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STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2018

A N A C T

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

Introduced By: Senators Seveney, Coyne, Miller, DiPalma, and Calkin

Date Introduced: March 01, 2018

Referred To: Senate Health & Human Services

(Governor)

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. Coverage for treatment of mental health and substance use disorders.**
5 **[Effective April 1, 2018.].**

6 (a) A group health plan and an individual or group health insurance plan shall provide
7 coverage for the treatment of mental health and substance-use disorders under the same terms and
8 conditions as that coverage is provided for other illnesses and diseases.

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

11 (c) Financial requirements and quantitative treatment limitations on coverage for the
12 treatment of mental health and substance-use disorders shall be no more restrictive than the
13 predominant financial requirements applied to substantially all coverage for medical conditions in
14 each treatment classification.

15 (d) Coverage shall not impose non-quantitative treatment limitations for the treatment of
16 mental health and substance-use disorders unless the processes, strategies, evidentiary standards,
17 or other factors used in applying the non-quantitative treatment limitation, as written and in
18 operation, are comparable to, and are applied no more stringently than, the processes, strategies,

1 evidentiary standards, or other factors used in applying the limitation with respect to
2 medical/surgical benefits in the classification.
3 (e) The following classifications shall be used to apply the coverage requirements of this
4 chapter: (1) Inpatient, in-network; (2) Inpatient, out-of-network; (3) Outpatient, in-network; (4)
5 Outpatient, out-of-network; (5) Emergency care; and (6) Prescription drugs.
6 (f) Medication-assisted treatment or medication-assisted maintenance services of
7 substance-use disorders, opioid overdoses, and chronic addiction, including methadone,
8 buprenorphine, naltrexone, or other clinically appropriate medications, is included within the
9 appropriate classification based on the site of the service.
10 (g) Payors shall rely upon the criteria of the American Society of Addiction Medicine
11 when developing coverage for levels of care for substance-use disorder treatment.
12 (h) Patients with substance-use disorders shall have access to evidence-based, non-opioid
13 treatment for pain, therefore coverage shall apply to medically necessary chiropractic care and
14 osteopathic manipulative treatment performed by an individual licensed under § 5-37-2.
15 <u>(i) Parity of cost-sharing requirements. Regardless of the professional license of the</u>
16 <u>provider of care, if that care is consistent with the provider's scope of practice and the health</u>
17 <u>plan's credentialing and contracting provisions, behavioral health counseling visits and</u>
18 <u>medication maintenance visits shall be considered as primary care visits for the purpose of</u>
19 <u>application of any patient cost-sharing requirements imposed by the health plan.</u>
20 SECTION 2. Section 42-14.5-3 of the General Laws in Chapter 42-14.5 entitled "The
21 Rhode Island Health Care Reform Act of 2004 - Health Insurance Oversight" is hereby amended
22 to read as follows:
23 **42-14.5-3.** ~~**Powers and duties [Contingent effective date; see effective dates under**~~
24 ~~**this section.**~~ <u>**Powers and duties [Contingent effective date; see effective dates under this**</u>
25 <u>**section.]**</u>
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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(v) A standard payor-denial review process for providers when they request a 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

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

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

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

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

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

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

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

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

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

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

(1) Utilization review;

(2) Contracting; and

(3) Licensing and regulation.

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

(p) To work to ensure the health insurance coverage of behavioral health care under the same terms and conditions as other health care, and to integrate behavioral health parity requirements into the OHIC insurance oversight and health care transformation efforts.

(q) To work with other state agencies to seek delivery system improvements that enhance access to a continuum of mental health and substance use disorder treatment in the state; and integrate that treatment with primary and other medical care to the fullest extent possible.

(r) To direct insurers toward policies and practices that address the behavioral health needs of the public and greater integration of physical and behavioral health care delivery.

SECTION 3. This act shall take effect upon passage and section 2 shall apply to all policies issued, revised, delivered, or renewed on or after January 1, 2020.

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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

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1 This act would include behavioral health counseling visits and medication maintenance
2 visits as primary care visits for patient cost-sharing requirements under the provisions of a health
3 plan.
4 This act would take effect upon passage and section 2 would apply to all policies issued,
5 revised, delivered, or renewed on or after January 1, 2020.

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