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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. 2018

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A N A C T

RELATING TO INSURANCE -- INSURANCE COVERAGE FOR MENTAL HEALTH AND SUBSTANCE ABUSE DISORDERS

Introduced By: Representatives Blazejewski, Johnston, Keable, Diaz, and Amore

Date Introduced: January 31, 2018

Referred To: House Corporations

It is enacted by the General Assembly as follows:

SECTION 1. Legislative findings. - The general assembly hereby finds and declares as follows:

(1) A substantial amount of health care debt incurred by patients in this state is due to the increasing amount of patient responsibility for covered services outside of the premium of an insurance policy.

(2) It has been shown that patients, especially those in need of mental health and substance use disorder treatment have been discouraged from seeking treatment based upon the increasing amount of patient financial liability for such covered services.

(3) The imposition of coinsurance by insurers as a percentage of the allowable payment brings much confusion to consumers in attempting to control health care costs. Collection of coinsurance at the point of service by a provider is difficult due to the calculation of a percentage of an insurer's allowable cost of a service prior to the filing of a claim. This confusion further compounds a patient's financial and emotional stress in obtaining necessary covered services and meeting the patient's financial responsibility for such covered service.

(4) The power of insurers to unilaterally impose coinsurance based upon a percentage of an allowable cost of a covered service determined after the provider has filed a claim may further jeopardize the ability of patients and consumers to be educated and knowledgeable in their full financial responsibility under a health insurance plan or contract.

It is the intention of the general assembly to enable those in need of mental health and substance use disorder treatment to have greater access for care with fewer financial burdens that may result in avoidance of needed care. It is also the intention of the general assembly to lessen the financial complexity and burden on patients and easing the difficulty in the imposition of cost-sharing under health insurance plans.

SECTION 2. Section 27-18-8 of the General Laws in Chapter 27-18 entitled "Accident and Sickness Insurance Policies" is hereby amended to read as follows:

27-18-8. Filing of accident and sickness insurance policy forms.

(a) Any insurance company authorized to do an accident and sickness business within this state in accordance with the provisions of this title shall file all accident and sickness insurance policy forms and rates used by it in the state with the insurance commissioner, including the forms of any rider, endorsement, application blank, and other matter generally used or incorporated by reference in its policies or contracts of insurance. No such form shall be approved if it utilizes a coinsurance method, as defined in § 27-18-83, for the collection of patient financial requirements for covered benefits. such form shall be used if disapproved by the commissioner under this section, or if the commissioner's approval has been withdrawn under § 27-18-8.3, or until the expiration of the waiting period established under § 27-18-8.3. Such a company shall comply with its filed and approved forms. If the commissioner finds from an examination of any form that it is contrary to the public interest, or the requirements of this code or duly promulgated regulations, he or she shall forbid its use, and shall notify the company in writing as provided in § 27-18-8.2.

(b) Each rate filing shall include a certification by a qualified actuary that to the best of the actuary's knowledge and judgment, the entire rate filing is in compliance with applicable laws and that the benefits offered or proposed to be offered are reasonable in relation to the premium to be charged. A health insurance carrier shall comply with its filed and approved rates and forms.

SECTION 3. Section 27-19-7.2 of the General Laws in Chapter 27-19 entitled "Nonprofit Hospital Service Corporations" is hereby amended to read as follows:

27-19-7.2. Filing of policy forms.

(a) A nonprofit hospital service corporation shall file all policy forms and rates used by it in the state with the commissioner, including the forms of any rider, endorsement, application blank, and other matter generally used or incorporated by reference in its policies or contracts of insurance. No such form shall be approved if it utilizes a coinsurance method, as defined in § 27-19-74, for the collection of patient financial requirements for covered benefits. No such form shall be used if disapproved by the commissioner under this section, or if the commissioner's

approval has been withdrawn after notice and an opportunity to be heard, or until the expiration of sixty (60) days following the filing of the form. Such a company shall comply with its filed and approved forms. If the commissioner finds from an examination of any form that it is contrary to the public interest, or the requirements of this code or duly promulgated regulations, he or she shall forbid its use, and shall notify the corporation in writing.

(b) Each rate filing shall include a certification by a qualified actuary that to the best of the actuary's knowledge and judgment, the entire rate filing is in compliance with applicable laws and that the benefits offered or proposed to be offered are reasonable in relation to the premium to be charged. A health insurance carrier shall comply with its filed and approved rates and forms.

SECTION 4. Section 27-20-6.2 of the General Laws in Chapter 27-20 entitled "Nonprofit Medical Service Corporations" is hereby amended to read as follows:

27-20-6.2. Filing of policy forms.

(a) A nonprofit medical service corporation shall file all policy forms and rates used by it in the state with the commissioner, including the forms of any rider, endorsement, application blank, and other matter generally used or incorporated by reference in its policies or contracts of insurance. No such form shall be approved if it utilizes a coinsurance method, as defined in § 27-20-70, for the collection of patient financial requirements for covered benefits. No such form shall be used if disapproved by the commissioner under this section, or if the commissioner's approval has been withdrawn after notice and an opportunity to be heard, or until the expiration of sixty (60) days following the filing of the form. Such a company shall comply with its filed and approved forms. If the commissioner finds from an examination of any form that it is contrary to the public interest, or the requirements of this code or duly promulgated regulations, he or she shall forbid its use, and shall notify the corporation in writing.

(b) Each rate filing shall include a certification by a qualified actuary that to the best of the actuary's knowledge and judgment, the entire rate filing is in compliance with applicable laws and that the benefits offered or proposed to be offered are reasonable in relation to the premium to be charged. A health insurance carrier shall comply with its filed and approved rates and forms.

SECTION 5. Sections 27-38.2-1 and 27-38.2-2 of the General Laws in Chapter 27-38.2 entitled "Insurance Coverage for Mental Illness and Substance Abuse" are hereby amended to read as follows:

27-38.2-1. Coverage for treatment of mental health and substance use disorders. [Effective April 1, 2018.].

(a) A group health plan and an individual or group health insurance plan shall provide coverage for the treatment of mental health and substance-use disorders under the same terms and

conditions as that coverage is provided for other illnesses and diseases.

(b) Coverage for the treatment of mental health and substance-use disorders shall not impose any annual or lifetime dollar limitation.

(c) Financial requirements ~~and quantitative~~ as defined in § 27-38.2-2 shall not apply to coverage for the treatment of mental health and substance use disorders. Quantitative treatment limitations on coverage for the treatment of mental health and substance-use disorders shall be no more restrictive than the ~~predominant financial requirements~~ limitations applied to substantially all coverage for medical conditions in each treatment classification.

(d) Coverage shall not impose non-quantitative treatment limitations for the treatment of mental health and substance-use disorders unless the processes, strategies, evidentiary standards, or other factors used in applying the non-quantitative treatment limitation, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification.

(e) The following classifications shall be used to apply the coverage requirements of this chapter: (1) Inpatient, in-network; (2) Inpatient, out-of-network; (3) Outpatient, in-network; (4) Outpatient, out-of-network; (5) Emergency care; and (6) Prescription drugs.

(f) Medication-assisted treatment or medication-assisted maintenance services of substance-use disorders, opioid overdoses, and chronic addiction, including methadone, buprenorphine, naltrexone, or other clinically appropriate medications, is included within the appropriate classification based on the site of the service.

(g) Payors shall rely upon the criteria of the American Society of Addiction Medicine when developing coverage for levels of care for substance-use disorder treatment.

(h) Patients with substance-use disorders shall have access to evidence-based, non-opioid treatment for pain, therefore coverage shall apply to medically necessary chiropractic care and osteopathic manipulative treatment performed by an individual licensed under § 5-37-2.

27-38.2-2. Definitions.

For the purposes of this chapter, the following words and terms have the following meanings:

(1) "Financial requirements" means deductibles, copayments, ~~coinsurance,~~ or out-of-pocket maximums.

(2) "Group health plan" means an employee welfare benefit plan as defined in 29 U.S.C. § 1002(1) to the extent that the plan provides health benefits to employees or their dependents directly or through insurance, reimbursement, or otherwise. For purposes of this chapter, a group

health plan shall not include a plan that provides health benefits directly to employees or their dependents, except in the case of a plan provided by the state or an instrumentality of the state.

(3) "Health insurance plan" means health insurance coverage offered, delivered, issued for delivery, or renewed by a health insurer.

(4) "Health insurers" means all persons, firms, corporations, or other organizations offering and assuring health services on a prepaid or primarily expense-incurred basis, including but not limited to, policies of accident or sickness insurance, as defined by chapter 18 of this title; nonprofit hospital or medical service plans, whether organized under chapter 19 or 20 of this title or under any public law or by special act of the general assembly; health maintenance organizations, or any other entity that insures or reimburses for diagnostic, therapeutic, or preventive services to a determined population on the basis of a periodic premium. Provided, this chapter does not apply to insurance coverage providing benefits for:

(i) Hospital confinement indemnity;

(ii) Disability income;

(iii) Accident only;

(iv) Long-term care;

(v) Medicare supplement;

(vi) Limited benefit health;

(vii) Specific disease indemnity;

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

(ix) Other limited benefit policies.

(5) "Mental health or substance use disorder" means any mental disorder and substance use disorder that is listed in the most recent revised publication or the most updated volume of either the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association or the International Classification of Disease Manual (ICO) published by the World Health Organization; provided, that tobacco and caffeine are excluded from the definition of "substance" for the purposes of this chapter.

(6) "Non-quantitative treatment limitations" means: (i) Medical management standards; (ii) Formulary design and protocols; (iii) Network tier design; (iv) Standards for provider admission to participate in a network; (v) Reimbursement rates and methods for determining usual, customary, and reasonable charges; and (vi) Other criteria that limit scope or duration of coverage for services in the treatment of mental health and substance use disorders, including restrictions based on geographic location, facility type, and provider specialty.

(7) "Quantitative treatment limitations" means numerical limits on coverage for the

treatment of mental health and substance use disorders based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment.

SECTION 6. Section 27-41-29.2 of the General Laws in Chapter 27-41 entitled "Health Maintenance Organizations" is hereby amended to read as follows:

27-41-29.2. Filing of policy forms.

(a) A health maintenance organization shall file all policy forms and rates used by it in the state with the commissioner, including the forms of any rider, endorsement, application blank, and other matter generally used or incorporated by reference in its policies or contracts of insurance. No such form shall be approved if it utilizes a coinsurance method, as defined in § 27-41-87, for the collection of patient financial requirements for covered benefits. No such form shall be used if disapproved by the commissioner under this section, or if the commissioner's approval has been withdrawn after notice and an opportunity to be heard, or until the expiration of sixty (60) days following the filing of the form. Such a company shall comply with its filed and approved forms. If the commissioner finds from an examination of any form that it is contrary to the public interest or the requirements of this code or duly promulgated regulations, he or she shall forbid its use, and shall notify the corporation in writing.

(b) Each rate filing shall include a certification by a qualified actuary that to the best of the actuary's knowledge and judgment, the entire rate filing is in compliance with applicable laws and that the benefits offered or proposed to be offered are reasonable in relation to the premium to be charged. A health insurance carrier shall comply with its filed and approved rates and forms.

SECTION 7. Chapter 27-18 of the General Laws entitled "Accident and Sickness Insurance Policies" is hereby amended by adding thereto the following section:

27-18-84. Patient financial requirements.

Every individual or group hospital or medical expense insurance policy or individual or group hospital or medical services plan contract delivered, issued for delivery, or renewed in this state on or after January 1, 2020, shall not utilize coinsurance as a method for collecting amounts due from patients beyond the premium responsibility for covered services as required under the insured's benefit plan. For purposes of this section, "coinsurance" is defined as a percentage of the allowable charge, after a copayment, if any, that an insured will pay for covered benefits. Provided, however, this section shall not apply to insurance coverage providing benefits for:

(1) Hospital confinement indemnity;

(2) Disability income;

(3) Accident only;

(4) Long-term care;

(5) Medicare supplement;

(6) Limited benefit health;

(7) Specified disease indemnity;

(8) Sickness or bodily injury or death by accident or both; and

(9) Other limited benefit policies.

SECTION 8. Chapter 27-19 of the General Laws entitled "Nonprofit Hospital Service Corporations" is hereby amended by adding thereto the following section:

27-19-76. Patient financial requirements.

Every individual or group hospital or medical expense insurance policy or individual or group hospital or medical services plan contract delivered, issued for delivery, or renewed in this state on or after January 1, 2020, shall not utilize coinsurance as a method for collecting amounts due from patients beyond the premium responsibility for covered services as required under the insured's benefit plan. For purposes of this section, "coinsurance" is defined as a percentage of the allowable charge, after a copayment, if any, that an insured will pay for covered benefits.

SECTION 9. Chapter 27-20 of the General Laws entitled "Nonprofit Medical Service Corporations" is hereby amended by adding thereto the following section:

27-20-72. Patient financial requirements.

Every individual or group hospital or medical expense insurance policy or individual or group hospital or medical services plan contract delivered, issued for delivery, or renewed in this state on or after January 1, 2020, shall not utilize coinsurance as a method for collecting amounts due from patients beyond the premium responsibility for covered services as required under the insured's benefit plan. For purposes of this section, "coinsurance" is defined as a percentage of the allowable charge, after a copayment, if any, that an insured will pay for covered benefits.

SECTION 10. Chapter 27-41 of the General Laws entitled "Health Maintenance Organizations" is hereby amended by adding thereto the following section:

27-41-89. Patient financial requirements.

Every individual or group hospital or medical expense insurance policy or individual or group hospital or medical services plan contract delivered, issued for delivery, or renewed in this state on or after January 1, 2020, shall not utilize coinsurance as a method for collecting amounts due from patients beyond the premium responsibility for covered services as required under the insured's benefit plan. For purposes of this section, "coinsurance" is defined as a percentage of the allowable charge, after a copayment, if any, that an insured will pay for covered benefits.

SECTION 11. 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 HEALTH AND SUBSTANCE ABUSE DISORDERS

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This act would amend provisions, define coinsurance as a percentage of the allowable charge, after a copayment that an insured will pay for covered benefits and would prohibit insurance contracts or policies from using coinsurance to calculate and collect additional funds from patients, including mental health and substance abuse patients and would amend various provisions relative to the filing of policy forms required by the commission.

This act would take effect upon passage.

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