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LC001754

STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2025

A N A C T

RELATING TO STATE AFFAIRS AND GOVERNMENT -- THE RHODE ISLAND HEALTH CARE REFORM ACT OF 2004 -- HEALTH INSURANCE OVERSIGHT

Introduced By: Representatives Tanzi, Fogarty, McEntee, Spears, Morales, Read, Hopkins, Alzate, Boylan, and Furtado

Date Introduced: February 28, 2025

Referred To: House Corporations

It is enacted by the General Assembly as follows:

1 SECTION 1. Section 42-14.5-3 of the General Laws in Chapter 42-14.5 entitled "The  
2 Rhode Island Health Care Reform Act of 2004 — Health Insurance Oversight" is hereby amended  
3 to read as follows:

4 **42-14.5-3. Powers and duties.**

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

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

15 (b) To make recommendations to the governor and the house of representatives and senate  
16 finance committees regarding healthcare insurance and the regulations, rates, services,  
17 administrative expenses, reserve requirements, and operations of insurers providing health  
18 insurance in the state, and to prepare or comment on, upon the request of the governor or

1 chairpersons of the house or senate finance committees, draft legislation to improve the regulation  
2 of health insurance. In making the recommendations, the commissioner shall recognize that it is  
3 the intent of the legislature that the maximum disclosure be provided regarding the reasonableness  
4 of individual administrative expenditures as well as total administrative costs. The commissioner  
5 shall make recommendations on the levels of reserves, including consideration of: targeted reserve  
6 levels; trends in the increase or decrease of reserve levels; and insurer plans for distributing excess  
7 reserves.

8 (c) To establish a consumer/business/labor/medical advisory council to obtain information  
9 and present concerns of consumers, business, and medical providers affected by health insurance  
10 decisions. The council shall develop proposals to allow the market for small business health  
11 insurance to be affordable and fairer. The council shall be involved in the planning and conduct of  
12 the quarterly public meetings in accordance with subsection (a). The advisory council shall develop  
13 measures to inform small businesses of an insurance complaint process to ensure that small  
14 businesses that experience rate increases in a given year may request and receive a formal review  
15 by the department. The advisory council shall assess views of the health provider community  
16 relative to insurance rates of reimbursement, billing, and reimbursement procedures, and the  
17 insurers' role in promoting efficient and high-quality health care. The advisory council shall issue  
18 an annual report of findings and recommendations to the governor and the general assembly and  
19 present its findings at hearings before the house and senate finance committees. The advisory  
20 council is to be diverse in interests and shall include representatives of community consumer  
21 organizations; small businesses, other than those involved in the sale of insurance products; and  
22 hospital, medical, and other health provider organizations. Such representatives shall be nominated  
23 by their respective organizations. The advisory council shall be co-chaired by the health insurance  
24 commissioner and a community consumer organization or small business member to be elected by  
25 the full advisory council.

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

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

33 (2) A standardized provider application and credentials verification process, for the  
34 purpose of verifying professional qualifications of participating healthcare providers;

- 1 (3) The uniform health plan claim form utilized by participating providers;
- 2 (4) Methods for health maintenance organizations, as defined by § 27-41-2, and nonprofit  
3 hospital or medical service corporations, as defined by chapters 19 and 20 of title 27, to make  
4 facility-specific data and other medical service-specific data available in reasonably consistent  
5 formats to patients regarding quality and costs. This information would help consumers make  
6 informed choices regarding the facilities and clinicians or physician practices at which to seek care.  
7 Among the items considered would be the unique health services and other public goods provided  
8 by facilities and clinicians or physician practices in establishing the most appropriate cost  
9 comparisons;
- 10 (5) All activities related to contractual disclosure to participating providers of the  
11 mechanisms for resolving health plan/provider disputes;
- 12 (6) The uniform process being utilized for confirming, in real time, patient insurance  
13 enrollment status, benefits coverage, including copays and deductibles;
- 14 (7) Information related to temporary credentialing of providers seeking to participate in the  
15 plan's network and the impact of the activity on health plan accreditation;
- 16 (8) The feasibility of regular contract renegotiations between plans and the providers in  
17 their networks; and
- 18 (9) Efforts conducted related to reviewing impact of silent PPOs on physician practices.
- 19 (e) To enforce the provisions of title 27 and title 42 as set forth in § 42-14-5(d).
- 20 (f) To provide analysis of the Rhode Island affordable health plan reinsurance fund. The  
21 fund shall be used to effectuate the provisions of §§ 27-18.5-9 and 27-50-17.
- 22 (g) To analyze the impact of changing the rating guidelines and/or merging the individual  
23 health insurance market, as defined in chapter 18.5 of title 27, and the small-employer health  
24 insurance market, as defined in chapter 50 of title 27, in accordance with the following:
- 25 (1) The analysis shall forecast the likely rate increases required to effect the changes  
26 recommended pursuant to the preceding subsection (g) in the direct-pay market and small-employer  
27 health insurance market over the next five (5) years, based on the current rating structure and  
28 current products.
- 29 (2) The analysis shall include examining the impact of merging the individual and small-  
30 employer markets on premiums charged to individuals and small-employer groups.
- 31 (3) The analysis shall include examining the impact on rates in each of the individual and  
32 small-employer health insurance markets and the number of insureds in the context of possible  
33 changes to the rating guidelines used for small-employer groups, including: community rating  
34 principles; expanding small-employer rate bonds beyond the current range; increasing the employer

1 group size in the small-group market; and/or adding rating factors for broker and/or tobacco use.

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

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

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

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

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

22 (h) To establish and convene a workgroup representing healthcare providers and health  
23 insurers for the purpose of coordinating the development of processes, guidelines, and standards to  
24 streamline healthcare administration that are to be adopted by payors and providers of healthcare  
25 services operating in the state. This workgroup shall include representatives with expertise who  
26 would contribute to the streamlining of healthcare administration and who are selected from  
27 hospitals, physician practices, community behavioral health organizations, each health insurer, and  
28 other affected entities. The workgroup shall also include at least one designee each from the Rhode  
29 Island Medical Society, Rhode Island Council of Community Mental Health Organizations, the  
30 Rhode Island Health Center Association, and the Hospital Association of Rhode Island. In any year  
31 that the workgroup meets and submits recommendations to the office of the health insurance  
32 commissioner, the office of the health insurance commissioner shall submit such recommendations  
33 to the health and human services committees of the Rhode Island house of representatives and the  
34 Rhode Island senate prior to the implementation of any such recommendations and subsequently

1 shall submit a report to the general assembly by June 30, 2024. The report shall include the  
2 recommendations the commissioner may implement, with supporting rationale. The workgroup  
3 shall consider and make recommendations for:

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

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

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

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

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

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

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

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

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

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

29 (iv) Uniformity in the processing of claims by payors; and the processing of corrections to  
30 claims by providers and payors;

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

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

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

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

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

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

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

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

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

34 (vi) Require the review of medical services, including behavioral health services, and

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

5 (vii) Improve communication channels between health plans, healthcare providers, and  
6 patients by:

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

11 (B) Supporting:

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

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

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

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

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

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

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

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

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

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

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

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

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

25 (k) To monitor the transition from fee-for-service and toward global and other alternative  
26 payment methodologies for the payment for healthcare services. Alternative payment  
27 methodologies should be assessed for their likelihood to promote access to affordable health  
28 insurance, health outcomes, and performance. To ensure that population-based contracts shall  
29 include a provision that agrees on a budget for each contract year, review and prior approval by the  
30 office of the health insurance commissioner shall be required if any annual increase in the total cost  
31 of care for services reimbursed under the contract, after risk adjustment, exceeds the Consumer  
32 Price Index for all Urban Consumers (CPI-U) percentage increase (reported by the commissioner  
33 by October 1 of each year, in accordance with established regulations). Such percentage increase  
34 shall be plus three and one-half percent (3.5%) beginning October 1, 2025 and ending on September



1 [30, 2028.](#)

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

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

8 (1) The impact of the current, mandated healthcare benefits as defined in §§ 27-18-48.1,  
9 27-18-60, 27-18-62, 27-18-64, similar provisions in chapters 19, 20 and 41 of title 27, and §§ 27-  
10 18-3(c), 27-38.2-1 et seq., or others as determined by the commissioner, on the cost of health  
11 insurance for fully insured employers, subject to available resources;

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

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

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

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

23 (1) Utilization review;

24 (2) Contracting; and

25 (3) Licensing and regulation.

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

30 (p) To work to ensure the health insurance coverage of behavioral health care under the  
31 same terms and conditions as other health care, and to integrate behavioral health parity  
32 requirements into the office of the health insurance commissioner insurance oversight and  
33 healthcare transformation efforts.

34 (q) To work with other state agencies to seek delivery system improvements that enhance

1 access to a continuum of mental health and substance use disorder treatment in the state; and  
2 integrate that treatment with primary and other medical care to the fullest extent possible.

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

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

8 (t) To undertake the analyses, reports, and studies contained in this section:

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

11 (i) The firm shall undertake a comprehensive review of all social and human service  
12 programs having a contract with or licensed by the state or any subdivision of the department of  
13 children, youth and families (DCYF), the department of behavioral healthcare, developmental  
14 disabilities and hospitals (BHDDH), the department of human services (DHS), the department of  
15 health (DOH), and Medicaid for the purposes of:

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

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

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

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

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

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

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

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

1 senate health and human services committees, and the governor.

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

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

7 (ii) An assessment and detailed reporting on eligibility standards and processes of all  
8 mandatory and discretionary social and human service programs to be completed by January 1,  
9 2023;

10 (iii) An assessment and detailed reporting on utilization trends from the period of January  
11 1, 2017, through December 31, 2021, for social and human service programs to be completed by  
12 January 1, 2023;

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

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

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

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

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

25 (ix) An assessment and reporting on usual and customary rates paid by private insurers and  
26 private pay for similar social and human service providers, both nationally and regionally, by April  
27 1, 2023; and

28 (x) Completion of the development of an assessment and review process that includes the  
29 following components: eligibility; scope of services; relationship of social and human service  
30 provider and the state; national and regional rate comparisons and accountability standards that  
31 result in recommended rate adjustments; and this process shall be completed by September 1, 2023,  
32 and conducted biennially hereafter. The biennial rate setting shall be consistent with payment  
33 requirements established in § 1902(a)(30)(A) of the Social Security Act, 42 U.S.C. §  
34 1396a(a)(30)(A), and all federal and state law, regulations, and quality and safety standards. The

1 results and findings of this process shall be transparent, and public meetings shall be conducted to  
2 allow providers, recipients, and other interested parties an opportunity to ask questions and provide  
3 comment beginning in September 2023 and biennially thereafter.

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

6 (u) Annually, each department (namely, EOHHS, DCYF, DOH, DHS, and BHDDH) shall  
7 include the corresponding components of the assessment and review (i.e., eligibility; scope of  
8 services; relationship of social and human service provider and the state; and national and regional  
9 rate comparisons and accountability standards including any changes or substantive issues between  
10 biennial reviews) including the recommended rates from the most recent assessment and review  
11 with their annual budget submission to the office of management and budget and provide a detailed  
12 explanation and impact statement if any rate variances exist between submitted recommended  
13 budget and the corresponding recommended rate from the most recent assessment and review  
14 process starting October 1, 2023, and biennially thereafter.

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

18 (w) To ensure that hospital contracts shall include a provision that agrees on rates for each  
19 contract year, review and prior approval by the office of the health insurance commissioner shall  
20 be required if the average rate increase including estimated quality incentive payments is greater  
21 than the Consumer Price Index for all Urban Consumers (CPI-U) percentage increase (reported by  
22 the commissioner by October 1 each year, in accordance with established regulations). Such  
23 percentage increase shall be plus three percent (3%) beginning October 1, 2025 and ending on  
24 September 30, 2028.

25 SECTION 2. This act shall take effect upon passage.

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EXPLANATION  
BY THE LEGISLATIVE COUNCIL  
OF

A N A C T

RELATING TO STATE AFFAIRS AND GOVERNMENT -- THE RHODE ISLAND HEALTH  
CARE REFORM ACT OF 2004 -- HEALTH INSURANCE OVERSIGHT

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1           This act would amend the powers and duties of the office of the health insurance  
2 commissioner (OHIC) to review and grant prior approval to payment of healthcare services and  
3 hospital contracts, if any annual increase in the total cost of care for services reimbursed and  
4 hospital contracts after risk adjustment exceeds the Consumer Price Index for all Urban Consumers  
5 (CPI-U) percentage increase.

6           This act would take effect upon passage.

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