 27, and §§ 27-  
16 18-3(c), 27-38.2-1 et seq., or others as determined by the commissioner, on the cost of health  
17 insurance for fully insured employers, subject to available resources;

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

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

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

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

29 (1) Utilization review;

30 (2) Contracting; and

31 (3) Licensing and regulation.

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

- 1    regard to patients with mental health and substance-use disorders.
- 2           SECTION 2. This act shall take effect upon passage.

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LC005469/SUB A/2  
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EXPLANATION  
BY THE LEGISLATIVE COUNCIL  
OF

A N A C T  
RELATING TO STATE AFFAIRS AND GOVERNMENT - HEALTH INSURANCE  
OVERSIGHT

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- 1           This act would empower the health insurance commissioner to establish guidelines for
- 2   payors to develop and maintain a system that gives patients electronic access to their health
- 3   claims information pursuant to federal regulations on or before July 1, 2017.
- 4           This act would take effect upon passage.

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