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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 INSURANCE - INSURANCE COVERAGE FOR MENTAL ILLNESS AND
SUBSTANCE ABUSE

Introduced By: Representatives Bennett, Hull, Guthrie, Canario, and Morin

Date Introduced: March 13, 2014

Referred To: House Corporations

It is enacted by the General Assembly as follows:

1 SECTION 1. Section 27-38.2-1 of the General Laws in Chapter 27-38.2 entitled
2 "Insurance Coverage for Mental Illness and Substance Abuse" is hereby amended to read as
3 follows:

4 **27-38.2-1. Mental illness coverage. -- Mental illness and substance abuse coverage. --**

5 (a) Every health care insurer that delivers or issues for delivery or renews in this state a contract,
6 plan, or policy except contracts providing supplemental coverage to Medicare or other
7 governmental programs, shall provide coverage for the medical treatment of mental illness and
8 substance abuse under the same terms and conditions as that coverage is provided for other
9 illnesses and diseases. Insurance coverage offered pursuant to this statute must include the same
10 durational limits, amount limits, deductibles, and co-insurance factors for mental illness as for
11 other illnesses and diseases.

12 (b) In addition to the requirements of subsection (a), every healthcare insurer that delivers
13 or issues for delivery or renews in this state a contract, plan, or policy, except contracts providing
14 supplemental coverage to Medicare or other governmental programs, shall also provide
15 prescription drug coverage for:

16 (1) Anti-opioid and anti-opiate drugs, including, but not limited to, narcan and other
17 forms of naloxone for use of intervention in opioid overdoses; and

18 (2) Drugs used for the treatment of substance abuse disorders, including, but not limited

1 [to, methadone, suboxone, naltrexone, and buprenorphine;](#)

2 [\(3\) Provided, the prescription drug coverage pursuant to subsection \(b\) of this section](#)
3 [shall be under the same terms and conditions as that coverage is provided for other illnesses and](#)
4 [diseases. Insurance coverage offered pursuant to subsection \(b\) of this section must include the](#)
5 [same durational limits, amount limits, deductibles, and co-insurance factors for mental illness as](#)
6 [for other illnesses and diseases.](#)

7 SECTION 2. Section 23-17.26-3 of the General Laws in Chapter 23-17.26 entitled
8 "Comprehensive Discharge Planning" is hereby amended to read as follows:

9 **23-17.26-3. Comprehensive discharge planning.** -- (a) On or before July 1, 2015, each
10 hospital operating in the State of Rhode Island shall submit to the director:

11 (1) Evidence of participation in a high-quality comprehensive discharge planning and
12 transitions improvement project operated by a nonprofit organization in this state; or

13 (2) A plan for the provision of comprehensive discharge planning and information to be
14 shared with patients transitioning from the hospitals care. Such plan shall contain the adoption of
15 evidence-based practices including, but not limited to:

- 16 (i) Providing in-hospital education prior to discharge;
- 17 (ii) Ensuring patient involvement such that, at discharge, patients, and caregivers
18 understand the patient's conditions and medications and have a point of contact for follow-up
19 questions;
- 20 (iii) Attempting to identify patients' primary care providers and assisting with scheduling
21 post-hospital follow-up appointments prior to patient discharge;
- 22 (iv) Expanding the transmission of the department of health's continuity of care form, or
23 successor program, to include primary care providers' receipt of information at patient discharge
24 when the primary care provider is identified by the patient; and
- 25 (v) Coordinating and improving communication with outpatient providers.

26 [\(3\) Such discharge plan and transition process shall also be made for patients with opioid](#)
27 [and other substance abuse addictions, which plan and transition process shall include all the](#)
28 [elements contained in subsections \(a\)\(1\) or \(a\)\(2\) of this section as applicable. In addition, such](#)
29 [discharge and transition process shall also include: \(i\) A requirement that there be a follow-up](#)
30 [contact made with the patient within thirty \(30\) days post-discharge from hospital care to assess](#)
31 [the patient's progress; and \(ii\) A requirement that at least one follow-up appointment be](#)
32 [scheduled for the patient, either at the hospital or at another appropriate facility. Said appointment](#)
33 [shall be scheduled and the patient shall be informed of the appointment prior to the patient being](#)
34 [discharged from the hospital.](#)

1 [\(4\) Such discharge plan and transition process shall also include any recommendations of](#)
2 [the healthcare planning advisory council that are implemented by the state agencies within the](#)
3 [executive office of health and human services, pursuant to the provisions of chapter 81 of title 23.](#)

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

7 **42-14.5-3. Powers and duties [Contingent effective date; see effective dates under**
8 **this section.] --** The health insurance commissioner shall have the following powers and duties:

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

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

30 (c) To establish a consumer/business/labor/medical advisory council to obtain
31 information and present concerns of consumers, business and medical providers affected by
32 health insurance decisions. The council shall develop proposals to allow the market for small
33 business health insurance to be affordable and fairer. The council shall be involved in the
34 planning and conduct of the quarterly public meetings in accordance with subsection (a) above.

1 The advisory council shall develop measures to inform small businesses of an insurance
2 complaint process to ensure that small businesses that experience rate increases in a given year
3 may request and receive a formal review by the department. The advisory council shall assess
4 views of the health provider community relative to insurance rates of reimbursement, billing and
5 reimbursement procedures, and the insurers' role in promoting efficient and high quality health
6 care. The advisory council shall issue an annual report of findings and recommendations to the
7 governor and the general assembly and present their findings at hearings before the house and
8 senate finance committees. The advisory council is to be diverse in interests and shall include
9 representatives of community consumer organizations; small businesses, other than those
10 involved in the sale of insurance products; and hospital, medical, and other health provider
11 organizations. Such representatives shall be nominated by their respective organizations. The
12 advisory council shall be co-chaired by the health insurance commissioner and a community
13 consumer organization or small business member to be elected by the full advisory council.

14 (d) To establish and provide guidance and assistance to a subcommittee ("The
15 Professional Provider-Health Plan Work Group") of the advisory council created pursuant to
16 subsection (c) above, composed of health care providers and Rhode Island licensed health plans.
17 This subcommittee shall include in its annual report and presentation before the house and senate
18 finance committees the following information:

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

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

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

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

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

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

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

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

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

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

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

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

10 (g) To analyze the impact of changing the rating guidelines and/or merging the
11 individual health insurance market as defined in chapter 27-18.5 and the small employer health
12 insurance market as defined in chapter 27-50 in accordance with the following:

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

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

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

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

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

32 (6) The health insurance commissioner shall work with an insurance market merger task
33 force to assist with the analysis. The task force shall be chaired by the health insurance
34 commissioner and shall include, but not be limited to, representatives of the general assembly, the

1 business community, small employer carriers as defined in section 27-50-3, carriers offering
2 coverage in the individual market in Rhode Island, health insurance brokers and members of the
3 general public.

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

9 (8) The task force shall meet as necessary and include their findings in the annual report
10 and the commissioner shall include the information in the annual presentation before the house
11 and senate finance committees.

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

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

24 (i) Include standards for eligibility inquiry and response and, wherever possible, be
25 consistent with the standards adopted by nationally recognized organizations, such as the centers
26 for Medicare and Medicaid services;

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

29 (iii) Provide reasonably detailed information on a consumer's eligibility for health care
30 coverage, scope of benefits, limitations and exclusions provided under that coverage, cost-sharing
31 requirements for specific services at the specific time of the inquiry, current deductible amounts,
32 accumulated or limited benefits, out-of-pocket maximums, any maximum policy amounts, and
33 other information required for the provider to collect the patient's portion of the bill;

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

1 eligibility and benefits information;

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

6 (2) Developing implementation guidelines and promoting adoption of such guidelines
7 for:

8 (i) The use of the national correct coding initiative code edit policy by payors and
9 providers in the state;

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

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

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

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

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

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

28 (3) Developing and promoting widespread adoption by payors and providers of
29 guidelines to:

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

33 (ii) Require payors to use common and consistent processes and time frames when
34 responding to provider requests for medical management approvals. Whenever possible, such

1 time frames shall be consistent with those established by leading national organizations and be
2 based upon the acuity of the patient's need for care or treatment. For the purposes of this section,
3 medical management includes prior authorization of services, preauthorization of services,
4 precertification of services, post service review, medical necessity review, and benefits advisory;

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

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

11 (i) To issue an ANTI-CANCER MEDICATION REPORT. - Not later than June 30,
12 2014 and annually thereafter, the office of the health insurance commissioner (OHIC) shall
13 provide the senate committee on health and human services, and the house committee on
14 corporations, with: (1) Information on the availability in the commercial market of coverage for
15 anti-cancer medication options; (2) For the state employee's health benefit plan, the costs of
16 various cancer treatment options; (3) The changes in drug prices over the prior thirty-six (36)
17 months; and (4) Member utilization and cost-sharing expense.

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

22 (k) To monitor the transition from fee for service and toward global and other alternative
23 payment methodologies for the payment for healthcare services. Alternative payment
24 methodologies should be assessed for their likelihood to promote access to affordable health
25 insurance, health outcomes and performance.

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

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

32 (1) The impact of the current mandated healthcare benefits as defined in sections 27-18-
33 48.1, 27-18-60, 27-18-62, 27-18-64, similar provisions in title 27, chapters 19, 20 and 41, and
34 subsection 27-18-3(c), 27-38.2-1 et seq., or others as determined by the commissioner, on the cost

1 of health insurance for fully insured employers, subject to available resources;

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

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

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

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

13 (1) Utilization review;

14 (2) Contracting; and

15 (3) Licensing and regulation.

16 (o) On or before December 31, 2015, and annually thereafter, the health insurance
17 commissioner shall also assess the adequacy of each health plan's compliance with the provisions
18 of § 27-38.2-1 regarding mental illness and substance abuse prescription drug coverage.

19 (p) On or before December 31, 2015, and annually thereafter, the health insurance
20 commissioner shall also assess the adequacy of those discharge plans and transition processes
21 developed by hospitals for patients with opioid and other substance abuse addictions pursuant to
22 the provisions of § 23-17.26-3.

23 SECTION 4. This act shall take effect upon passage.

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EXPLANATION
BY THE LEGISLATIVE COUNCIL
OF

A N A C T

RELATING TO INSURANCE - INSURANCE COVERAGE FOR MENTAL ILLNESS AND
SUBSTANCE ABUSE

1 This act would require mandatory health insurance coverage for certain listed drugs
2 which treat opioid substance abuse and addictions. This act would also require hospitals to amend
3 their discharge plans and discharge processes to address patients with opioid and other substance
4 abuse addictions. The act would require at least one follow-up contact by the hospital with the
5 patient after discharge, and the scheduling of at least one follow-up appointment with an
6 appropriate facility for the patient. The health insurance commissioner would annually review the
7 adequacy of both the health insurers' insurance coverage and the discharge plans and transition
8 processes developed by the hospitals.

9 This act would take effect upon passage.

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