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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. 2025

A N A C T

RELATING TO INSURANCE -- THIRD-PARTY HEALTH INSURANCE ADMINISTRATORS -- PRESCRIPTION DRUG COST CONTROL AND TRANSPARENCY

Introduced By: Representatives J. Lombardi, Hull, Sanchez, Cruz, Potter, Stewart, Alzate, Voas, Diaz, and Morales
Date Introduced: February 12, 2025

Referred To: House Health & Human Services

It is enacted by the General Assembly as follows:

SECTION 1. Legislative intent.

The intent of this legislation is to protect Rhode Islanders from high prescription drug costs by requiring greater pharmacy benefit manager (PBM) transparency and accountability.

SECTION 2. Section 27-20.7-12 of the General Laws in Chapter 27-20.7 entitled "Third-Party Health Insurance Administrators" is hereby amended to read as follows:

27-20.7-12. Certificate of authority required.

(a) No person shall act as, or offer to act as, or hold himself or herself out to be an administrator in this state without a valid certificate of authority as an administrator issued by the commissioner.

(b) Applicants to be an administrator shall make an application to the commissioner upon a form to be furnished by the commissioner. The application shall include or be accompanied by the following information and documents:

(1) All basic organizational documents of the administrator, including any articles of incorporation, articles of association, partnership agreement, trade name certificate, trust agreement, shareholder agreement, and other applicable documents and all amendments to those documents;

(2) The bylaws, rules, regulations, or similar documents regulating the internal affairs of the administrator;

(3) The names, addresses, official positions, and professional qualifications of the individuals who are responsible for the conduct of affairs of the administrator; including all members of the board of directors, board of trustees, executive committee, or other governing board or committee; the principal officers in the case of a corporation or the partners or members in the case of a partnership or association; shareholders holding directly or indirectly ten percent (10%) or more of the voting securities of the administrator; and any other person who exercises control or influence over the affairs of the administrator;

(4) Annual financial statements or reports for the two (2) most recent years which prove that the applicant is solvent and any information that the commissioner may require in order to review the current financial condition of the applicant;

(5) A statement describing the business plan including information on staffing levels and activities proposed in this state and nationwide. The plan must provide details setting forth the administrator's capability for providing a sufficient number of experienced and qualified personnel in the areas of claims processing, recordkeeping and underwriting;

(6) If the applicant will be managing the solicitation of new or renewal business, proof that it employs or has contracted with an agent licensed by this state for solicitation and taking of applications. An applicant that intends to directly solicit insurance contracts or to act as an insurance producer must provide proof that it has a license as an insurance producer in this state; ~~and~~

(7) Information required pursuant to §27-29.1-7; and

(8) Any other pertinent information that may be required by the commissioner.

(c) The applicant shall make available, for inspection by the commissioner, copies of all contracts with insurers or other persons utilizing the services of the administrator.

(d) The commissioner may refuse to issue a certificate of authority if the commissioner determines that the administrator, or any individual responsible for the conduct of affairs of the administrator as defined in subsection (b)(3) of this section, is not competent, trustworthy, financially responsible or of good personal and business reputation, or has had an insurance or an administrator license denied or revoked for cause by any state.

(e) A certificate of authority issued under this section shall remain valid, unless surrendered, suspended, or revoked by the commissioner, for so long as the administrator continues in business in this state and remains in compliance with this chapter.

(f) An administrator is not required to hold a certificate of authority as an administrator in this state if all of the following conditions are met:

(1) The administrator has its principal place of business in another state;

(2) The administrator is not soliciting business as an administrator in this state;

(3) In the case of any group policy or plan of insurance serviced by the administrator, the lesser of five percent (5%) or one hundred (100) certificate holders reside in this state.

(g) A person is not required to hold a certificate of authority as an administrator in this state if the person exclusively provides services to one or more bona fide employee benefit plans each of which is established by an employer or an employee organization, or both, and for which the insurance laws of this state are preempted pursuant to the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 et seq. These persons shall register with the commissioner annually, verifying their status as described in this section.

(h) An administrator shall immediately notify the commissioner of any material change in its ownership, control, or other fact or circumstance affecting its qualification for a certificate of authority in this state.

(i) No bonding shall be required by the commissioner of any administrator whose business is restricted solely to benefit plans that are either fully insured by an authorized insurer or that are bona fide employee benefit plans established by an employer or any employee organization, or both, for which the insurance laws of this state are preempted pursuant to the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 et seq.

SECTION 3. Section 27-29.1-7 of the General Laws in Chapter 27-29.1 entitled "Pharmacy Freedom of Choice — Fair Competition and Practices" is hereby amended to read as follows:

27-29.1-7. Regulation of pharmacy benefits managers.

(a) Pharmacy benefits managers shall be included within the definition of third-party administrator under chapter 20.7 of this title and shall be regulated as such. The annual report filed by third-party administrators with the department of business regulation shall include: contractual language that provides a complete description of the financial arrangements between the third-party administrator and each of the insurers covering benefit contracts delivered in Rhode Island; and if the third-party administrator is owned by or affiliated with another entity or entities, it shall include an organization chart and brief description that shows the relationships among all affiliates within a holding company or otherwise affiliated. The reporting shall be in a format required by the director and filed with the department as a public record as defined and regulated under chapter 2 of title 38.

(b) Pharmacy benefit managers shall:

(1) Cease activities that result in spread pricing, a payment model where the pharmacy benefit manager charges a health plan more than it reimburses the pharmacy for a prescription drug and retains the difference;

(2) Use pass-through pricing, a payment model where the pharmacy benefit manager

charges the health plan or insurer the same amount it reimburses the pharmacy, with no additional profit margin, and retains only a pre-determined administrative fee;

(3) Cease discriminatory treatment of non-affiliated pharmacies and pharmacists;

(4) Cease utilization management processes, including prior authorizations, step therapy, and non-medical drug switching, that delay, reduce, or prevent medically necessary care;

(5) Ensure enrollee benefits result from discounts, price reductions, or other financial incentives provided to pharmacy benefit managers by drug manufacturers including, but not limited to, rebates for formulary placements;

(6) Provide information and documents that permit enforcement of this subsection to executive office of health and human services or the office of the health insurance commissioner, upon request.

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 healthcare 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 healthcare 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 healthcare 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 copays 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 healthcare providers and health insurers for the purpose of coordinating the development of processes, guidelines, and standards to streamline healthcare administration that are to be adopted by payors and providers of healthcare services operating in the state. This workgroup shall include representatives with expertise who would contribute to the streamlining of healthcare 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. In any year that the workgroup meets and submits recommendations to the office of the health insurance commissioner, the office of the health insurance commissioner shall submit such recommendations to the health and human services committees of the Rhode Island house of representatives and the Rhode Island senate prior to the implementation of any such recommendations and subsequently shall submit a report to the general assembly by June 30, 2024. The report shall include the recommendations the commissioner may implement, with supporting rationale. 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 & 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 healthcare 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) Uniformity in the processing of claims by payors; and 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;

(v) Develop and implement the use of programs that implement selective prior authorization requirements, based on stratification of healthcare providers' performance and adherence to evidence-based medicine with the input of contracted healthcare providers and/or provider organizations. Such criteria shall be transparent and easily accessible to contracted providers. Such selective prior authorization programs shall be available when healthcare providers participate directly with the insurer in risk-based payment contracts and may be available to providers who do not participate in risk-based contracts;

(vi) Require the review of medical services, including behavioral health services, and prescription drugs, subject to prior authorization on at least an annual basis, with the input of contracted healthcare providers and/or provider organizations. Any changes to the list of medical services, including behavioral health services, and prescription drugs requiring prior authorization, shall be shared via provider-accessible websites;

(vii) Improve communication channels between health plans, healthcare providers, and

patients by:

(A) Requiring transparency and easy accessibility of prior authorization requirements, criteria, rationale, and program changes to contracted healthcare providers and patients/health plan enrollees which may be satisfied by posting to provider-accessible and member-accessible websites; and

(B) Supporting:

(I) Timely submission by healthcare providers of the complete information necessary to make a prior authorization determination, as early in the process as possible; and

(II) Timely notification of prior authorization determinations by health plans to impacted health plan enrollees, and healthcare providers, including, but not limited to, ordering providers, and/or rendering providers, and dispensing pharmacists which may be satisfied by posting to provider-accessible websites or similar electronic portals or services;

(viii) Increase and strengthen continuity of patient care by:

(A) Defining protections for continuity of care during a transition period for patients undergoing an active course of treatment, when there is a formulary or treatment coverage change or change of health plan that may disrupt their current course of treatment and when the treating physician determines that a transition may place the patient at risk; and for prescription medication by allowing a grace period of coverage to allow consideration of referred health plan options or establishment of medical necessity of the current course of treatment;

(B) Requiring continuity of care for medical services, including behavioral health services, and prescription medications for patients on appropriate, chronic, stable therapy through minimizing repetitive prior authorization requirements; and which for prescription medication shall be allowed only on an annual review, with exception for labeled limitation, to establish continued benefit of treatment; and

(C) Requiring communication between healthcare providers, health plans, and patients to facilitate continuity of care and minimize disruptions in needed treatment which may be satisfied by posting to provider-accessible websites or similar electronic portals or services;

(D) Continuity of care for formulary or drug coverage shall distinguish between FDA designated interchangeable products and proprietary or marketed versions of a medication;

(ix) Encourage healthcare providers and/or provider organizations and health plans to accelerate use of electronic prior authorization technology, including adoption of national standards where applicable; and

(x) For the purposes of subsections (h)(3)(v) through (h)(3)(x) of this section, the workgroup meeting may be conducted in part or whole through electronic methods.

(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.

(5) No provision of this subsection (h) shall preclude the ongoing work of the office of health insurance commissioner's administrative simplification task force, which includes meetings with key stakeholders in order to improve, and provide recommendations regarding, the prior authorization process.

(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 healthcare 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 healthcare 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 healthcare 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 healthcare 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 healthcare 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 healthcare 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 undertake the analyses, reports, and studies contained in this section:

(1) The office shall hire the necessary staff and prepare a request for proposal for a qualified and competent firm or firms to undertake the following analyses, reports, and studies:

(i) The firm shall undertake a comprehensive review of all social and human service programs having a contract with or licensed by the state or any subdivision of the department of

children, youth and families (DCYF), the department of behavioral healthcare, developmental disabilities and hospitals (BHDDH), the department of human services (DHS), the department of health (DOH), and Medicaid for the purposes of:

(A) Establishing a baseline of the eligibility factors for receiving services;

(B) Establishing a baseline of the service offering through each agency for those determined eligible;

(C) Establishing a baseline understanding of reimbursement rates for all social and human service programs including rates currently being paid, the date of the last increase, and a proposed model that the state may use to conduct future studies and analyses;

(D) Ensuring accurate and adequate reimbursement to social and human service providers that facilitate the availability of high-quality services to individuals receiving home and community-based long-term services and supports provided by social and human service providers;

(E) Ensuring the general assembly is provided accurate financial projections on social and human service program costs, demand for services, and workforce needs to ensure access to entitled beneficiaries and services;

(F) Establishing a baseline and determining the relationship between state government and the provider network including functions, responsibilities, and duties;

(G) Determining a set of measures and accountability standards to be used by EOHHS and the general assembly to measure the outcomes of the provision of services including budgetary reporting requirements, transparency portals, and other methods; and

(H) Reporting the findings of human services analyses and reports to the speaker of the house, senate president, chairs of the house and senate finance committees, chairs of the house and senate health and human services committees, and the governor.

(2) The analyses, reports, and studies required pursuant to this section shall be accomplished and published as follows and shall provide:

(i) An assessment and detailed reporting on all social and human service program rates to be completed by January 1, 2023, including rates currently being paid and the date of the last increase;

(ii) An assessment and detailed reporting on eligibility standards and processes of all mandatory and discretionary social and human service programs to be completed by January 1, 2023;

(iii) An assessment and detailed reporting on utilization trends from the period of January 1, 2017, through December 31, 2021, for social and human service programs to be completed by January 1, 2023;

(iv) An assessment and detailed reporting on the structure of the state government as it relates to the provision of services by social and human service providers including eligibility and functions of the provider network to be completed by January 1, 2023;

(v) An assessment and detailed reporting on accountability standards for services for social and human service programs to be completed by January 1, 2023;

(vi) An assessment and detailed reporting by April 1, 2023, on all professional licensed and unlicensed personnel requirements for established rates for social and human service programs pursuant to a contract or established fee schedule;

(vii) An assessment and reporting on access to social and human service programs, to include any wait lists and length of time on wait lists, in each service category by April 1, 2023;

(viii) An assessment and reporting of national and regional Medicaid rates in comparison to Rhode Island social and human service provider rates by April 1, 2023;

(ix) An assessment and reporting on usual and customary rates paid by private insurers and private pay for similar social and human service providers, both nationally and regionally, by April 1, 2023; and

(x) Completion of the development of an assessment and review process that includes the following components: eligibility; scope of services; relationship of social and human service provider and the state; national and regional rate comparisons and accountability standards that result in recommended rate adjustments; and this process shall be completed by September 1, 2023, and conducted biennially hereafter. The biennial rate setting shall be consistent with payment requirements established in § 1902(a)(30)(A) of the Social Security Act, 42 U.S.C. § 1396a(a)(30)(A), and all federal and state law, regulations, and quality and safety standards. The results and findings of this process shall be transparent, and public meetings shall be conducted to allow providers, recipients, and other interested parties an opportunity to ask questions and provide comment beginning in September 2023 and biennially thereafter.

(3) In fulfillment of the responsibilities defined in subsection (t), the office of the health insurance commissioner shall consult with the Executive Office of Health and Human Services.

(u) Annually, each department (namely, EOHHS, DCYF, DOH, DHS, and BHDDH) shall include the corresponding components of the assessment and review (i.e., eligibility; scope of services; relationship of social and human service provider and the state; and national and regional rate comparisons and accountability standards including any changes or substantive issues between biennial reviews) including the recommended rates from the most recent assessment and review with their annual budget submission to the office of management and budget and provide a detailed explanation and impact statement if any rate variances exist between submitted recommended

budget and the corresponding recommended rate from the most recent assessment and review process starting October 1, 2023, and biennially thereafter.

(v) The office of health insurance commissioner shall promulgate rules and regulations, and employ staff and independent contractors familiar with pharmacy benefit managers' operations and finances, to implement and enforce the provisions of § 27-29.1-7(b) and may impose civil fines up to ten thousand dollars ($10,000) per violation, or take any other enforcement action not prohibited by law. This section does not limit the attorney general from taking any actions against pharmacy benefit managers. Should any provision of this section be found unconstitutional, preempted, or otherwise invalid, that provision shall be severed and such decision shall not affect the validity of other parts of this section. OHIC shall consult with the EOHHS, the commissioner of insurance, the department of business regulation, and other state authorities to ensure effective pharmacy benefit manager oversight.

~~(v)~~(w) The general assembly shall appropriate adequate funding as it deems necessary to undertake the analyses, reports, and studies contained in this section relating to the powers and duties of the office of the health insurance commissioner.

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 INSURANCE -- THIRD-PARTY HEALTH INSURANCE ADMINISTRATORS -- PRESCRIPTION DRUG COST CONTROL AND TRANSPARENCY

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This act would provide certain controls over prescription drug costs by imposing transparency, oversight and accountability requirements on commercial insurers and their pharmacy benefit managers (PBMs).

This act would take effect upon passage.

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