

**STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
OFFICE OF THE HEALTH INSURANCE COMMISSIONER
1511 PONTIAC AVENUE, BLDG 69-1
CRANSTON, RI 02920**

In Re: Examination of Health Insurance Carrier Compliance)
with Mental Health and Substance Abuse) OHIC-2014-3
Laws and Regulations)

NOTICE OF EXAMINATION, WARRANT, AND APPOINTMENT

Whereas, Blue Cross Blue Shield of Rhode Island (“Blue Cross”) is engaging in business of health insurance in the State of Rhode Island (“State”);

Whereas, Neighborhood Health Plan of RI (“Neighborhood”) is engaging in the business of health insurance in the State;

Whereas, Tufts Insurance Company and Tufts Associated Health Maintenance Organization (collectively “Tufts”) is engaging in the business of health insurance in the State;

Whereas, UnitedHealthcare Insurance Company, and UnitedHealthcare of New England, Inc. (collectively “United”) is engaging in the business of health insurance in the State;

Whereas, Blue Cross, Neighborhood, Tufts, and United (collectively “the Carriers”), are subject to the jurisdiction of the Office of the Health Insurance Commissioner (“the Office”) by virtue of Title 27, and by virtue of Title 42 Chapters 14 and 14.5 of the General Laws of Rhode Island;

Whereas, pursuant to Chapter 13.1 of Title 27 of the General Laws of Rhode Island, the Health Insurance Commissioner (“Commissioner”) or her designee, in her sole discretion, may upon proper notice order an examination of any Rhode Island health insurance carrier to ascertain carriers’ compliance with their legal obligations;

Whereas, the Rhode Island Legislature has requested the Office to conduct a review of the Carriers’ compliance with their legal obligations under mental health and substance abuse (“behavioral health”) laws and regulations. R.I. Gen. Laws § 42-14.5-3(j) and (m); and

Whereas, this notice shall be considered the examination warrant pursuant to Section 27-13.1-4(a).

Now therefore be it **ORDERED:**

A. The Office of the Health Insurance Commissioner (“the Office”) shall conduct a market conduct examination of the Carriers.

B. Linda Johnson, Herbert Olson, Charles DeWeese, and Jack Broccoli (“the Examiners”) are appointed pursuant to R.I. Gen. Laws § 27-13.1-4 to represent the Commissioner in this examination. The Examiners are authorized to retain, utilize and rely on the services and work of consultants, experts, actuaries or other persons as they deem necessary to assist in the conduct of this examination.

C. The examination will be a targeted examination to determine:

1. Whether the Carriers are complying with their legal obligations relating to emergency behavioral health services, including the prohibition on the use of prior authorization as a condition of coverage of emergency behavioral health services, in accordance with state and federal laws and regulations.

2. Whether the Carriers are complying with their legal obligations to provided coverage of behavioral health services, in accordance with state and federal laws and regulations.

3. Whether the Carriers are complying with their legal obligations to provided coverage of behavioral health services at parity with other health care coverage, in accordance with state and federal laws and regulations.

D. In accordance with R.I. Gen. Laws §§ 27-13.1-4(b) and 27-13.1-4(c), the Carriers must provide timely, convenient and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents, and any or all computer or other recordings relating to the property, assets, business, and affairs of the company and provide timely and complete access to all persons under the company's control from whom the Office seeks to take testimony under oath.

E. In accordance with R.I. Gen. Laws §§ 27-13.1-7 and 27-13.1-4(d), the total cost of such examinations, including the costs of any attorneys, appraisers, independent actuaries, independent certified public accountants, or other professionals and specialists used as examiners, but excluding the costs of employees of the Office and of the Department of Business Regulation, must be borne by the Carriers.

Dated at Cranston, RI this 8th day of January, 2015.


Kathleen C. Hittner, MD
Health Insurance Commissioner

the covered person of his or her obligation to forward the bill to their health carrier for consideration under the Provider Mediation Process described in Subsection G if the difference in the billed charge and the plan's allowable amount is more than [\$500.00].

Drafting Note: A state that has enacted provisions concerning payment for emergency services provided by a non-participating provider, which permit a non-participating provider to balance bill the covered person, should be aware that the provisions of Paragraph (1) above would not permit a non-participating provider to balance bill the covered person in that situation. As such, if a state decides to adopt the provisions of Paragraph (1) above, the state should review their laws or regulations that may be equivalent to Section 11C of the Utilization Review and Benefit Determination Model Act (#73) and revise them accordingly.

(2) Nothing in this section precludes a covered person from agreeing to accept and pay the charges for the out-of-network service(s) and not using the Provider Mediation Process described in Subsection G.

D. Limitation on balance billing covered persons.

(1) In instances where a non-participating facility-based provider sends a billing notice directly to a covered person for the non-participating facility-based provider's service(s), the billing notice shall include the Payment Responsibility Notice in Paragraph (2).

(2) The Payment Responsibility Notice shall state the following or substantially similar language:

"Payment Responsibility Notice – The service[s] outlined below was [were] performed by a facility-based provider who is a non-participating provider with your health care plan. At this time, you are responsible for paying your applicable cost-sharing obligation - copayment, coinsurance or deductible amount – just as you would be if the provider is within your plan's network. With regard to the remaining balance, you have three choices: 1) you may choose to pay the balance of the bill; OR 2) if the difference in the billed charge and the plan's allowable amount is more than [\$500.00], you may send the bill to your health care plan for processing pursuant to the health carrier's non-participating facility-based provider billing process or the provider mediation process required by [this Section] OR 3) you may rely on other rights and remedies that may be available in your state."

(3) Non-participating facility-based providers may not attempt to collect payment, excluding appropriate cost-sharing, from covered persons when the provider has elected to trigger the health carrier's non-participating facility-based provider billing process described in Subsection E.

(4) Non-participating facility-based providers who do not provide a covered person with a Payment Responsibility Notice, as outlined in Paragraph (2), may not balance bill the covered person.

(5) Nothing in this section precludes a covered person from agreeing to accept and pay the bill received from the non-participating facility-based provider and not using the Provider Mediation Process described in Subsection G.

E. Health carrier out-of-network facility-based provider payments.

(1) Health carriers shall develop a program for payment of non-participating facility-based provider bills submitted pursuant to this section.

(2) Health carriers may elect to pay non-participating facility-based provider bills as submitted or the health carrier may pay in accordance with the benchmark established in Subsection F.

(3) Non-participating facility-based providers who object to the payment(s) made in Paragraph (2) may elect the Provider Mediation Process described in Subsection G.

(4) This section does not preclude a health carrier and an out-of-network facility-based provider from agreeing to a separate payment arrangement.

F. Benchmark for non-participating facility-based provider payments. Payments to non-participating facility-based providers shall be presumed to be reasonable if it is based on the higher of the health carrier's © 2015 National Association of Insurance Commissioners 20

contracted rate or [XX] percentage of the Medicare payment rate for the same or similar services in the same geographic area.

Drafting Note: Subsection F above proposes that states set a benchmark or benchmarks for payments to non-participating facility-based providers. States can consider a number of options to use as the default reimbursement presumed to be reasonable, including, as provided in Subsection F, using a percentage of the Medicare payment that a state considers appropriate to determine the rate for the same or similar services in the same geographic area as provided in Subsection F and others such as: a) some percentage of a public, independent, database of charges for the same or similar services in the same geographic area; or b) some percentage of usual, customary and reasonable (UCR) charges in the state, if defined in state law or regulation. In setting a benchmark or benchmarks, states should carefully consider the impact on the market. Setting a rate too high or too low may negatively impact the ability of facility-based providers and health carriers to agree on a contract.

G. Provider Mediation Process.

(1) Health carriers shall establish a provider mediation process for payment of non-participating facility-based provider bills for providers objecting to the application of the established payment rate outlined in Subsection F.

(2) The health carrier provider mediation process shall be established in accordance with one of the following recognized mediation standards:

(a) The Uniform Mediation Act;

(b) Mediation.org, a division of the American Arbitration Association;

(c) The Association for Conflict Resolution (ACR);

(d) The American Bar Association Dispute Resolution Section; or

(e) The State of [XX] [state dispute resolution, mediation or arbitration section].

Drafting Note: Some states have included a provider mediation process in an independent dispute resolution process. *The intent and effect is similar to this process.*

(3) *Following completion of the provider mediation process, the cost of mediation shall be split evenly and paid by the health carrier and the non-participating facility-based provider.*

(4) *A health carrier provider mediation process may not be used when the health carrier and the non-participating facility-based provider agree to a separate payment arrangement or when the covered person agrees to accept and pay the non-participating facility-based provider's charges for the out-of-network service(s).*

(5) *A health carrier shall maintain records on all requests for mediation and completed mediations under this subsection during a calendar year and, upon request, submit a report to the commissioner in the format specified by the commissioner.*

Drafting Note: *In promulgating regulations to implement this section, the commissioner and other appropriate state agencies involved in the rulemaking process should consider a number of provisions related to this subsection, such as the timing of the notice that the mediation process has been triggered, the timeframe to trigger the process and the standard rights and obligations of the parties participating in the mediation process.*

H. The rights and remedies provided under this section to covered persons shall be in addition to and may not preempt any other rights and remedies available to covered persons under state or federal law.

I. Enforcement. The [insert appropriate state agency with hospital/provider oversight, consumer protection division, or attorney general] and the [insurance department] shall be responsible for enforcement of the requirements of this section. © 2015 National Association of Insurance Commissioners 21

J. Applicability.

(1) The provisions of this section shall not apply to a policy or certificate that provides coverage only for a specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance, as defined by [insert the reference to state law that defines long-term care insurance], vision care or any other limited supplemental benefit or to a Medicare supplement policy of insurance, as defined by the commissioner by regulation, coverage under a plan through Medicare, Medicaid, or the federal employees health benefits program, any coverage issued under Chapter 55 of Title 10, U.S. Code and any coverage issued as supplement to that coverage, any coverage issued as supplemental to liability insurance, workers' compensation or similar insurance, automobile medical-payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket or individual basis.

(2) The requirements of this section do not apply to providers or covered persons using the process established in Section 5C of this Act.

(3) The requirements of this section do not apply to facilities that have made arrangements with facility-based providers they employ or with whom they have contracts which prevent balance bills from being sent to persons covered by the same health benefit plans with which the facility contracts.

Drafting Note: *This section is not intended to be used in situations where the covered person affirmatively chooses, prior to the provision of the services, to obtain health care services from a non-participating facility-based provider.*

K. Regulations. *The commissioner and the [insert appropriate state agency with hospital/provider oversight, consumer protection division, or attorney general as indicated in Subsection I, above] may, after notice and hearing, promulgate reasonable regulations to carry out the provisions of this section. The regulations shall be subject to review in accordance with [insert statutory citation providing for administrative rulemaking and review of regulations].*