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STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2017

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A N A C T

RELATING TO HEALTH AND SAFETY -- COMPREHENSIVE HEALTH INSURANCE  
PROGRAM

Introduced By: Representatives Regunberg, Walsh, Ajello, Ranglin-Vassell, and Amore

Date Introduced: January 11, 2017

Referred To: House Finance

It is enacted by the General Assembly as follows:

1 SECTION 1. Chapter 42-14.5 of the General Laws entitled "The Rhode Island Health  
2 Care Reform Act of 2004 - Health Insurance Oversight" is hereby repealed in its entirety.

3 ~~CHAPTER 42-14.5~~

4 ~~The Rhode Island Health Care Reform Act of 2004—Health Insurance Oversight~~

5 ~~42-14.5-1. Health insurance commissioner.~~

6 ~~There is hereby established, within the department of business regulation, an office of the~~  
7 ~~health insurance commissioner. The health insurance commissioner shall be appointed by the~~  
8 ~~governor, with the advice and consent of the senate. The director of business regulation shall~~  
9 ~~grant to the health insurance commissioner reasonable access to appropriate expert staff.~~

10 ~~42-14.5-1.1. Legislative findings.~~

11 ~~The general assembly hereby finds and declares as follows:~~

12 ~~(1) A substantial amount of health care services in this state are purchased for the benefit~~  
13 ~~of patients by health care insurers engaged in the provision of health care financing services or is~~  
14 ~~otherwise delivered subject to the terms of agreements between health care insurers and providers~~  
15 ~~of the services.~~

16 ~~(2) Health care insurers are able to control the flow of patients to providers of health care~~  
17 ~~services through compelling financial incentives for patients in their plans to utilize only the~~  
18 ~~services of providers with whom the insurers have contracted.~~

1 ~~(3) Health care insurers also control the health care services rendered to patients through~~  
2 ~~utilization review programs and other managed care tools and associated coverage and payment~~  
3 ~~policies.~~

4 ~~(4) By incorporation or merger the power of health care insurers in markets of this state~~  
5 ~~for health care services has become great enough to create a competitive imbalance, reducing~~  
6 ~~levels of competition and threatening the availability of high quality, cost-effective health care.~~

7 ~~(5) The power of health care insurers to unilaterally impose provider contract terms may~~  
8 ~~jeopardize the ability of physicians and other health care providers to deliver the superior quality~~  
9 ~~health care services that have been traditionally available in this state.~~

10 ~~(6) It is the intention of the general assembly to authorize health care providers to jointly~~  
11 ~~discuss with health care insurers topics of concern regarding the provision of quality health care~~  
12 ~~through a committee established by an advisory to the health insurance commissioner.~~

13 **42-14.5-2. Purpose.**

14 ~~With respect to health insurance as defined in § 42-14-5, the health insurance~~  
15 ~~commissioner shall discharge the powers and duties of office to:~~

16 ~~(1) Guard the solvency of health insurers;~~

17 ~~(2) Protect the interests of consumers;~~

18 ~~(3) Encourage fair treatment of health care providers;~~

19 ~~(4) Encourage policies and developments that improve the quality and efficiency of~~  
20 ~~health care service delivery and outcomes; and~~

21 ~~(5) View the health care system as a comprehensive entity and encourage and direct~~  
22 ~~insurers towards policies that advance the welfare of the public through overall efficiency,~~  
23 ~~improved health care quality, and appropriate access.~~

24 **42-14.5-3. Powers and duties [Contingent effective date; see effective dates under**  
25 **this section].**

26 ~~The health insurance commissioner shall have the following powers and duties:~~

27 ~~(a) To conduct quarterly public meetings throughout the state, separate and distinct from~~  
28 ~~rate hearings pursuant to § 42-62-13, regarding the rates, services, and operations of insurers~~  
29 ~~licensed to provide health insurance in the state; the effects of such rates, services, and operations~~  
30 ~~on consumers, medical care providers, patients, and the market environment in which such~~  
31 ~~insurers operate; and efforts to bring new health insurers into the Rhode Island market. Notice of~~  
32 ~~not less than ten (10) days of said hearing(s) shall go to the general assembly, the governor, the~~  
33 ~~Rhode Island Medical Society, the Hospital Association of Rhode Island, the director of health,~~  
34 ~~the attorney general, and the chambers of commerce. Public notice shall be posted on the~~

1 ~~department's web site and given in the newspaper of general circulation, and to any entity in~~  
2 ~~writing requesting notice.~~

3 ~~(b) To make recommendations to the governor and the house of representatives and~~  
4 ~~senate finance committees regarding health care insurance and the regulations, rates, services,~~  
5 ~~administrative expenses, reserve requirements, and operations of insurers providing health~~  
6 ~~insurance in the state, and to prepare or comment on, upon the request of the governor or~~  
7 ~~chairpersons of the house or senate finance committees, draft legislation to improve the regulation~~  
8 ~~of health insurance. In making such recommendations, the commissioner shall recognize that it is~~  
9 ~~the intent of the legislature that the maximum disclosure be provided regarding the~~  
10 ~~reasonableness of individual administrative expenditures as well as total administrative costs. The~~  
11 ~~commissioner shall make recommendations on the levels of reserves, including consideration of:~~  
12 ~~targeted reserve levels; trends in the increase or decrease of reserve levels; and insurer plans for~~  
13 ~~distributing excess reserves.~~

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

32 ~~(d) To establish and provide guidance and assistance to a subcommittee ("the~~  
33 ~~professional provider health plan work group") of the advisory council created pursuant to~~  
34 ~~subsection (c), composed of health care providers and Rhode Island licensed health plans. This~~

1 ~~subcommittee shall include in its annual report and presentation before the house and senate~~  
2 ~~finance committees the following information:~~

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

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

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

8 ~~(4) Methods for health maintenance organizations, as defined by § 27-41-2, and nonprofit~~  
9 ~~hospital or medical service corporations, as defined by chapters 19 and 20 of title 27, to make~~  
10 ~~facility specific data and other medical service specific data available in reasonably consistent~~  
11 ~~formats to patients regarding quality and costs. This information would help consumers make~~  
12 ~~informed choices regarding the facilities and/or clinicians or physician practices at which to seek~~  
13 ~~care. Among the items considered would be the unique health services and other public goods~~  
14 ~~provided by facilities and/or clinicians or physician practices in establishing the most appropriate~~  
15 ~~cost comparisons;~~

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

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

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

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

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

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

26 ~~(f) To provide analysis of the Rhode Island affordable health plan reinsurance fund. The~~  
27 ~~fund shall be used to effectuate the provisions of §§ 27-18.5-9 and 27-50-17.~~

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

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

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

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

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

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

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

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

27           ~~(8) The task force shall meet as necessary and include its findings in the annual report,~~  
28 ~~and the commissioner shall include the information in the annual presentation before the house~~  
29 ~~and senate finance committees.~~

30           ~~(h) To establish and convene a workgroup representing health care providers and health~~  
31 ~~insurers for the purpose of coordinating the development of processes, guidelines, and standards~~  
32 ~~to streamline health care administration that are to be adopted by payors and providers of health-~~  
33 ~~care services operating in the state. This workgroup shall include representatives with expertise~~  
34 ~~who would contribute to the streamlining of health care administration and who are selected from~~

1 ~~hospitals, physician practices, community behavioral health organizations, each health insurer,~~  
2 ~~and other affected entities. The workgroup shall also include at least one designee each from the~~  
3 ~~Rhode Island Medical Society, Rhode Island Council of Community Mental Health~~  
4 ~~Organizations, the Rhode Island Health Center Association, and the Hospital Association of~~  
5 ~~Rhode Island. The workgroup shall consider and make recommendations for:~~

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

7 ~~Such standard shall:~~

8 ~~(i) Include standards for eligibility inquiry and response and, wherever possible, be~~  
9 ~~consistent with the standards adopted by nationally recognized organizations, such as the Centers~~  
10 ~~for Medicare and Medicaid Services;~~

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

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

18 ~~(iv) Reflect the necessary limitations imposed on payors by the originator of the~~  
19 ~~eligibility and benefits information;~~

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

24 ~~(2) Developing implementation guidelines and promoting adoption of such guidelines~~  
25 ~~for:~~

26 ~~(i) The use of the National Correct Coding Initiative code edit policy by payors and~~  
27 ~~providers in the state;~~

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

30 ~~(iii) Use of Health Insurance Portability and Accountability Act standard group codes,~~  
31 ~~reason codes, and remark codes by payors in electronic remittances sent to providers;~~

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

33 ~~(v) A standard payor denial review process for providers when they request a~~  
34 ~~reconsideration of a denial of a claim that results from differences in clinical edits where no~~

1 ~~single, common standards body or process exists and multiple conflicting sources are in use by~~  
2 ~~payors and providers.~~

3 ~~(vi) Nothing in this section, nor in the guidelines developed, shall inhibit an individual~~  
4 ~~payor's ability to employ, and not disclose to providers, temporary code edits for the purpose of~~  
5 ~~detecting and deterring fraudulent billing activities. The guidelines shall require that each payor~~  
6 ~~disclose to the provider its adjudication decision on a claim that was denied or adjusted based on~~  
7 ~~the application of such edits and that the provider have access to the payor's review and appeal~~  
8 ~~process to challenge the payor's adjudication decision.~~

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

12 ~~(3) Developing and promoting widespread adoption by payors and providers of~~  
13 ~~guidelines to:~~

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

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

23 ~~(iii) Develop, maintain, and promote widespread adoption of a single, common website~~  
24 ~~where providers can obtain payors' preauthorization, benefits advisory, and preadmission~~  
25 ~~requirements;~~

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

29 ~~(4) To provide a report to the house and senate, on or before January 1, 2017, with~~  
30 ~~recommendations for establishing guidelines and regulations for systems that give patients~~  
31 ~~electronic access to their claims information, particularly to information regarding their~~  
32 ~~obligations to pay for received medical services, pursuant to 45 C.F.R. 164.524.~~

33 ~~(i) To issue an anti-cancer medication report. Not later than June 30, 2014 and annually~~  
34 ~~thereafter, the office of the health insurance commissioner (OHIC) shall provide the senate~~

~~1 committee on health and human services, and the house committee on corporations, with: (1)  
2 Information on the availability in the commercial market of coverage for anti-cancer medication  
3 options; (2) For the state employee's health benefit plan, the costs of various cancer treatment  
4 options; (3) The changes in drug prices over the prior thirty six (36) months; and (4) Member  
5 utilization and cost sharing expense.~~

~~6 (j) To monitor the adequacy of each health plan's compliance with the provisions of the  
7 federal Mental Health Parity Act, including a review of related claims processing and  
8 reimbursement procedures. Findings, recommendations, and assessments shall be made available  
9 to the public.~~

~~10 (k) To monitor the transition from fee for service and toward global and other alternative  
11 payment methodologies for the payment for health care services. Alternative payment  
12 methodologies should be assessed for their likelihood to promote access to affordable health  
13 insurance, health outcomes, and performance.~~

~~14 (l) To report annually, no later than July 1, 2014, then biannually thereafter, on hospital  
15 payment variation, including findings and recommendations, subject to available resources.~~

~~16 (m) Notwithstanding any provision of the general or public laws or regulation to the  
17 contrary, provide a report with findings and recommendations to the president of the senate and  
18 the speaker of the house, on or before April 1, 2014, including, but not limited to, the following  
19 information:~~

~~20 (1) The impact of the current, mandated health care benefits as defined in §§ 27-18-48.1,  
21 27-18-60, 27-18-62, 27-18-64, similar provisions in chapters 19, 20 and 41, of title 27, and §§ 27-  
22 18-3(c), 27-38.2-1 et seq., or others as determined by the commissioner, on the cost of health  
23 insurance for fully insured employers, subject to available resources;~~

~~24 (2) Current provider and insurer mandates that are unnecessary and/or duplicative due to  
25 the existing standards of care and/or delivery of services in the health care system;~~

~~26 (3) A state by state comparison of health insurance mandates and the extent to which  
27 Rhode Island mandates exceed other states benefits; and~~

~~28 (4) Recommendations for amendments to existing mandated benefits based on the  
29 findings in (m)(1), (m)(2), and (m)(3) above.~~

~~30 (n) On or before July 1, 2014, the office of the health insurance commissioner, in  
31 collaboration with the director of health and lieutenant governor's office, shall submit a report to  
32 the general assembly and the governor to inform the design of accountable care organizations  
33 (ACOs) in Rhode Island as unique structures for comprehensive health care delivery and value-  
34 based payment arrangements, that shall include, but not be limited to:~~





1 ~~acts.~~

2 ~~(3) "Health plan" and "qualified health plan" have the same meanings as those terms are~~  
3 ~~defined in § 1301 of the Federal Act.~~

4 ~~(4) "Insurer" means every medical service corporation, hospital service corporation,~~  
5 ~~accident and sickness insurer, dental service corporation, and health maintenance organization~~  
6 ~~licensed under title 27, or as defined in § 42-62-4.~~

7 ~~(5) "Secretary" means the secretary of the Federal Department of Health and Human~~  
8 ~~Services.~~

9 ~~(6) "Qualified dental plan" means a dental plan as described in § 1311(d)(2)(B)(ii) of the~~  
10 ~~Federal Act [42 U.S.C. § 18031].~~

11 ~~(7) "Qualified individuals" and "qualified employers" shall have the same meaning as~~  
12 ~~defined in federal law.~~

13 **42-157-3. General requirements.**

14 ~~(a) The exchange shall make qualified health plans available to qualified individuals and~~  
15 ~~qualified employers. The exchange shall not make available any health benefit plan that has not~~  
16 ~~been certified by the exchange as a qualified health plan in accordance with federal law.~~

17 ~~(b) The exchange shall allow an insurer to offer a plan that provides limited scope dental~~  
18 ~~benefits meeting the requirements of § 9832(c)(2)(A) of the Internal Revenue Code of 1986~~  
19 ~~through the exchange, either separately or in conjunction with a qualified health plan, if the plan~~  
20 ~~provides pediatric dental benefits meeting the requirements of § 1302(b)(1)(J) of the Federal Act~~  
21 ~~[42 U.S.C. § 18022].~~

22 ~~(c) Any health plan that delivers a benefit plan on the exchange that covers abortion~~  
23 ~~services, as defined in 45 C.F.R. § 156.280(d)(1), shall comply with segregation of funding~~  
24 ~~requirements, as well as an annual assurance statement to the Office of the Health Insurance~~  
25 ~~Commissioner, in accordance with 45 C.F.R. §§ 156.680(e)(3) and (5).~~

26 ~~(d) At least one plan variation for individual market plan designs offered on the exchange~~  
27 ~~at each level of coverage, as defined by section 1302(d)(1) of the federal act [42 U.S.C. § 18022]~~  
28 ~~at which the carrier is offering a plan or plans, shall exclude coverage for abortion services as~~  
29 ~~defined in 45 C.F.R. § 156.280(d)(1). If the health plan proposes different rates for such plan~~  
30 ~~variations, each listed plan design shall include the associated rate. Except for Religious~~  
31 ~~Employers (as defined in Section 6033(a)(3)(A)(i) of the Internal Revenue Code), employers~~  
32 ~~selecting a plan under this religious exemption subsection may not designate it as the single plan~~  
33 ~~for employees, but shall offer their employees full choice of small employer plans on the~~  
34 ~~exchange, using the employer selected plan as the base plan for coverage. The employer is not~~

1 ~~responsible for payment that exceeds that designated for the employer selected plan.~~

2 ~~(e) Health plans that offer a plan variation that excludes coverage for abortion services as~~  
3 ~~defined in 45 C.F.R. § 156.280(d)(1) for a religious exemption variation in the small group market~~  
4 ~~shall treat such a plan as a separate plan offering with a corresponding rate.~~

5 ~~(f) An employer who elects a religious exemption variation shall provide written notice to~~  
6 ~~prospective enrollees prior to enrollment that the plan excludes coverage for abortion services as~~  
7 ~~defined in 45 C.F.R. § 156.280(d)(1). The carrier must include notice that the plan excludes~~  
8 ~~coverage for abortion services as part of the Summary of Benefits and Coverage required by 42~~  
9 ~~U.S.C. § 300gg-15.~~

10 ~~**42-157-4. Financing.**~~

11 ~~(a) The department is authorized to assess insurers offering qualified health plans and~~  
12 ~~qualified dental plans. The revenue raised in accordance with this subsection shall not exceed the~~  
13 ~~revenue able to be raised through the federal government assessment and shall be established in~~  
14 ~~accordance and conformity with the federal government assessment upon those insurers offering~~  
15 ~~products on the Federal Health Benefit exchange. Revenues from the assessment shall be~~  
16 ~~deposited in a restricted receipt account for the sole use of the exchange and shall be exempt from~~  
17 ~~the indirect cost recovery provisions of § 35-4-27 of the general laws.~~

18 ~~(b) The general assembly may appropriate general revenue to support the annual budget~~  
19 ~~for the exchange in lieu of or to supplement revenues raised from the assessment under § 42-157-~~  
20 ~~4(a).~~

21 ~~(c) If the director determines that the level of resources obtained pursuant to § 42-157-~~  
22 ~~4(a) will be in excess of the budget for the exchange, the department shall provide a report to the~~  
23 ~~governor, the speaker of the house and the senate president identifying the surplus and detailing~~  
24 ~~how the assessment established pursuant to § 42-157-4(a) may be offset in a future year to~~  
25 ~~reconcile with impacted insurers and how any future supplemental or annual budget submission~~  
26 ~~to the general assembly may be revised accordingly.~~

27 ~~**42-157-5. Regional purchasing, efficiencies, and innovation.**~~

28 ~~To take advantage of economies of scale and to lower costs, the exchange is hereby~~  
29 ~~authorized to pursue opportunities to jointly negotiate, procure or otherwise purchase exchange~~  
30 ~~services with or partner with another state or multiple states and to pursue a Federal Affordable~~  
31 ~~Care Act 1332-Waiver.~~

32 ~~**42-157-6. Audit.**~~

33 ~~(a) Annually, the exchange shall cause to have a financial and/or performance audit of its~~  
34 ~~functions and operations performed in compliance with the generally accepted governmental~~

1 ~~auditing standards and conducted by the state office of internal audit or a certified public~~  
2 ~~accounting firm qualified in performance audits.~~

3 ~~(b) If the audit is not directly performed by the state office of internal audit, the selection~~  
4 ~~of the auditor and the scope of the audit shall be subject to the approval of the state office of~~  
5 ~~internal audit.~~

6 ~~(c) The results of the audit shall be made public upon completion, posted on the~~  
7 ~~department's website and otherwise made available for public inspection.~~

8 ~~**42-157-7. Exchange advisory board.**~~

9 ~~The exchange shall maintain an advisory board which shall be appointed by the director.~~  
10 ~~The director shall consider the expertise of the members of the board and make appointments so~~  
11 ~~that the board's composition reflects a range and diversity of skills, backgrounds and stakeholder~~  
12 ~~perspectives.~~

13 ~~**42-157-8. Reporting.**~~

14 ~~HealthSource RI shall provide a monthly report to the chairpersons of the house finance~~  
15 ~~committee and the senate finance committee by the fifteenth day of each month beginning in July~~  
16 ~~2015. The report shall include, but not be limited to, the following information: actual enrollment~~  
17 ~~data by market and insurer, total new and renewed customers, number of paid customers, actual~~  
18 ~~average premium costs by market and insurer, number of enrollees receiving financial assistance~~  
19 ~~as defined in the Federal Act, as well as the number of inbound calls and the number of walk-ins~~  
20 ~~received. The data on inbound calls shall be segregated by type of call.~~

21 ~~**42-157-9. Relation to other laws.**~~

22 ~~Nothing in this chapter, and no action taken by the exchange pursuant to this chapter,~~  
23 ~~shall be construed to preempt or supersede the authority of the health insurance commissioner to~~  
24 ~~regulate the business of insurance within this state, the director of the department of health to~~  
25 ~~oversee the licensure of health care providers, the certification of health plans under chapter 17.13~~  
26 ~~of title 23, or the licensure of utilization review agents under chapter 17.13 of title 23, or the~~  
27 ~~director of the department of human services to oversee the provision of medical assistance under~~  
28 ~~chapter 8 of title 40. In addition to the provisions of this chapter, all insurers offering qualified~~  
29 ~~health plans or qualified dental plans in this state shall comply fully with all applicable health~~  
30 ~~insurance laws and regulations of this state.~~

31 ~~**42-157-10. Severability.**~~

32 ~~The provisions of this chapter are severable, and if any provision hereof shall be held~~  
33 ~~invalid in any circumstances, any invalidity shall not affect any other provisions or~~  
34 ~~circumstances. This chapter shall be construed in all respects so as to meet any constitutional~~

1 ~~requirements. In carrying out the purposes and provisions of this chapter, all steps shall be taken~~  
2 ~~which are necessary to meet constitutional requirements.~~

3 SECTION 3. Title 23 of the General Laws entitled "HEALTH AND SAFETY" is hereby  
4 amended by adding thereto the following chapter:

5 CHAPTER 94

6 THE RHODE ISLAND COMPREHENSIVE HEALTH INSURANCE PROGRAM

7 **23-94-1. Legislative findings and purpose.**

8 The general assembly finds that Rhode Island residents face significant and increasingly  
9 overwhelming problems obtaining adequate affordable health insurance due to unnecessary costs  
10 and obstacles created by our current health insurance system, and that removing the burden on  
11 Rhode Island businesses to secure health insurance for employees will benefit the state's  
12 economic development. This chapter, therefore, creates an affordable, comprehensive, and  
13 effective health insurance program to benefit all Rhode Island residents.

14 **23-94-2. Definitions.**

15 As used in this chapter:

16 (1) "Dependent" has the same definition as set forth in federal tax law (26 U.S.C. §152).

17 (2) "Emergency and urgently needed services" has the same definition as set forth in the  
18 federal Medicare law (42 CFR 422.113).

19 (3) "For-profit provider" means any health care professional or health care institution that  
20 provides payments, profits or dividends to investors or owners who do not directly provide health  
21 care.

22 (4) "Program" means, "the Rhode Island comprehensive health insurance program"  
23 (RICHIP).

24 (5) "Qualified Rhode Island resident" means any individual who is a "resident" as defined  
25 by §§44-30-5(a)(1) and (2) or a dependent of that resident.

26 (6) "RICHIP" or "Rhode Island comprehensive health insurance program" means  
27 affordable, comprehensive and effective health insurance as set forth in §23-94-3.

28 (7) "RICHIP Premiums" means funds from qualified Rhode Island residents that are  
29 placed into the RICHIP trust fund pursuant to §23-94-11, and are based on income and unearned  
30 income including capital gains.

31 **23-94-3. Rhode Island Comprehensive Health Insurance Program.**

32 (a) Organization. This chapter creates the Rhode Island comprehensive health insurance  
33 program (RICHIP), an independent government agency consisting of a director and staff, as set  
34 forth below.

1 (b) Director. A director shall be appointed by the governor with the advice and consent of  
2 the senate to lead RICHIP and serve a term of six (6) years. The director shall be compensated in  
3 accordance with the job title and job classification established by the division of human resources  
4 and approved by the general assembly. The director may be removed by a two-thirds (2/3)  
5 majority vote of each house of the general assembly. The director shall have the following duties:

6 (1) Oversee management of the RICHIP trust fund;

7 (2) Create and oversee RICHIP budgets;

8 (3) Appoint an advisory committee of health care professionals and others (hereinafter,  
9 the "RICHIP advisory committee");

10 (4) Establish RICHIP benefits as set forth in §23-94-5;

11 (5) Establish RICHIP provider reimbursement as set forth in §23-94-8;

12 (6) Coordinate with the state comptroller to facilitate billing from and payments to  
13 providers using the state's computerized financial system, the Rhode Island financial and  
14 accounting network system (RIFANS);

15 (7) Coordinate with federal health care programs, including Medicare and Medicaid, to  
16 streamline federal funding and reimbursement;

17 (8) Monitor billing and reimbursements to detect inappropriate behavior by providers and  
18 patients;

19 (9) Oversee RICHIP registration for qualified Rhode Island residents;

20 (10) Create RICHIP expenditure, status, and assessment reports;

21 (11) Review RICHIP disbursements on a quarterly basis and recommend adjustments in  
22 fee schedules needed to achieve budgetary targets and permit adequate access to care;

23 (12) Review capital budget proposals from providers;

24 (13) Create a committee to study long-term care and develop a plan to deal with this  
25 health care necessity;

26 (14) Create other prohibitions regarding RICHIP participation, and procedures by which  
27 they will be enforced.

28 **23-94-4. Extent of coverage.**

29 (a) Eligibility. All qualified Rhode Island residents are eligible to be covered under  
30 RICHIP.

31 (b) Registration. The director shall develop procedures by which:

32 (1) RICHIP can identify, automatically register, and provide a RICHIP card to qualified  
33 Rhode Island residents identified by September 1, 2017; and

34 (2) RICHIP can process applications from individuals seeking to become qualified Rhode

1 Island residents or obtain RICHIP coverage for dependents after September 1, 2017.

2 (c) Disqualification. The director shall establish criteria and procedures for disqualifying  
3 individuals from receiving RICHIP benefits or funds, including for ceasing to be a resident of  
4 Rhode Island, and for RICHIP-related criminal activity (e.g., the fraudulent receiving of benefits  
5 or reimbursements). Disqualified individuals shall be required to reimburse RICHIP for all  
6 benefits or funds they received upon disqualification and may be subject to civil and criminal  
7 penalties.

8 (d) Medicare eligible residents. Qualified Rhode Island residents eligible for federal  
9 Medicare ("Medicare eligible residents") shall continue to pay required fees to the federal  
10 government. RICHIP shall establish procedures to ensure that Medicare eligible residents shall  
11 have such amounts deducted from what they owe to RICHIP under §23-94-11. RICHIP shall  
12 become the equivalent of qualifying coverage under Medicare part D and Medicare advantage  
13 programs, and as such shall be the vendor for coverage to qualified Rhode Island residents.  
14 RICHIP shall provide Medicare eligible residents benefits equal to those available to all other  
15 RICHIP participants and equal to or greater than those available through the federal Medicare  
16 programs. To streamline the process, RICHIP shall seek to receive federal reimbursements for  
17 services to Medicare eligible residents and administer all Medicare funds.

18 (e) Medicaid eligible residents. RICHIP shall become the state's sole Medicaid provider.  
19 RICHIP shall create procedures to enroll all qualified Rhode Island residents eligible for  
20 Medicaid ("Medicaid eligible residents" in the federal Medicaid program to ensure a maximum  
21 amount of federal Medicaid funds go to the RICHIP trust fund. RICHIP shall provide benefits to  
22 Medicaid eligible residents equal to those available to all other RICHIP participants.

23 **23-94-5. RICHIP benefits.**

24 (a) In general. This chapter shall provide insurance coverage for services, goods and  
25 prescription drugs currently covered under the federal Medicare program (Social Security Act  
26 title XVIII) parts A, B and D. The director may permit additional medically necessary coverage  
27 within the following general categories:

28 (1) Primary and preventive care;

29 (2) Approved dietary and nutritional therapies;

30 (3) Inpatient care;

31 (4) Outpatient care;

32 (5) Emergency and urgently needed care;

33 (6) Prescription drugs;

34 (7) Approved medical goods;

- 1           (8) Palliative care;
- 2           (9) Mental health services;
- 3           (10) Dental services, including periodontics, oral surgery, and endodontics;
- 4           (11) Substance abuse treatment services;
- 5           (12) Physical therapy and chiropractic services;
- 6           (13) Vision care and vision correction;
- 7           (14) Hearing services, including coverage of hearing aids; and
- 8           (15) Podiatric care.

9           (b) RICHIP benefits. RICHIP benefits shall, at a minimum, be the same as those covered  
10 by the federal Medicare program, as defined by applicable federal statute and regulations. The  
11 director shall create a procedure that permits increases in coverage beyond that provided by the  
12 federal Medicare program within the areas set forth in §23-94-5(a) in consultation with the  
13 RICHIP advisory committee.

14           **23-94-6. Providers.**

15           (a) Rhode Island providers.  
16           (1) Licensing. Participating providers must meet state licensing requirements in order to  
17 participate in the program. No provider whose license is under suspension or has been revoked  
18 may participate in the program.

19           (2) Participation. All providers may participate in RICHIP by providing items on the  
20 RICHIP benefits list for which they are licensed. Providers may elect either to participate fully, or  
21 not at all, in the program.

22           (3) For-profit providers. For-profit providers may continue to offer services and goods in  
23 Rhode Island, but are prohibited from charging patients more than RICHIP reimbursement rates  
24 for covered services and goods and must notify qualified Rhode Island residents when the  
25 services and goods they offer will not be reimbursed under RICHIP.

26           (b) Out-of-state providers. Except for emergency and urgently needed service, as set forth  
27 in §23-94-7, RICHIP shall not pay for health care services obtained outside of Rhode Island  
28 unless the following requirements are met:

29           (1) The patient secures a written referral from a qualified Rhode Island physician prior to  
30 seeking such services; and

31           (2) The referring physician determines that the services are not available in the state or  
32 cannot be performed within the state at the level of expertise medically necessary.

33           (c) Out-of-state provider reimbursement. The program shall pay out-of-state health care  
34 providers an amount not to exceed the RICHIP rate. The qualified Rhode Island resident is



1 responsible for paying all costs of out-of-state services that fail to meet the requirements of §§23-  
2 94-6(b)(1) and (b)(2). Qualified Rhode Island residents are responsible for paying out-of-state  
3 providers for costs in excess of RICHIP reimbursements.

4 (d) Out-of-state residents. Rhode Island providers who provide any services to  
5 individuals who are not qualified Rhode Island residents shall not be reimbursed by RICHIP and  
6 must seek reimbursement from those individuals or other sources.

7 **23-94-7. Emergency and urgently needed services exceptions.**

8 (a) In Rhode Island. Nothing in this chapter prevents any individual from receiving or  
9 any provider from giving emergency or urgently needed services in Rhode Island. RICHIP shall  
10 reimburse all providers for emergency and urgently needed services given to qualified Rhode  
11 Island residents to the extent provided for under the federal Medicare program in accordance with  
12 §23-94-9.

13 (b) Out-of-State. The program shall pay for emergency and urgently needed services that  
14 are obtained by qualified Rhode Island residents anywhere outside Rhode Island to the same  
15 extent allowed under the federal Medicare program in accordance with §23-94-9. Qualified  
16 Rhode Island residents are responsible for paying out-of-state providers for costs in excess of  
17 RICHIP reimbursements.

18 **23-94-8. Private Insurance Companies.**

19 (a) Non-duplication. It is unlawful for a private health insurer to sell health insurance  
20 coverage to qualified Rhode Island residents outside of employer-provided health benefit  
21 programs that duplicates the benefits provided under this chapter.

22 (b) Displaced employees. Re-education and job placement of persons employed in  
23 Rhode Island-located enterprises who have lost their jobs as a result of this chapter shall be  
24 managed by the Rhode Island department of labor and training or an appropriate federal  
25 retraining program.

26 **23-94-9. Provider Reimbursement.**

27 (a) Rates. RICHIP reimbursements to providers shall be the same as the federal Medicare  
28 program reimbursement rates in effect at the time services, goods or prescription drugs are  
29 provided. If the director determines that there are no applicable Medicare reimbursement rates or  
30 that such rates are significantly different from those in neighboring states, the director shall create  
31 such rates in consultation with the RICHIP advisory committee.

32 (b) Billing and payments. Providers shall submit billing for services to qualified Rhode  
33 Island residents in the form of electronic invoices entered into RIFANS, the state's computerized  
34 financial system. The director shall coordinate the manner of processing and payment with the

1 office of accounts and control and the RIFANS support team within the division of information  
2 technology. Payments shall be made by check or electronic funds transfer in accordance with  
3 terms and procedures coordinated by the director and the office of accounts and control and  
4 consistent with the fiduciary management of the RICHIP trust fund.

5 (c) Provider restrictions. Providers who accept any payment from RICHIP may not bill  
6 any patient for any covered benefit. Providers cannot use any of their operating budgets for  
7 expansion, profit, excessive executive income, marketing, or major capital purchases or leases.

8 **23-94-10. Budgeting.**

9 (a) Operating budget. Annually, the director shall create an operating budget for the  
10 program that includes the costs for all benefits set forth in §23-94-5 and the costs for RICHIP  
11 administration. The director shall determine appropriate reimbursement rates for benefits  
12 pursuant to §23-94-9(a).

13 (b) Capital Expenditures. The director and the Rhode Island department of administration  
14 office of capital projects shall review the capital expenditure budgets proposed by providers,  
15 including amounts to be spent on construction and renovation of health facilities and major  
16 equipment purchases. To the extent that providers are seeking RICHIP funds for capital  
17 expenditures, the director shall have the authority to approve or deny such funding.

18 (c) Prohibition against co-mingling operations and capital improvement funds. It is  
19 prohibited to use funds under this chapter that are earmarked:

20 (1) For operations for capital expenditures; or

21 (2) For capital expenditures for operations.

22 (d) Limits. The total overhead and administrative portion of the program budget may not  
23 exceed twelve percent (12%) of the total operating budget of the program for the first two (2)  
24 years that the program is in operation; eight percent (8%) for the following two (2) years; and five  
25 percent (5%) for each year thereafter.

26 **23-94-11. Financing.**

27 (a) RICHIP trust fund. There shall be established a RICHIP trust fund into which funds  
28 collected pursuant to this chapter are deposited and from which funds are distributed. The  
29 governor or general assembly may provide funds to the RICHIP trust fund, but may not remove  
30 or borrow funds from the RICHIP trust fund.

31 (b) Savings. RICHIP will lower health care costs by:

32 (1) Eliminating payments for expensive, non-comprehensive private health care  
33 insurance;

34 (2) Reducing paperwork and administrative expenses;

1           (3) Allowing public health strategic planning; and  
2           (4) Improving access to preventive health care.  
3           (c) Funding. Funds sufficient to carry out this chapter shall be obtained in the following  
4 ways and may be changed only by a two-thirds (2/3) majority vote of each house of the general  
5 assembly.

6           (1) Seeking the maximum amount of existing and future federal government funds  
7 available for Rhode Island residents' health care, including, but not limited to, funds under the  
8 Medicare program, under title XVIII of the Social Security Act, under the Medicaid program  
9 under title XIX of such act, and under the children's health insurance program under title XXI of  
10 such act;

11           (2) Collecting RICHIP premiums;

12           (3) Applying any other funds specifically ear-marked for health care or health care  
13 education, such as settlements from litigation.

14           **23-94-12. Compliance with federal laws.**

15           RICHIP shall comply with all applicable federal laws, including the ACA and privacy  
16 laws.

17           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 HEALTH AND SAFETY -- COMPREHENSIVE HEALTH INSURANCE  
PROGRAM

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1           This act would repeal the "Rhode Island Health Care Reform Act of 2004 – Health  
2 Insurance Oversight" as well as the "Rhode Island Health Benefit Exchange. This act would also  
3 establish the Rhode Island comprehensive health insurance program, a new affordable, and  
4 effective health insurance program to benefit all Rhode Islanders.

5           This act would take effect upon passage.

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