2012 -- H 7621

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

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2012

A N A C T

RELATING TO INSURANCE

Introduced By: Representatives Lally, DaSilva, and Kennedy

Date Introduced: February 16, 2012

Referred To: House Labor

It is enacted by the General Assembly as follows:

SECTION 1. Title 27 of the General Laws entitled "INSURANCE" is hereby amended by adding thereto the following chapter:

CHAPTER 76

HOSPITAL AND INSURER BARGAINING AND ARBITRATION ACT OF 2012

27-76.1-1. Short title. – This chapter shall be known and may be cited as the "Hospital and Insurer Bargaining and Arbitration Act of 2012" or "HIBAA".

27-76.1-2. Legislative findings. – The general assembly hereby finds and declares as follows:

(1) As community hospitals bargain with commercial health insurers in an increasingly concentrated Rhode Island hospital and health insurance market, the potential for misallocation of health care resources from a public health perspective increases;

(2) The same potential for misallocation exists as commercial health insurers must bargain with increasingly concentrated hospital systems;

(3) How Rhode Islanders pay for health care ultimately determines who has access to what care. High concentrations of payer and hospital power have the potential to shift limited health care resources to entities that have market power, regardless of need, quality or affordability;

(4) Inequitable reimbursement and other unfair payment terms adversely affect quality patient care, access to necessary services and health insurance affordability by concentrating

resources in entities with bargaining power independent of public health needs;

(5) The Legislature recognizes that when the playing field is level, and no one party to a health care negotiation can overwhelm the other, markets may work best; while at other times regulation is required to achieve fairness and social goals that markets do not value;

(6) HIBAA creates a system that allows markets to work if they can, but provides a regulatory back-up if they do not.

(7) This act is necessary, proper and constitutes an appropriate exercise of the authority of this state to regulate the delivery of health care services in order to safeguard the public health and safety of Rhode Islanders.

27-76.1-3. Definitions. – The following words and phrases when used in this act shall have meanings given to them in this section unless the context clearly indicates otherwise:

(1) "Health care insurer." A health care insurer whose premiums are paid in whole or in part by employers and as otherwise defined in general laws subdivision 27-20.6-1(1), including any health care insurer affiliate or third-party administrator interacting with hospitals and enrollees on behalf of such an insurer, but specifically not including the following types of insurance policy:

(i) Hospital confinement indemnity;

(ii) Disability income;

(iii) Accident only;

(iv) Long-term care;

(v) Medicare supplement;

(vi) Limited benefit health;

(vii) Specified disease indemnity;

(viii) Sickness or bodily injury or death by accident or both;

(ix) Other limited benefit policies; and

(x) Health care insurance issued or administrated by a small health care insurer.

(2) "Health care insurer affiliate" means a health care insurer that is affiliated with another entity by either the insurer or entity having a five percent (5%) or greater, direct or indirect, ownership or investment interest in the other through equity, debt or other means;

(3) "Hospital" means an entity licensed as a hospital by the Rhode Island department of health pursuant to general laws chapter 23-17;

(4) "Hospital/insurer contract" means an agreement between a hospital or hospital network, and a health care insurer, that sets forth the terms and conditions under which the hospital or hospital network is to deliver covered health care services to enrollees of the health

care insurer;

(5) “Hospital network” means a group of commonly-owned hospitals;

(6) “Impasse” means an impasse exists when either party to negotiation of a hospital/insurer contract believes in good faith that the parties have reached a point in meetings and negotiations regarding the terms of a hospital/insurer contract where their differences in position are so substantial or pronounced that future meetings and negotiations would be futile.

(7) “Office of health insurance commissioner” means the office of health insurance commissioner established by chapter 42-14.5 of the general laws;

(8) “Self-funded health benefit plan” means a plan that provides for the assumption of the cost of or spreading the risk of loss resulting from health care services of covered lives by an employer, union or other sponsor, substantially out of the current revenues, assets or any other funds of the sponsor;

(9) “Service” means the American health lawyers’ association alternative dispute resolution service;

(10) “Small health care insurer” means any health care insurer that would otherwise be covered under this act, but that insures or administers health care benefits for a total number of covered lives that is five percent (5%) or less than the total number of lives covered by all health care insurers as of January 1 of each year (including all small health care insurers); and

(11) “Third-party administrator” means an entity that provides utilization review, provider network credentialing or other administrative services for a health care insurer or a self-funded health benefit plan.

27-76.1-4. Impasse and arbitration. – (a) Arbitration of contract terms.--Any hospital or health care insurer participating in negotiation of a hospital/insurer contract that believes in good faith an impasse has been reached shall have the right to have the matter decided by binding arbitration in Providence, Rhode Island, in accordance with the service’s rules of procedure for arbitration for a single arbitrator. The arbitrator shall apply the criteria set forth in subsection (b) below in making his or her decision. The fees of the arbitrator shall be borne equally by the parties. The judgment of the arbitrator shall be binding not only on all parties to the arbitration, but on any other entity controlled by, in control of or under common control with the party that is a hospital, health care insurer, self-funded health benefit plan or third-party administrator, and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction thereof. Any arbitration under this chapter shall be completed within one hundred twenty (120) days from the date the arbitrator is selected.

(b) Arbitration criteria.--The arbitrator shall base his or her decision on the criteria listed

in this subsection (b) and shall document the arbitrator's analysis of these criteria in a written decision:

(1) Patient services come first. Hospital payment rates should be equitable and sufficient to ensure appropriate community access to needed services taking into account amounts paid to other hospitals for similar services, the unique charitable burden borne by the hospital and the reasonableness of the hospital's expense base;

(2) Contractual arrangements should contain incentives to improve the quality and efficiency of health care service delivery and outcomes;

(3) Contract terms should promote recruitment and retention of providers needed in the relevant community;

(4) Health insurance should be affordable for consumers;

(5) Insurers deserve to remain solvent;

(6) Insurers' operating expenses and returns on investment deserve to be reasonable, but determined based on the services they provide and the market they serve, not necessarily comparable to expenses and returns that are available in national markets that are stronger and larger than Rhode Island; and

(7) The health care system is a comprehensive entity and the arbitrator's decision should encourage and direct the parties towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access.

27-76.1-5. Insurer reporting to office of health insurance commissioner. – Each health care insurer shall annually report the financial terms and conditions of its hospital/payer contracts to the office of health insurance commissioner. Except as specifically provided otherwise in this section, such information shall be treated as commercial information of a privileged or confidential nature under Rhode Island general laws subparagraph 38-2-2(4)(B). Notwithstanding the foregoing, the office of health insurance commissioner shall release such financial information to any arbitrator conducting an arbitration under this chapter upon the arbitrator's request. The arbitrator may use such information in making a decision and may refer to such information in an way that does not result in the publication or other release of such information

27-76.1-6. Good faith negotiations. – It shall be unlawful for either party in negotiation of a hospital/insurer contract to refuse or fail to meet and negotiate in good faith.

27-76.1-7. Construction. – Nothing contained in this chapter shall be construed to require approval of hospital/insurer contract terms to the extent that the terms are exempt from state regulation under section 514 of the employee retirement income security act of 1974 (public

law 93-406,88 stat. 829).

27-76.1-8. Severability. – If any provision of this chapter or the application thereof to any person or circumstances is held invalid, such invalidity shall not affect other provisions or applications of the chapter which can be given effect without the invalid provision or application, and of this end the provisions of this chapter are declared to be severable.

SECTION 2. This act shall take effect on January 1, 2013.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

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RELATING TO INSURANCE

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This act would authorize hospitals and health insurers to declare an impasse and submit to binding arbitration the terms of agreements between hospitals and commercial health insurers.

This act would take effect on January 1, 2013.

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