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STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2025

A N A C T

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

Introduced By: Senators Ujifusa, Burke, Lawson, Bell, Quezada, Murray, Mack, Acosta,
DiMario, and Lauria

Date Introduced: February 10, 2025

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

1 SECTION 1. Legislative intent.

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

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

6 **27-20.7-12. Certificate of authority required.**

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

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

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

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

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

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

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

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

19 (7) [Information required pursuant to §27-29.1-7; and](#)

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

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

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

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

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

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

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

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

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

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

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

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

19 **27-29.1-7. Regulation of pharmacy benefits managers.**

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

30 (b) Pharmacy benefit managers shall:

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

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

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

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

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

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

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

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

15 **42-14.5-3. Powers and duties.**

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

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

26 (b) To make recommendations to the governor and the house of representatives and senate
27 finance committees regarding healthcare insurance and the regulations, rates, services,
28 administrative expenses, reserve requirements, and operations of insurers providing health
29 insurance in the state, and to prepare or comment on, upon the request of the governor or
30 chairpersons of the house or senate finance committees, draft legislation to improve the regulation
31 of health insurance. In making the recommendations, the commissioner shall recognize that it is
32 the intent of the legislature that the maximum disclosure be provided regarding the reasonableness
33 of individual administrative expenditures as well as total administrative costs. The commissioner
34 shall make recommendations on the levels of reserves, including consideration of: targeted reserve

1 levels; trends in the increase or decrease of reserve levels; and insurer plans for distributing excess
2 reserves.

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

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

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

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

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

31 (4) Methods for health maintenance organizations, as defined by § 27-41-2, and nonprofit
32 hospital or medical service corporations, as defined by chapters 19 and 20 of title 27, to make
33 facility-specific data and other medical service-specific data available in reasonably consistent
34 formats to patients regarding quality and costs. This information would help consumers make

1 informed choices regarding the facilities and clinicians or physician practices at which to seek care.
2 Among the items considered would be the unique health services and other public goods provided
3 by facilities and clinicians or physician practices in establishing the most appropriate cost
4 comparisons;

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

7 (6) The uniform process being utilized for confirming, in real time, patient insurance
8 enrollment status, benefits coverage, including copays and deductibles;

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

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

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

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

15 (f) To provide analysis of the Rhode Island affordable health plan reinsurance fund. The
16 fund shall be used to effectuate the provisions of §§ 27-18.5-9 and 27-50-17.

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

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

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

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

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

34 (5) The analysis shall include assessment of possible reinsurance mechanisms and/or

1 federal high-risk pool structures and funding to support the health insurance market in Rhode Island
2 by reducing the risk of adverse selection and the incremental insurance premiums charged for this
3 risk, and/or by making health insurance affordable for a selected at-risk population.

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

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

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

17 (h) To establish and convene a workgroup representing healthcare providers and health
18 insurers for the purpose of coordinating the development of processes, guidelines, and standards to
19 streamline healthcare administration that are to be adopted by payors and providers of healthcare
20 services operating in the state. This workgroup shall include representatives with expertise who
21 would contribute to the streamlining of healthcare administration and who are selected from
22 hospitals, physician practices, community behavioral health organizations, each health insurer, and
23 other affected entities. The workgroup shall also include at least one designee each from the Rhode
24 Island Medical Society, Rhode Island Council of Community Mental Health Organizations, the
25 Rhode Island Health Center Association, and the Hospital Association of Rhode Island. In any year
26 that the workgroup meets and submits recommendations to the office of the health insurance
27 commissioner, the office of the health insurance commissioner shall submit such recommendations
28 to the health and human services committees of the Rhode Island house of representatives and the
29 Rhode Island senate prior to the implementation of any such recommendations and subsequently
30 shall submit a report to the general assembly by June 30, 2024. The report shall include the
31 recommendations the commissioner may implement, with supporting rationale. The workgroup
32 shall consider and make recommendations for:

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

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

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

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

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

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

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

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

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

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

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

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

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

1 process to challenge the payor's adjudication decision.

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

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

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

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

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

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

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

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

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

1 patients by:

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

6 (B) Supporting:

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

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

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

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

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

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

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

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

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

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

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

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

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

20 (k) To monitor the transition from fee-for-service and toward global and other alternative
21 payment methodologies for the payment for healthcare services. Alternative payment
22 methodologies should be assessed for their likelihood to promote access to affordable health
23 insurance, health outcomes, and performance.

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

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

30 (1) The impact of the current, mandated healthcare benefits as defined in §§ 27-18-48.1,
31 27-18-60, 27-18-62, 27-18-64, similar provisions in chapters 19, 20 and 41 of title 27, and §§ 27-
32 18-3(c), 27-38.2-1 et seq., or others as determined by the commissioner, on the cost of health
33 insurance for fully insured employers, subject to available resources;

34 (2) Current provider and insurer mandates that are unnecessary and/or duplicative due to

1 the existing standards of care and/or delivery of services in the healthcare system;

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

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

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

11 (1) Utilization review;

12 (2) Contracting; and

13 (3) Licensing and regulation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

29 (ii) An assessment and detailed reporting on eligibility standards and processes of all
30 mandatory and discretionary social and human service programs to be completed by January 1,
31 2023;

32 (iii) An assessment and detailed reporting on utilization trends from the period of January
33 1, 2017, through December 31, 2021, for social and human service programs to be completed by
34 January 1, 2023;

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

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

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

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

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

13 (ix) An assessment and reporting on usual and customary rates paid by private insurers and
14 private pay for similar social and human service providers, both nationally and regionally, by April
15 1, 2023; and

16 (x) Completion of the development of an assessment and review process that includes the
17 following components: eligibility; scope of services; relationship of social and human service
18 provider and the state; national and regional rate comparisons and accountability standards that
19 result in recommended rate adjustments; and this process shall be completed by September 1, 2023,
20 and conducted biennially hereafter. The biennial rate setting shall be consistent with payment
21 requirements established in § 1902(a)(30)(A) of the Social Security Act, 42 U.S.C. §
22 1396a(a)(30)(A), and all federal and state law, regulations, and quality and safety standards. The
23 results and findings of this process shall be transparent, and public meetings shall be conducted to
24 allow providers, recipients, and other interested parties an opportunity to ask questions and provide
25 comment beginning in September 2023 and biennially thereafter.

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

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

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

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

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

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

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EXPLANATION
BY THE LEGISLATIVE COUNCIL
OF

A N A C T

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

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

4 This act would take effect upon passage.

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