

**2014 -- S 2359 SUBSTITUTE B**

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LC004580/SUB B  
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**STATE OF RHODE ISLAND**

**IN GENERAL ASSEMBLY**

**JANUARY SESSION, A.D. 2014**

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A N A C T

RELATING TO HEALTH AND SAFETY - HEALTH CARE SERVICES - UTILIZATION  
REVIEW ACT

Introduced By: Senators Miller, Cool Rumsey, Ottiano, Sosnowski, and Goldin

Date Introduced: February 12, 2014

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

1           SECTION 1. Section 23-17.12-12 of the General Laws in Chapter 23-17.12 entitled  
2 "Health Care Services - Utilization Review Act" is hereby amended to read as follows:

3           **23-17.12-12. Reporting requirements.** -- (a) The department shall establish reporting  
4 requirements to determine if the utilization review programs are in compliance with the  
5 provisions of this chapter and applicable regulations.

6           (b) By November 14, 2014, the department shall report to the general assembly regarding  
7 hospital admission practices and procedures and the effects of such practices and procedures on  
8 the care and wellbeing of patients who present behavioral healthcare conditions on an emergency  
9 basis. The report shall be developed with the cooperation of the department of behavioral  
10 healthcare, developmental disabilities, and hospitals and of the department of children, youth, and  
11 families, and shall recommend changes to state law and regulation to address any necessary and  
12 appropriate revisions to the department's regulations related to utilization review based on the  
13 Federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and the Patient  
14 Protection and Affordable Care Act, Pub. L.111-148, and the state's regulatory interpretation of  
15 parity in insurance coverage of behavioral healthcare. These recommended or adopted revisions  
16 to the department's regulations shall include, but not be limited to:

17           (1) Adverse determination and internal appeals, with particular regard to the time  
18 necessary to complete a review of urgent and/or emergent services for patients with behavioral

1 [health needs;](#)

2 [\(2\) External appeal requirements;](#)

3 [\(3\) The process for investigating whether insurers and agents are complying with the](#)  
4 [provisions of chapter 17.12 of title 23 in light of parity in insurance coverage for behavioral](#)  
5 [healthcare, with particular regard to emergency admissions; and](#)

6 [\(4\) Enforcement of the provisions of chapter 17.12 of title 23 in light of insurance parity](#)  
7 [for behavioral healthcare.](#)

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

11 **42-14.5-3. Powers and duties [Contingent effective date; see effective dates under**  
12 **this section.] --** The health insurance commissioner shall have the following powers and duties:

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

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

34 (c) To establish a consumer/business/labor/medical advisory council to obtain

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

18 (d) To establish and provide guidance and assistance to a subcommittee ("~~The~~  
19 ~~P~~rofessional ~~P~~rovider-~~H~~ealth ~~P~~lan ~~W~~ork ~~G~~roup") of the advisory council created pursuant  
20 to subsection (c) above, composed of health care providers and Rhode Island licensed health  
21 plans. This subcommittee shall include in its annual report and presentation before the house and  
22 senate finance committees the following information:

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

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

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

28 (4) Methods for health maintenance organizations as defined by ~~section~~ §27-41-1, and  
29 nonprofit hospital or medical service corporations as defined by chapters ~~27-19~~ and ~~27-20~~ of title  
30 27, to make facility-specific data and other medical service-specific data available in reasonably  
31 consistent formats to patients regarding quality and costs. This information would help consumers  
32 make informed choices regarding the facilities and/or clinicians or physician practices at which to  
33 seek care. Among the items considered would be the unique health services and other public  
34 goods provided by facilities and/or clinicians or physician practices in establishing the most

1 appropriate cost comparisons;

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

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

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

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

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

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

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

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

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

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

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

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

33 (5) The analysis shall include assessment of possible reinsurance mechanisms and/or  
34 federal high-risk pool structures and funding to support the health insurance market in Rhode

1 Island by reducing the risk of adverse selection and the incremental insurance premiums charged  
2 for this risk, and/or by making health insurance affordable for a selected at-risk population.

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

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

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

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

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

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

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

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

1 coverage; scope of benefits; limitations and exclusions provided under that coverage; cost-  
2 sharing requirements for specific services at the specific time of the inquiry; current deductible  
3 amounts; accumulated or limited benefits; out-of-pocket maximums; any maximum policy  
4 amounts; and other information required for the provider to collect the patient's portion of the  
5 bill;

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

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

12 (2) Developing implementation guidelines and promoting adoption of such guidelines  
13 for:

14 (i) The use of the [National eCorrect eCoding Initiative](#) code edit policy by payors and  
15 providers in the state;

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

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

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

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

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

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

34 (3) Developing and promoting widespread adoption by payors and providers of

1 guidelines to:

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

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

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

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

17 (i) To issue an ANTI-CANCER MEDICATION REPORT. - Not later than June 30,  
18 2014 and annually thereafter, the office of the health insurance commissioner (OHIC) shall  
19 provide the senate committee on health and human services, and the house committee on  
20 corporations, with: (1) Information on the availability in the commercial market of coverage for  
21 anti-cancer medication options; (2) For the state employee's health benefit plan, the costs of  
22 various cancer treatment options; (3) The changes in drug prices over the prior thirty-six (36)  
23 months; and (4) Member utilization and cost-sharing expense.

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

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

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

34 (m) Notwithstanding any provision of the general or public laws or regulation to the

1 contrary, provide a report with findings and recommendations to the president of the senate and  
2 the speaker of the house, on or before April 1, 2014, including, but not limited to, the following  
3 information:

4 (1) The impact of the current mandated healthcare benefits as defined in ~~sections~~ [§§27-](#)  
5 [18-48.1, 27-18-60, 27-18-62, 27-18-64](#), similar provisions in ~~title 27~~, chapters 19, 20 and 41 [of](#)  
6 [title 27](#), and ~~subsection~~ [§§27-18-3\(c\), 27-38.2-1 et seq.](#), or others as determined by the  
7 commissioner, on the cost of health insurance for fully insured employers, subject to available  
8 resources;

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

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

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

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

20 (1) Utilization review;

21 (2) Contracting; and

22 (3) Licensing and regulation.

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

27 SECTION 3. This act shall take effect upon passage.

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EXPLANATION  
BY THE LEGISLATIVE COUNCIL  
OF

A N A C T  
RELATING TO HEALTH AND SAFETY - HEALTH CARE SERVICES - UTILIZATION  
REVIEW ACT

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1           This act would require the department of health in cooperation with the department of  
2 behavioral healthcare, developmental disabilities and hospitals and the department of children,  
3 youth and families, to submit a written report to the general assembly, that proposes regulatory  
4 changes concerning the issue of parity in behavioral health care insurance coverage.

5           This act would take effect upon passage.

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