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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 -- BENEFIT DETERMINATION AND UTILIZATION ACT

Introduced By: Representatives Ackerman, Potter, McNamara, Edwards, Donovan, and Shallcross Smith
Date Introduced: May 09, 2025

Referred To: House Health & Human Services

(Attorney General)

It is enacted by the General Assembly as follows:

SECTION 1. Section 27-18.9-2 of the General Laws in Chapter 27-18.9 entitled "Benefit Determination and Utilization Review Act" is hereby amended to read as follows:

27-18.9-2. Definitions.

As used in this chapter, the following terms are defined as follows:

(1) “Adverse benefit determination” means a decision not to authorize a healthcare service, including a denial, reduction, or termination of, or a failure to provide or make a payment, in whole or in part, for a benefit. A decision by a utilization-review agent to authorize a healthcare service in an alternative setting, a modified extension of stay, or an alternative treatment shall not constitute an adverse determination if the review agent and provider are in agreement regarding the decision. Adverse benefit determinations include:

(i) “Administrative adverse benefit determinations,” meaning any adverse benefit determination that does not require the use of medical judgment or clinical criteria such as a determination of an individual’s eligibility to participate in coverage, a determination that a benefit is not a covered benefit, or any rescission of coverage; and

(ii) “Non-administrative adverse benefit determinations,” meaning any adverse benefit determination that requires or involves the use of medical judgement or clinical criteria to determine whether the service being reviewed is medically necessary and/or appropriate. This includes the denial of treatments determined to be experimental or investigational, and any denial of coverage of a prescription drug because that drug is not on the healthcare entity’s formulary.

(2) “Appeal” or “internal appeal” means a subsequent review of an adverse benefit determination upon request by a claimant to include the beneficiary or provider to reconsider all or part of the original adverse benefit determination.

(3) “Authorization” means a review by a review agent, performed according to this chapter, concluding that the allocation of healthcare services ordered by a provider, given or proposed to be given to a beneficiary, was approved or authorized.

(4) “Authorized representative” means an individual acting on behalf of the beneficiary and shall include: the ordering provider; any individual to whom the beneficiary has given express written consent to act on his or her behalf; a person authorized by law to provide substituted consent for the beneficiary; and, when the beneficiary is unable to provide consent, a family member of the beneficiary.

(5) “Beneficiary” means a policy-holder subscriber, enrollee, or other individual participating in a health-benefit plan.

(6) “Benefit determination” means a decision to approve or deny a request to provide or make payment for a healthcare service or treatment.

(7) “Certificate” means a certificate granted by the commissioner to a review agent meeting the requirements of this chapter.

(8) “Claim” means a request for plan benefit(s) made by a claimant in accordance with the healthcare entity’s reasonable procedures for filing benefit claims. This shall include pre-service, concurrent, and post-service claims.

(9) “Claimant” means a healthcare entity participant, beneficiary, and/or authorized representative who makes a request for plan benefit(s).

(10) “Commissioner” means the health insurance commissioner.

(11) “Complaint” means an oral or written expression of dissatisfaction by a beneficiary, authorized representative, or a provider. The appeal of an adverse benefit determination is not considered a complaint.

(12) “Concurrent assessment” means an assessment of healthcare services conducted during a beneficiary’s hospital stay, course of treatment or services over a period of time, or for the number of treatments. If the medical problem is ongoing, this assessment may include the review of services after they have been rendered and billed.

(13) “Concurrent claim” means a request for a plan benefit(s) by a claimant that is for an ongoing course of treatment or services over a period of time or for the number of treatments.

(14) “Delegate” means a person or entity authorized pursuant to a delegation of authority or re-delegation of authority, by a healthcare entity or network plan to perform one or more of the

functions and responsibilities of a healthcare entity and/or network plan set forth in this chapter or regulations or guidance promulgated thereunder.

(15) “Emergency services” or “emergent services” means those resources provided in the event of the sudden onset of a medical, behavioral health, or other health condition that the absence of immediate medical attention could reasonably be expected, by a prudent layperson, to result in placing the patient’s health in serious jeopardy, serious impairment to bodily or mental functions, or serious dysfunction of any bodily organ or part.

(16) “External review” means a review of a non-administrative adverse benefit determination (including final internal adverse benefit determination) conducted pursuant to an applicable external review process performed by an independent review organization.

(17) “External review decision” means a determination by an independent review organization at the conclusion of the external review.

(18) “Final internal adverse benefit determination” means an adverse benefit determination that has been upheld by a plan or issuer at the completion of the internal appeals process or when the internal appeals process has been deemed exhausted as defined in § 27-18.9-7(b)(1).

(19) “Health-benefit plan” or “health plan” means a policy, contract, certificate, or agreement entered into, offered, or issued by a healthcare entity to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services.

(20) “Healthcare entity” means an insurance company licensed, or required to be licensed, by the state of Rhode Island or other entity subject to the jurisdiction of the commissioner or the jurisdiction of the department of business regulation pursuant to chapter 62 of title 42, that contracts or offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services, including, without limitation: a for-profit or nonprofit hospital, medical or dental service corporation or plan, a health maintenance organization, a health insurance company, or any other entity providing a plan of health insurance, accident and sickness insurance, health benefits, or healthcare services.

(21) “Healthcare services” means and includes, but is not limited to: an admission, diagnostic procedure, therapeutic procedure, treatment, extension of stay, the ordering and/or filling of formulary or non-formulary medications, and any other medical, behavioral, dental, vision care services, activities, or supplies that are covered by the beneficiary’s health-benefit plan.

(22) “Independent review organization” or “IRO” means an entity that conducts independent external reviews of adverse benefit determinations or final internal adverse benefit determinations.

(23) “Insurer”, for the purposes of § 27-18.9-16, means all insurance companies licensed

to do business in Rhode Island, including those subject to chapter 1 of title 27 ("domestic insurance companies"), a foreign insurance company licensed to do business in Rhode Island and subject to chapter 2 of title 27 ("foreign insurance companies"), a health insurance carrier subject and organized pursuant to chapter 18 of title 27 ("accident and sickness insurance policies"), a nonprofit hospital service corporation subject and organized pursuant to chapter 19 of title 27 ("nonprofit hospital service corporations"), a nonprofit medical services corporation subject and organized pursuant to chapter 20 of title 27 ("nonprofit medical service corporations"), a qualified health maintenance organization subject and organized pursuant to chapter 41 of title 27 ("health maintenance organizations"), and Medicaid Managed Care Organizations.

(24) "Network" means the group or groups of participating providers providing healthcare services under a network plan.

~~(24)~~(25) "Network plan" means a health-benefit plan or health plan that either requires a beneficiary to use, or creates incentives, including financial incentives, for a beneficiary to use the providers managed, owned, under contract with, or employed by the healthcare entity.

~~(25)~~(26) "Office" means the office of the health insurance commissioner.

~~(26)~~(27) "Pre-service claim" means the request for a plan benefit(s) by a claimant prior to a service being rendered and is not considered a concurrent claim.

(28) "Primary care provider (PCP)", for the purposes of § 27-18.9-16, means internal medicine physicians, family medicine physicians, pediatricians, geriatricians, OB-GYNs, nurse practitioners, certified nurse midwives, and physician's assistants.

(29) "Prior authorization and other utilization review", for the purposes of § 27-18.9-16, means the approval a primary care provider is required by an insurer to obtain from an insurer or pharmacy benefit manager for healthcare to be covered for a patient, in accordance with the definition of utilization review in this section.

~~(27)~~(30) "Professional provider" means an individual provider or healthcare professional licensed, accredited, or certified to perform specified healthcare services consistent with state law and who provides healthcare services and is not part of a separate facility or institutional contract.

~~(28)~~(31) "Prospective assessment" or "pre-service assessment" means an assessment of healthcare services prior to services being rendered.

~~(29)~~(32) "Provider" means a physician, hospital, professional provider, pharmacy, laboratory, dental, medical, or behavioral health provider or other state-licensed or other state-recognized provider of health care or behavioral health services or supplies.

~~(30)~~(33) "Retrospective assessment" or "post-service assessment" means an assessment of healthcare services that have been rendered. This shall not include reviews conducted when the

review agency has been obtaining ongoing information.

~~(31)~~(34) "Retrospective claim" or "post-service claim" means any claim for a health-plan benefit that is not a pre-service or concurrent claim.

~~(32)~~(35) "Review agent" means a person or healthcare entity performing benefit determination reviews that is either employed by, affiliated with, under contract with, or acting on behalf of a healthcare entity.

~~(33)~~(36) "Same or similar specialty" means a practitioner who has the appropriate training and experience that is the same or similar as the attending provider in addition to experience in treating the same problems to include any potential complications as those under review.

~~(34)~~(37) "Therapeutic interchange" means the interchange or substitution of a drug with a dissimilar chemical structure within the same therapeutic or pharmacological class that can be expected to have similar outcomes and similar adverse reaction profiles when given in equivalent doses, in accordance with protocols approved by the president of the medical staff or medical director and the director of pharmacy.

~~(35)~~(38) "Tiered network" means a network that identifies and groups some or all types of providers into specific groups to which different provider reimbursement, beneficiary cost-sharing, or provider access requirements, or any combination thereof, apply for the same services.

~~(36)~~(39) "Urgent healthcare services" includes those resources necessary to treat a symptomatic medical, mental health, substance use, or other healthcare condition that a prudent layperson, acting reasonably, would believe necessitates treatment within a twenty-four hour (24) period of the onset of such a condition in order that the patient's health status not decline as a consequence. This does not include those conditions considered to be emergent healthcare services as defined in this section.

~~(37)~~(40) "Utilization review" means the prospective, concurrent, or retrospective assessment of the medical necessity and/or appropriateness of the allocation of healthcare services of a provider, given or proposed to be given, to a beneficiary. Utilization review does not include:

(i) The therapeutic interchange of drugs or devices by a pharmacy operating as part of a licensed inpatient healthcare facility; or

(ii) The assessment by a pharmacist licensed pursuant to the provisions of chapter 19.1 of title 5, and practicing in a pharmacy operating as part of a licensed inpatient healthcare facility, in the interpretation, evaluation and implementation of medical orders, including assessments and/or comparisons involving formularies and medical orders.

~~(38)~~(41) "Utilization review plan" means a description of the standards governing utilization review activities performed by a review agent.

SECTION 2. Chapter 27-18.9 of the General Laws entitled "Benefit Determination and Utilization Review Act" is hereby amended by adding thereto the following section:

27-18.9-16. Limitations on prior authorization for primary care.

(a) Except as provided in subsection (b) of this section, an insurer shall not impose any prior authorization requirement for any admission, item, service, treatment, test, exam, study, procedure, or any generic or brand name prescription drug ordered by a primary care provider.

(b) The prohibition set forth in subsection (a) of this section shall not be construed to prohibit prior authorization requirements for controlled substances, or for individual primary care providers after documented cases of fraud, waste or abuse by the Centers of Medicare and Medicaid Services.

(c) Notwithstanding any other provision of law to the contrary, in order to establish uniformity in the submission of prior authorization forms, on or after January 1, 2026, any issuer issuing any lawful prior authorization shall use only a single, standardized prior authorization form, in accordance with the following requirements:

(1) Except as otherwise allowable by federal law, the form shall not exceed two (2) pages in length, excluding any instructions or guiding documentation;

(2) The form shall be made available electronically, and the prescribing provider may submit the completed form electronically to the health benefit plan;

(3) In order to lower burden on providers, all insurers must create an online payor portal to allow for online submission of the standardized form. These online portals must contain all relevant prior authorization information, including access to the standardized form, to allow providers to fill out and submit the form online. These portals must be accessible to providers by January 1, 2026; and

(4) The issuer must submit its prior authorization form to the office of the health insurance commissioner to be kept on file on January 1, 2026. A copy of any subsequent replacements or modifications of a health insurance issuer's prior authorization form shall be filed with the office of the health insurance commissioner. The office of the health insurance commissioner may promulgate rules and regulations to further standardize and reduce the burden of prior authorization on providers.

SECTION 3. Section 42-7.2-5 of the General Laws in Chapter 42-7.2 entitled "Office of Health and Human Services" is hereby amended to read as follows:

42-7.2-5. Duties of the secretary.

The secretary shall be subject to the direction and supervision of the governor for the oversight, coordination, and cohesive direction of state-administered health and human services

and in ensuring the laws are faithfully executed, notwithstanding any law to the contrary. In this capacity, the secretary of the executive office of health and human services (EOHHS) shall be authorized to:

(1) Coordinate the administration and financing of healthcare benefits, human services, and programs including those authorized by the state's Medicaid section 1115 demonstration waiver and, as applicable, the Medicaid state plan under Title XIX of the U.S. Social Security Act. However, nothing in this section shall be construed as transferring to the secretary the powers, duties, or functions conferred upon the departments by Rhode Island public and general laws for the administration of federal/state programs financed in whole or in part with Medicaid funds or the administrative responsibility for the preparation and submission of any state plans, state plan amendments, or authorized federal waiver applications, once approved by the secretary.

(2) Serve as the governor's chief advisor and liaison to federal policymakers on Medicaid reform issues as well as the principal point of contact in the state on any such related matters.

(3)(i) Review and ensure the coordination of the state's Medicaid section 1115 demonstration waiver requests and renewals as well as any initiatives and proposals requiring amendments to the Medicaid state plan or formal amendment changes, as described in the special terms and conditions of the state's Medicaid section 1115 demonstration waiver with the potential to affect the scope, amount, or duration of publicly funded healthcare services, provider payments or reimbursements, or access to or the availability of benefits and services as provided by Rhode Island general and public laws. The secretary shall consider whether any such changes are legally and fiscally sound and consistent with the state's policy and budget priorities. The secretary shall also assess whether a proposed change is capable of obtaining the necessary approvals from federal officials and achieving the expected positive consumer outcomes. Department directors shall, within the timelines specified, provide any information and resources the secretary deems necessary in order to perform the reviews authorized in this section.

(ii) Direct the development and implementation of any Medicaid policies, procedures, or systems that may be required to assure successful operation of the state's health and human services integrated eligibility system and coordination with HealthSource RI, the state's health insurance marketplace.

(iii) Beginning in 2015, conduct on a biennial basis a comprehensive review of the Medicaid eligibility criteria for one or more of the populations covered under the state plan or a waiver to ensure consistency with federal and state laws and policies, coordinate and align systems, and identify areas for improving quality assurance, fair and equitable access to services, and opportunities for additional financial participation.

(iv) Implement service organization and delivery reforms that facilitate service integration, increase value, and improve quality and health outcomes.

(4) Beginning in 2020, prepare and submit to the governor, the chairpersons of the house and senate finance committees, the caseload estimating conference, and to the joint legislative committee for health-care oversight, by no later than September 15 of each year, a comprehensive overview of all Medicaid expenditures outcomes, administrative costs, and utilization rates. The overview shall include, but not be limited to, the following information:

(i) Expenditures under Titles XIX and XXI of the Social Security Act, as amended;

(ii) Expenditures, outcomes, and utilization rates by population and sub-population served (e.g., families with children, persons with disabilities, children in foster care, children receiving adoption assistance, adults ages nineteen (19) to sixty-four (64), and elders);

(iii) Expenditures, outcomes, and utilization rates by each state department or other municipal or public entity receiving federal reimbursement under Titles XIX and XXI of the Social Security Act, as amended;

(iv) Expenditures, outcomes, and utilization rates by type of service and/or service provider;

(v) Expenditures by mandatory population receiving mandatory services and, reported separately, optional services, as well as optional populations receiving mandatory services and, reported separately, optional services for each state agency receiving Title XIX and XXI funds; and

(vi) Information submitted to the Centers for Medicare & Medicaid Services for the mandatory annual state reporting of the Core Set of Children's Health Care Quality Measures for Medicaid and Children's Health Insurance Program, behavioral health measures on the Core Set of Adult Health Care Quality Measures for Medicaid and the Core Sets of Health Home Quality Measures for Medicaid to ensure compliance with the Bipartisan Budget Act of 2018, Pub. L. No. 115-123.

The directors of the departments, as well as local governments and school departments, shall assist and cooperate with the secretary in fulfilling this responsibility by providing whatever resources, information and support shall be necessary.

(5) Resolve administrative, jurisdictional, operational, program, or policy conflicts among departments and their executive staffs and make necessary recommendations to the governor.

(6) Ensure continued progress toward improving the quality, the economy, the accountability, and the efficiency of state-administered health and human services. In this capacity, the secretary shall:

(i) Direct implementation of reforms in the human resources practices of the executive

office and the departments that streamline and upgrade services, achieve greater economies of scale and establish the coordinated system of the staff education, cross-training, and career development services necessary to recruit and retain a highly-skilled, responsive, and engaged health and human services workforce;

(ii) Encourage EOHHS-wide consumer-centered approaches to service design and delivery that expand their capacity to respond efficiently and responsibly to the diverse and changing needs of the people and communities they serve;

(iii) Develop all opportunities to maximize resources by leveraging the state's purchasing power, centralizing fiscal service functions related to budget, finance, and procurement, centralizing communication, policy analysis and planning, and information systems and data management, pursuing alternative funding sources through grants, awards, and partnerships and securing all available federal financial participation for programs and services provided EOHHS-wide;

(iv) Improve the coordination and efficiency of health and human services legal functions by centralizing adjudicative and legal services and overseeing their timely and judicious administration;

(v) Facilitate the rebalancing of the long-term system by creating an assessment and coordination organization or unit for the expressed purpose of developing and implementing procedures EOHHS-wide that ensure that the appropriate publicly funded health services are provided at the right time and in the most appropriate and least restrictive setting;

(vi) Strengthen health and human services program integrity, quality control and collections, and recovery activities by consolidating functions within the office in a single unit that ensures all affected parties pay their fair share of the cost of services and are aware of alternative financing;

(vii) Assure protective services are available to vulnerable elders and adults with developmental and other disabilities by reorganizing existing services, establishing new services where gaps exist, and centralizing administrative responsibility for oversight of all related initiatives and programs.

(7) Prepare and integrate comprehensive budgets for the health and human services departments and any other functions and duties assigned to the office. The budgets shall be submitted to the state budget office by the secretary, for consideration by the governor, on behalf of the state's health and human services agencies in accordance with the provisions set forth in § 35-3-4.

(8) Utilize objective data to evaluate health and human services policy goals, resource use

and outcome evaluation and to perform short and long-term policy planning and development.

(9) Establishment of an integrated approach to interdepartmental information and data management that complements and furthers the goals of the unified health infrastructure project initiative and that will facilitate the transition to a consumer-centered integrated system of state-administered health and human services.

(10) At the direction of the governor or the general assembly, conduct independent reviews of state-administered health and human services programs, policies and related agency actions and activities and assist the department directors in identifying strategies to address any issues or areas of concern that may emerge thereof. The department directors shall provide any information and assistance deemed necessary by the secretary when undertaking such independent reviews.

(11) Provide regular and timely reports to the governor and make recommendations with respect to the state's health and human services agenda.

(12) Employ such personnel and contract for such consulting services as may be required to perform the powers and duties lawfully conferred upon the secretary.

(13) Assume responsibility for complying with the provisions of any general or public law or regulation related to the disclosure, confidentiality, and privacy of any information or records, in the possession or under the control of the executive office or the departments assigned to the executive office, that may be developed or acquired or transferred at the direction of the governor or the secretary for purposes directly connected with the secretary's duties set forth herein.

(14) Hold the director of each health and human services department accountable for their administrative, fiscal, and program actions in the conduct of the respective powers and duties of their agencies.

(15) Identify opportunities for inclusion with the EOHHS' October 1, 2023 budget submission, to remove fixed eligibility thresholds for programs under its purview by establishing sliding scale decreases in benefits commensurate with income increases up to four hundred fifty percent (450%) of the federal poverty level. These shall include but not be limited to, medical assistance, childcare assistance, and food assistance.

(16) Ensure that insurers minimize administrative burdens on providers that may delay medically necessary care, including requiring that insurers do not impose a prior authorization or other utilization management review requirement for any admission, item, service, treatment, test, exam, study procedure, or any generic or brand name prescription drug ordered by an in-network primary care provider; provided, however, the prohibition shall not be construed to prohibit prior authorization requirements for controlled substances. Provided further, that as used in this section, the terms "insurer," "primary care provider," and "prior authorization and other utilization

management" means the same as those terms are defined in § 27-18.9-2.

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 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.

(w) Ensure that insurers minimize administrative burdens that may delay medically necessary care, including by promulgating rules and regulations and taking enforcement actions to implement § 27-18.9-16.

SECTION 5. This act shall take effect on January 1, 2026.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N A C T

RELATING TO INSURANCE -- BENEFIT DETERMINATION AND UTILIZATION ACT

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This act would prohibit an insurer from imposing a requirement of prior authorization for any admission, item, service, treatment, test, exam, study, procedure, or any generic or brand name prescription drug ordered by a primary care provider unless it was a requirement for controlled substances, or individual primary care providers with documented cases of fraud, waste or abuse. The act would also require any issuer issuing any lawful prior authorization to use a single, standardized prior authorization form.

This act would take effect on January 1, 2026.

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