

2021 -- H 5195

=====
LC000092
=====

STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2021

—————
A N A C T

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

Introduced By: Representative David A. Bennett

Date Introduced: January 27, 2021

Referred To: House Health, Education & Welfare

It is enacted by the General Assembly as follows:

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

3 CHAPTER 17.28

4 OVERSIGHT OF RISK-BEARING PROVIDER ORGANIZATIONS

5 **23-17.28-1. Purpose.**

6 The legislature declares that:

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

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

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

15 **23-17.28-2. Definitions.**

16 As used in this chapter:

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

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

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

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

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

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

17 **23-17.28-3. Certification for provider organizations entering into health care risk**
18 **contracts for Medicaid enrollees.**

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

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

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

28 **23-17.28-4. Financial solvency filing and review.**

29 (a) Review of financial solvency.

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

33 (2) The commissioner shall issue a finding regarding financial solvency within sixty (60)
34 days of the receipt of a complete filing pursuant to subsection (c) or (d) of this section. The

1 commissioner shall find one of the following:

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

3 (ii) The risk-bearing provider organization does not meet the standards of financial
4 solvency. Such a finding may be appealed pursuant to the administrative procedures act, chapter
5 35 of title 42.

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

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

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

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

25 (e) If the commissioner has established one or more categories of risk contracts under §
26 42-14.5-3(t), the commissioner shall establish standards and requirements for risk-bearing provider
27 organizations that have entered into specific categories of risk contracts. The commissioner may
28 waive all requirements for certain risk contracts or categories of risk contracts based on a
29 determination that such contracts pose little risk to consumers.

30 **23-17.28-5. Corrective action plan.**

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

33 (1) The commissioner will identify specific deficiencies with respect to the standards of
34 financial solvency that need to be addressed by the risk-bearing provider organization.

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

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

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

12 **23-17.28-6. Prohibition on contracting with certain risk-bearing provider**
13 **organizations.**

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

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

21 **23-17.28-7. Duty to update.**

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

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

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

30 **23-17.28-8. Administrative penalties.**

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

34 (1) Levy an administrative penalty in an amount not less than one thousand dollars (\$1000)

1 nor more than fifty thousand dollars (\$50,000);

2 (2) Order the violator to cease such actions;

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

5 (4) Any combination of the above penalties.

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

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

10 **27-20.9-1. Health care contracts -- Required provisions -- Definitions.**

11 (a) On and after January 1, 2008, a health insurer that contracts with a health care provider
12 shall comply with the provisions of this chapter and shall include the provisions required by this
13 chapter in the health care contract. A contract in existence prior to January 1, 2008, that is renewed
14 or renews by its terms shall comply with the provisions of this chapter no later than December 31,
15 2008.

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

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

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

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

26 ~~(3)~~(4) "Health insurer" means every nonprofit medical service corporation, hospital service
27 corporation, health maintenance organization, or other insurer offering and/or insuring health
28 services; the term shall in addition include any entity defined as an insurer under § 42-62-4 and any
29 third-party administrator when interacting with health care providers and enrollees on behalf of
30 such an insurer.

31 (5) "Provider organization" means any corporation, partnership, business, trust,
32 association, or organized group of persons in the business of health care delivery or management
33 whether incorporated or not that represents one or more health care providers in contracting with
34 health insurers for the payments of health care services. "Provider organization" shall include, but

1 not be limited to, physician organizations, physician-hospital organizations, independent practice
2 associations, provider networks, accountable care organizations, systems of care, and any other
3 organization that contracts with health insurers for payment for health care services.

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

6 **27-20.9-4. Health care risk contracts.**

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

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

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

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

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

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

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

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

34 **42-14.5-3. Powers and duties.**

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

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

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

22 (c) To establish a consumer/business/labor/medical advisory council to obtain information
23 and present concerns of consumers, business, and medical providers affected by health-insurance
24 decisions. The council shall develop proposals to allow the market for small business health
25 insurance to be affordable and fairer. The council shall be involved in the planning and conduct of
26 the quarterly public meetings in accordance with subsection (a). The advisory council shall develop
27 measures to inform small businesses of an insurance complaint process to ensure that small
28 businesses that experience rate increases in a given year may request and receive a formal review
29 by the department. The advisory council shall assess views of the health-provider community
30 relative to insurance rates of reimbursement, billing, and reimbursement procedures, and the
31 insurers' role in promoting efficient and high-quality health care. The advisory council shall issue
32 an annual report of findings and recommendations to the governor and the general assembly and
33 present its findings at hearings before the house and senate finance committees. The advisory
34 council is to be diverse in interests and shall include representatives of community consumer

1 organizations; small businesses, other than those involved in the sale of insurance products; and
2 hospital, medical, and other health-provider organizations. Such representatives shall be nominated
3 by their respective organizations. The advisory council shall be co-chaired by the health insurance
4 commissioner and a community consumer organization or small business member to be elected by
5 the full advisory council.

6 (d) To establish and provide guidance and assistance to a subcommittee ("the professional-
7 provider-health-plan work group") of the advisory council created pursuant to subsection (c),
8 composed of health-care providers and Rhode Island licensed health plans. This subcommittee shall
9 include in its annual report and presentation before the house and senate finance committees the
10 following information:

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

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

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

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

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

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

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

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

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

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

34 (f) To provide analysis of the Rhode Island affordable health plan reinsurance fund. The

1 fund shall be used to effectuate the provisions of §§ 27-18.5-9 and 27-50-17.

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

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

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

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

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

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

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

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

34 (8) The task force shall meet as necessary and include its findings in the annual report, and

1 the commissioner shall include the information in the annual presentation before the house and
2 senate finance committees.

3 (h) To establish and convene a workgroup representing health-care providers and health
4 insurers for the purpose of coordinating the development of processes, guidelines, and standards to
5 streamline health-care administration that are to be adopted by payors and providers of health-care
6 services operating in the state. This workgroup shall include representatives with expertise who
7 would contribute to the streamlining of health-care administration and who are selected from
8 hospitals, physician practices, community behavioral-health organizations, each health insurer, and
9 other affected entities. The workgroup shall also include at least one designee each from the Rhode
10 Island Medical Society, Rhode Island Council of Community Mental Health Organizations, the
11 Rhode Island Health Center Association, and the Hospital Association of Rhode Island. The
12 workgroup shall consider and make recommendations for:

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

14 Such standard shall:

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

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

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

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

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

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

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

34 (ii) Publishing any variations from codes and mutually exclusive codes by payors in a

1 manner that makes for simple retrieval and implementation by providers;

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

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

5 (v) A standard payor-denial review process for providers when they request a
6 reconsideration of a denial of a claim that results from differences in clinical edits where no single,
7 common-standards body or process exists and multiple conflicting sources are in use by payors and
8 providers.

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

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

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

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

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

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

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

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

5 (i) To issue an anti-cancer medication report. Not later than June 30, 2014 and annually
6 thereafter, the office of the health insurance commissioner (OHIC) shall provide the senate
7 committee on health and human services, and the house committee on corporations, with: (1)
8 Information on the availability in the commercial market of coverage for anti-cancer medication
9 options; (2) For the state employee's health benefit plan, the costs of various cancer-treatment
10 options; (3) The changes in drug prices over the prior thirty-six (36) months; and (4) Member
11 utilization and cost-sharing expense.

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

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

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

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

26 (1) The impact of the current, mandated health-care benefits as defined in §§ 27-18-48.1,
27 27-18-60, 27-18-62, 27-18-64, similar provisions in chapters 19, 20 and 41, of title 27, and §§ 27-
28 18-3(c), 27-38.2-1 et seq., or others as determined by the commissioner, on the cost of health
29 insurance for fully insured employers, subject to available resources;

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

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

34 (4) Recommendations for amendments to existing mandated benefits based on the findings

1 in (m)(1), (m)(2), and (m)(3) above.

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

- 7 (1) Utilization review;
8 (2) Contracting; and
9 (3) Licensing and regulation.

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

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

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

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

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

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

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

31 (2) To establish multiple categories of health care risk contracts based on the amount of
32 risk to which the risk-bearing provider organization is exposed. The health insurance commissioner
33 may apply different standards and requirements related to health care risk contracts based on the
34 category of the relevant risk contract.

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

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

5 SECTION 5. This act shall take effect upon passage.

=====
LC000092
=====

EXPLANATION
BY THE LEGISLATIVE COUNCIL
OF

A N A C T

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

- 1 This act would provide the office of the health insurance commissioner with oversight of
- 2 risk-bearing provider organizations and health care risk contracts.
- 3 This act would take effect upon passage.

=====
LC000092
=====