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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. 2019

A N A C T

RELATING TO HEALTH AND SAFETY - OVERSIGHT OF RISK-BEARING PROVIDER ORGANIZATIONS

Introduced By: Senators Sheehan, Miller, Goodwin, McCaffrey, and Satchell

Date Introduced: March 14, 2019

Referred To: Senate Health & Human Services

(OHIC)

It is enacted by the General Assembly as follows:

SECTION 1. Title 23 of the General Laws entitled "HEALTH AND SAFETY" is hereby amended by adding thereto the following chapter:

CHAPTER 17.28

OVERSIGHT OF RISK-BEARING PROVIDER ORGANIZATIONS

23-17.28-1. Purpose.

The legislature declares that:

(1) It is in the best interest of the public that health care provider organizations that accept financial risk for the delivery of health care services in our state meet the standards of this chapter to ensure that patient access to health care services and continuity of care are not unnecessarily interrupted; and

(2) It is a vital state function to establish these standards for the conduct of health care provider organizations in Rhode Island; and

(3) Nothing in this legislation is intended to change the obligation of providers or insurers to comply with the provisions of title 27.

23-17.28-2. Definitions.

As used in this chapter:

(1) "Commissioner" means the health insurance commissioner.

(2) "Health care risk contract" means a health care contract that holds the provider

organization financially responsible for a negotiated portion or all costs that exceed a predetermined health care services budget and thereby transfers insurer risk to the provider organization.

(3) "Health insurer" means every nonprofit medical service corporation, hospital service corporation, health maintenance organization, or other insurer offering or insuring health services; the term shall in addition include any entity defined as an insurer under § 42-62-4 and any third-party administrator when interacting with health care providers and enrollees on behalf of the insurer.

(4) "Provider organization" means any corporation, partnership, business trust, association, or organized group of persons in the business of health care delivery or management, whether incorporated or not, that represents one or more health care providers in contracting with health insurers for the payments of health care services. "Provider organization" shall include, but not be limited to, physician organizations, physician-hospital organizations, independent practice associations, provider networks, accountable care organizations, systems of care, and any other organization that contracts with health insurers for payment for health care services.

(5) "Risk-bearing provider organization" means a provider organization that has entered into a health care risk contract to manage the treatment of a group of patients.

23-17.28-3. Certification for provider organizations entering into health care risk contracts for Medicaid enrollees.

(a) The commissioner shall establish a process for certifying provider organizations that intend to enter into health care risk contracts for Medicaid enrollees.

(b) The commissioner shall by regulation establish standards for certification, including the forms and information required to apply for certification. The standards may consider the provider organization's financial position, corporate structure, or other characteristics.

(c) The commissioner shall issue a finding regarding certification within sixty (60) days of the receipt of a complete request pursuant to subsection (b) of this section. If the commissioner denies the request for certification, the commissioner will state the reasons for the denial in writing, and the provider organization may reapply without prejudice.

23-17.28-4. Financial solvency filing and review.

(a) Review of financial solvency.

(1) The commissioner shall establish a process for reviewing the financial solvency of risk-bearing provider organizations according to the standards established under subsection (b) of this section.

(2) The commissioner shall issue a finding regarding financial solvency within sixty (60)

days of the receipt of a complete filing pursuant to subsection (c) or (d) of this section. The commissioner shall find one of the following:

(i) The risk-bearing provider organization meets the standards of financial solvency.

(ii) The risk-bearing provider organization does not meet the standards of financial solvency. Such a finding may be appealed pursuant to the administrative procedures act, chapter 35 of title 42.

(3) Regardless of the findings pursuant to subsection (a)(2) of this section, the commissioner may include additional observations concerning the risk-bearing provider organization's financial solvency, including the identification of material risks facing the provider organization.

(b) The commissioner shall establish standards for evaluating financial solvency of risk-bearing provider organizations. The standards will consider all the health care risk contracts that a provider organization has entered into at the time of a financial solvency review.

(c) Within thirty (30) days of executing a health care risk contract, a provider organization shall submit to the commissioner a financial report, and any other materials necessary to support the financial solvency review. The commissioner shall establish the form and content of this filing by regulation. Materials submitted under this subsection shall be considered confidential commercial information for the purposes of § 38-2-2(4)(B). This requirement shall not apply to any risk-bearing provider organization that has submitted materials under subsection (d) of this section within the previous twelve (12) months.

(d) Risk-bearing provider organizations shall annually submit to the commissioner a financial report, and any other materials necessary to support the financial solvency review. The commissioner shall establish the timing, form, and content of this filing by regulation. Materials submitted under this subsection shall be considered confidential commercial information for the purposes of § 38-2-2(4)(B).

(e) If the commissioner has established one or more categories of risk contracts under § 42-14.5-3(t), the commissioner shall establish standards and requirements for risk-bearing provider organizations that have entered into specific categories of risk contracts. The commissioner may waive all requirements for certain risk contracts or categories of risk contracts based on a determination that such contracts pose little risk to consumers.

23-17.28-5. Corrective action plan.

(a) If the commissioner finds that a risk-bearing provider organization does not meet the standards of financial solvency under § 23-17.28-4(a):

(1) The commissioner will identify specific deficiencies with respect to the standards of

financial solvency that need to be addressed by the risk-bearing provider organization.

(2) The commissioner will notify the executive office of health and human services and any health insurers that have informed the office of the health insurance commissioner that they are holding health care risk contracts with the provider organization.

(3) The risk-bearing provider organization will establish a corrective action plan to address the deficiencies identified by the commissioner, submit the plan to the commissioner, and update the commissioner on the status of corrective on actions an ongoing basis as requested. The commissioner may establish standards for such corrective action plans by regulation.

(b) Ninety (90) days following a finding that a risk-bearing provider organization does not meet the standards of financial solvency under § 23-17.28-4(a), the risk-bearing provider organization shall demonstrate compliance with the corrective action plan under subsection (a)(3) of this section.

23-17.28-6. Prohibition on contracting with certain risk-bearing provider organizations.

(a) If the commissioner has issued a finding that a risk-bearing provider organization does not meet the standards of financial solvency, the provider organization may not enter into or renew a health care risk contract without prior approval of the commissioner until such time as the commissioner issues a finding that the provider organization meets the standards of financial solvency.

(b) A provider organization may not enter into or renew a health care risk contract for Medicaid members if the provider organization has not been certified under § 23-17.28-3.

23-17.28-7. Duty to update.

Risk-bearing provider organizations that have previously submitted an annual financial report to the commissioner under § 23-17.28-4(c) shall:

(1) Notify the commissioner within thirty (30) days of any material changes to its financial position, including changes to health care risk contracts that increase the amount of risk borne by the provider organization, or reduces risk mitigation, such as through a reduction in stop loss insurance coverage, and;

(2) Notify the commissioner within two (2) days should the risk-bearing organization become insolvent, or recognize it is in the process of becoming insolvent.

23-17.28-8. Administrative penalties.

(a) Whenever the commissioner shall have cause to believe that a violation of this section has occurred by any provider organization, the commissioner may, in accordance with the requirements of the administrative procedures act, chapter 35 of title 42:

(1) Levy an administrative penalty in an amount not less than one thousand dollars ($1000) nor more than fifty thousand dollars ($50,000);

(2) Order the violator to cease such actions;

(3) Require the provider organization to take such actions as are necessary to comply with this section, or the regulations thereunder; or

(4) Any combination of the above penalties.

(b) Any monetary penalties assessed pursuant to this section shall be deposited as general revenues.

SECTION 2. Section 27-20.9-1 of the General Laws in Chapter 27-20.9 entitled "Contract With Health Care Providers" is hereby amended to read as follows:

27-20.9-1. Health care contracts -- Required provisions -- Definitions.

(a) On and after January 1, 2008, a health insurer that contracts with a health care provider shall comply with the provisions of this chapter and shall include the provisions required by this chapter in the health care contract. A contract in existence prior to January 1, 2008, that is renewed or renews by its terms shall comply with the provisions of this chapter no later than December 31, 2008.

(b) As used in this chapter, unless the context otherwise requires:

(1) "Health care contract" means a contract entered into or renewed between a health insurer and a health care provider for the delivery of health care services to others.

(2) "Health care provider" means a person licensed or certified in this state to practice medicine, pharmacy, chiropractic, nursing, physical therapy, podiatry, dentistry, optometry, occupational therapy, or other healing arts.

(3) "Health care risk contract" means a health care contract that holds the provider organization financially responsible for a negotiated portion or all of the costs that exceed a predetermined health care services budget and thereby transfers insurer risk to the provider organization.

~~(3)~~(4) "Health insurer" means every nonprofit medical service corporation, hospital service corporation, health maintenance organization, or other insurer offering and/or insuring health services; the term shall in addition include any entity defined as an insurer under § 42-62-4 and any third-party administrator when interacting with health care providers and enrollees on behalf of such an insurer.

(5) "Provider organization" means any corporation, partnership, business, trust, association, or organized group of persons in the business of health care delivery or management whether incorporated or not that represents one or more health care providers in contracting with

health insurers for the payments of health care services. "Provider organization" shall include, but not be limited to, physician organizations, physician-hospital organizations, independent practice associations, provider networks, accountable care organizations, systems of care, and any other organization that contracts with health insurers for payment for health care services.

SECTION 3. Chapter 27-20.9 of the General Laws entitled "Contract With Health Care Providers" is hereby amended by adding thereto the following section:

27-20.9-4. Health care risk contracts.

(a) A health insurer shall submit information about each health care risk contract as directed by the health insurance commissioner in regulation. The commissioner shall review the information for compliance with applicable laws and regulations.

(b) A health insurer shall submit health care risk contracts and relevant related material to the commissioner within thirty (30) days of a request of such information. Such contracts shall be considered confidential commercial information for the purposes of § 38-2-2(4)(B). The commissioner shall, as deemed appropriate, review such information for compliance with applicable laws and regulations.

(c) A health insurer shall not enter into or renew a health care risk contract with a provider organization for which the commissioner has issued a finding that the provider organization does not meet the standards of financial solvency under § 23-17.28-4, until such time as the commissioner issues a finding that the provider organization meets the standards of financial solvency.

(d) A health insurer shall not enter into or renew a health care risk contract for Medicaid members with a provider organization that has not been certified as provided in § 23-17.28-3.

(e) If the commissioner determines it necessary to protect consumers, the commissioner may order the health insurer to terminate some or all of its health care risk contracts.

(f) Each health insurer shall provide the commissioner with a list of all provider organizations with which it has entered into a health care risk contract on an annual basis. If the commissioner has established one or more categories of risk contracts under § 42-14.5-3(t), the health insurer will indicate which category of risk contract each risk-bearing provider organization holds.

(g) The commissioner may establish additional requirements for health care risk contracts by regulation.

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

42-14.5-3. Powers and duties.

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

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

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

(c) To establish a consumer/business/labor/medical advisory council to obtain information and present concerns of consumers, business, and medical providers affected by health-insurance decisions. The council shall develop proposals to allow the market for small business health insurance to be affordable and fairer. The council shall be involved in the planning and conduct of the quarterly public meetings in accordance with subsection (a). The advisory council shall develop measures to inform small businesses of an insurance complaint process to ensure that small businesses that experience rate increases in a given year may request and receive a formal review by the department. The advisory council shall assess views of the health-provider community relative to insurance rates of reimbursement, billing, and reimbursement procedures, and the insurers' role in promoting efficient and high-quality health care. The advisory council shall issue an annual report of findings and recommendations to the

governor and the general assembly and present its findings at hearings before the house and senate finance committees. The advisory council is to be diverse in interests and shall include representatives of community consumer organizations; small businesses, other than those involved in the sale of insurance products; and hospital, medical, and other health-provider organizations. Such representatives shall be nominated by their respective organizations. The advisory council shall be co-chaired by the health insurance commissioner and a community consumer organization or small business member to be elected by the full advisory council.

(d) To establish and provide guidance and assistance to a subcommittee ("the professional-provider-health-plan work group") of the advisory council created pursuant to 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 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 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 the 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 the 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 single, common-standards body or process exists and multiple conflicting sources are in use by payors and providers.

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

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

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

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

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

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

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

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

(i) To issue an anti-cancer medication report. Not later than June 30, 2014 and annually 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 office of the health insurance commissioner 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.

(s) The office of the health insurance commissioner shall conduct an analysis of the impact of the provisions of § 27-38.2-1(i) on health insurance premiums and access in Rhode Island and submit a report of its findings to the general assembly on or before June 1, 2023.

(t) To protect the consumer interest through establishment, monitoring and enforcement of requirements related to health care risk contracts as defined in § 27-20.9-1 and risk-bearing provider organizations as defined in § 23-17.28-2, including the following:

(1) To certify certain provider organizations as eligible to enter into health care risk contracts for Medicaid populations, pursuant to chapter 17.28 of title 23.

(2) To establish multiple categories of health care risk contracts based on the amount of

risk to which the risk-bearing provider organization is exposed. The health insurance commissioner may apply different standards and requirements related to health care risk contracts based on the category of the relevant risk contract.

(3) To evaluate the financial solvency of risk-bearing provider organizations and take additional actions pursuant to chapter 17.28 of title 23 and chapter 20.9 of title 27.

(4) To enact appropriate regulations to protect the consumer interest with respect to health care risk contracts.

SECTION 5. 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 - OVERSIGHT OF RISK-BEARING PROVIDER ORGANIZATIONS

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This act would provide the office of the health insurance commissioner with oversight of risk-bearing provider organizations and health care risk contracts.

This act would take effect upon passage.

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