

=====
LC004381
=====

STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2026

A N A C T

RELATING TO INSURANCE -- BENEFIT DETERMINATION AND UTILIZATION
REVIEW ACT

Introduced By: Senators Ujifusa, Ciccone, DiMario, Lauria, Mack, Valverde, Kallman,
Murray, Acosta, and Quezada

Date Introduced: February 06, 2026

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

1 SECTION 1. Section 27-18.9-5 of the General Laws in Chapter 27-18.9 entitled "Benefit
2 Determination and Utilization Review Act" is hereby amended to read as follows:

3 **27-18.9-5. Administrative and non-administrative benefit determination procedural**
4 **requirements.**

5 (a) **Procedural failure by claimant.**

6 (1) In the event of the failure of the claimant or an authorized representative to follow the
7 healthcare entities claims procedures for a pre-service claim, the healthcare entity or its review
8 agent must:

9 (i) Notify the claimant or the authorized representative, as appropriate, of this failure as
10 soon as possible and no later than five (5) calendar days following the failure and this notification
11 must also inform the claimant of the proper procedures to file a pre-service claim; and

12 (ii) Notwithstanding the above, if the pre-service claim relates to urgent or emergent
13 healthcare services, the healthcare entity or its review agent must notify and inform the claimant or
14 the authorized representative, as appropriate, of the failure and proper procedures within twenty-
15 four (24) hours following the failure. Notification may be oral, unless written notification is
16 requested by the claimant or authorized representative.

17 (2) The claimant must have stated name, specific medical condition or symptom, and
18 specific treatment, service, or product for which approval is requested and submitted to proper

1 claim processing unit.

2 **(b) Utilization review agent procedural requirements.**

3 (1) All initial, prospective, and concurrent non-administrative adverse benefit
4 determinations of a healthcare service that had been ordered by a physician, dentist, or other
5 practitioner shall be made, documented, and signed by a licensed practitioner with the same
6 licensure status as the ordering provider;

7 (2) Utilization review agents are not prohibited from allowing appropriately qualified
8 review agency staff to engage in discussions with the attending provider, the attending provider's
9 designee, or appropriate healthcare facility and office personnel regarding alternative service and/or
10 treatment options. Such a discussion shall not constitute an adverse benefit determination;
11 provided, however, that any change to the attending provider's original order and/or any decision
12 for an alternative level of care must be made and/or appropriately consented to by the attending
13 provider or the provider's designee responsible for treating the beneficiary and must be documented
14 by the review agent; and

15 (3) A utilization review agent shall not retrospectively deny authorization for healthcare
16 services provided to a covered person when an authorization has been obtained for that service
17 from the review agent unless the approval was based upon inaccurate information material to the
18 review or the healthcare services were not provided consistent with the provider's submitted plan
19 of care and/or any restrictions included in the prior approval granted by the review agent.

20 (c) Step therapy exceptions.

21 (1) Definitions. For purposes of this subsection:

22 (i) "Healthcare professional" means a physician or other healthcare practitioner licensed,
23 accredited, or certified to perform specified healthcare services consistent with state law.

24 (ii) "Insurer" has the meaning set forth in § 27-20.7-2.

25 (iii) "Step therapy" means a protocol or program that establishes a specific sequence in
26 which prescription drugs, therapies, medical tests, or other services for a specified medical
27 condition are covered by an insurer.

28 (2) Implementation.

29 (i) When an insurer uses a step therapy protocol to deny or restrict coverage of a
30 prescription drug, therapy, medical test, or other service prescribed by a healthcare professional to
31 diagnose or treat any medical condition, the insurer shall grant an exception to permit immediate
32 coverage if the step it requires:

33 (A) Is contraindicated or likely to cause an adverse reaction;

34 (B) Has been tried and found to be ineffective;

1 (C) Has not been tried, but will be ineffective based on the patient’s clinical history;
2 (D) Will delay or prevent medically necessary care; or
3 (E) Will disrupt the patient’s current stable and effective course of treatment.
4 (ii) Insurers shall create a clear, easily accessible, and convenient process for healthcare
5 professionals to submit exception requests electronically online.
6 (iii) Insurers shall approve or deny the exception request within seventy-two (72) hours
7 from receipt of the request. If the healthcare professional identifies the request as an urgent
8 medically necessary service, the insurer shall approve or deny the request within twenty-four (24)
9 hours of receipt of the request. If no determination occurs within these time frames, the request
10 shall be presumed granted.
11 (3) Clinical review. Insurers shall ensure that individuals who review or discuss exceptions
12 with healthcare professionals are themselves healthcare professionals with expertise in the medical
13 condition and treatment for which an exception is sought.
14 (4) Duration of approval. The determinations shall be valid for the length of time deemed
15 medically necessary by the provider, and shall remain in effect for not less than twelve (12) months
16 from the date of the determination, unless there is a material change in the patient’s clinical
17 condition.
18 (5) Limitation on number of required steps. No step therapy protocol shall require a covered
19 person to fail more than one prescription drug, therapy, or service before coverage is authorized for
20 the drug, therapy, or service prescribed by the healthcare professional.
21 (6) Limitation on duration of step therapy. A step therapy protocol shall not require a
22 patient to remain on a required step for longer than thirty (30) calendar days, after which the
23 prescribing healthcare professional may deem the step clinically ineffective and coverage shall be
24 provided for the prescribed treatment.
25 (7) Continuity of care during review. While a step therapy exception request or appeal is
26 pending, the insurer shall provide uninterrupted coverage of the prescribed drug, therapy, or service
27 without increased cost-sharing.
28 (8) Disease-specific protections. Step therapy protocols shall not apply to medications or
29 treatments prescribed for:
30 (A) Serious mental illness;
31 (B) Cancer, including metastatic and hematologic cancers; or
32 (C) Rare diseases or conditions for which treatment options are limited.
33 (9) Reporting and oversight. Insurers shall provide the office of the health insurance
34 commissioner information and documents sufficient to evaluate whether step therapy protocols

1 [delay or deny medically necessary care, including utilization and outcome data as required by the](#)
2 [commissioner.](#)

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

6 **42-14.5-3. Powers and duties.**

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

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

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

28 (c) To establish a consumer/business/labor/medical advisory council to obtain information
29 and present concerns of consumers, business, and medical providers affected by health insurance
30 decisions. The council shall develop proposals to allow the market for small business health
31 insurance to be affordable and fairer. The council shall be involved in the planning and conduct of
32 the quarterly public meetings in accordance with subsection (a). The advisory council shall develop
33 measures to inform small businesses of an insurance complaint process to ensure that small
34 businesses that experience rate increases in a given year may request and receive a formal review

1 by the department. The advisory council shall assess views of the health provider community
2 relative to insurance rates of reimbursement, billing, and reimbursement procedures, and the
3 insurers' role in promoting efficient and high-quality health care. The advisory council shall issue
4 an annual report of findings and recommendations to the governor and the general assembly and
5 present its findings at hearings before the house and senate finance committees. The advisory
6 council is to be diverse in interests and shall include representatives of community consumer
7 organizations; small businesses, other than those involved in the sale of insurance products; and
8 hospital, medical, and other health provider organizations. Such representatives shall be nominated
9 by their respective organizations. The advisory council shall be co-chaired by the health insurance
10 commissioner and a community consumer organization or small business member to be elected by
11 the full advisory council.

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

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

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

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

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

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

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

34 (7) Information related to temporary credentialing of providers seeking to participate in the

1 plan's network and the impact of the activity on health plan accreditation;

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

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

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

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

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

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

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

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

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

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

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

34 (7) For the purposes of conducting this analysis, the commissioner may contract with an

1 outside organization with expertise in fiscal analysis of the private insurance market. In conducting
2 its study, the organization shall, to the extent possible, obtain and use actual health plan data. Said
3 data shall be subject to state and federal laws and regulations governing confidentiality of health
4 care and proprietary information.

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

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

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

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

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

31 (iii) Provide reasonably detailed information on a consumer's eligibility for healthcare
32 coverage; scope of benefits; limitations and exclusions provided under that coverage; cost-sharing
33 requirements for specific services at the specific time of the inquiry; current deductible amounts;
34 accumulated or limited benefits; out-of-pocket maximums; any maximum policy amounts; and

1 other information required for the provider to collect the patient's portion of the bill;

2 (iv) Reflect the necessary limitations imposed on payors by the originator of the eligibility

3 and benefits information;

4 (v) Recommend a standard or common process to protect all providers from the costs of

5 services to patients who are ineligible for insurance coverage in circumstances where a payor

6 provides eligibility verification based on best information available to the payor at the date of the

7 request of eligibility.

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

9 (i) The use of the National Correct Coding Initiative code-edit policy by payors and

10 providers in the state;

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

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

13 (iii) Use of Health Insurance Portability and Accountability Act standard group codes,

14 reason codes, and remark codes by payors in electronic remittances sent to providers;

15 (iv) Uniformity in the processing of claims by payors; and the processing of corrections to

16 claims by providers and payors;

17 (v) A standard payor-denial review process for providers when they request a

18 reconsideration of a denial of a claim that results from differences in clinical edits where no single,

19 common-standards body or process exists and multiple conflicting sources are in use by payors and

20 providers.

21 (vi) Nothing in this section, nor in the guidelines developed, shall inhibit an individual

22 payor's ability to employ, and not disclose to providers, temporary code edits for the purpose of

23 detecting and deterring fraudulent billing activities. The guidelines shall require that each payor

24 disclose to the provider its adjudication decision on a claim that was denied or adjusted based on

25 the application of such edits and that the provider have access to the payor's review and appeal

26 process to challenge the payor's adjudication decision.

27 (vii) Nothing in this subsection shall be construed to modify the rights or obligations of

28 payors or providers with respect to procedures relating to the investigation, reporting, appeal, or

29 prosecution under applicable law of potentially fraudulent billing activities.

30 (3) Developing and promoting widespread adoption by payors and providers of guidelines

31 to:

32 (i) Ensure payors do not automatically deny claims for services when extenuating

33 circumstances make it impossible for the provider to obtain a preauthorization before services are

34 performed or notify a payor within an appropriate standardized timeline of a patient's admission;

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

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

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

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

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

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

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

31 (B) Supporting:

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

34 (II) Timely notification of prior authorization determinations by health plans to impacted

1 health plan enrollees, and healthcare providers, including, but not limited to, ordering providers,
2 and/or rendering providers, and dispensing pharmacists which may be satisfied by posting to
3 provider-accessible websites or similar electronic portals or services;

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

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

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

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

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

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

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

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

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

34 (i) To issue an anti-cancer medication report. Not later than June 30, 2014, and annually

1 thereafter, the office of the health insurance commissioner (OHIC) shall provide the senate
2 committee on health and human services, and the house committee on corporations, with: (1)
3 Information on the availability in the commercial market of coverage for anti-cancer medication
4 options; (2) For the state employee's health benefit plan, the costs of various cancer-treatment
5 options; (3) The changes in drug prices over the prior thirty-six (36) months; and (4) Member
6 utilization and cost-sharing expense.

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

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

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

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

21 (1) The impact of the current, mandated healthcare benefits as defined in §§ 27-18-48.1,
22 27-18-60, 27-18-62, 27-18-64, similar provisions in chapters 19, 20, and 41 of title 27, and §§ 27-
23 18-3(c), 27-38.2-1 et seq., or others as determined by the commissioner, on the cost of health
24 insurance for fully insured employers, subject to available resources;

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

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

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

31 (n) On or before July 1, 2014, the office of the health insurance commissioner, in
32 collaboration with the director of health and lieutenant governor's office, shall submit a report to
33 the general assembly and the governor to inform the design of accountable care organizations
34 (ACOs) in Rhode Island as unique structures for comprehensive healthcare delivery and value-

1 based payment arrangements, that shall include, but not be limited to:

2 (1) Utilization review;

3 (2) Contracting; and

4 (3) Licensing and regulation.

5 (o) On or before February 3, 2015, the office of the health insurance commissioner shall

6 submit a report to the general assembly and the governor that describes, analyzes, and proposes

7 recommendations to improve compliance of insurers with the provisions of § 27-18-76 with regard

8 to patients with mental health and substance use disorders.

9 (p) To work to ensure the health insurance coverage of behavioral health care under the

10 same terms and conditions as other health care, and to integrate behavioral health parity

11 requirements into the office of the health insurance commissioner insurance oversight and

12 healthcare transformation efforts.

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

14 access to a continuum of mental health and substance use disorder treatment in the state; and

15 integrate that treatment with primary and other medical care to the fullest extent possible.

16 (r) To direct insurers toward policies and practices that address the behavioral health needs

17 of the public and greater integration of physical and behavioral healthcare delivery.

18 (s) The office of the health insurance commissioner shall conduct an analysis of the impact

19 of the provisions of § 27-38.2-1(i) on health insurance premiums and access in Rhode Island and

20 submit a report of its findings to the general assembly on or before June 1, 2023.

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

22 (1) The office shall hire the necessary staff and prepare a request for proposal for a qualified

23 and competent firm or firms to undertake the following analyses, reports, and studies:

24 (i) The firm shall undertake a comprehensive review of all social and human service

25 programs having a contract with or licensed by the state or any subdivision of the department of

26 children, youth and families (DCYF), the department of behavioral healthcare, developmental

27 disabilities and hospitals (BHDDH), the department of human services (DHS), the department of

28 health (DOH), and Medicaid for the purposes of:

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

30 (B) Establishing a baseline of the service offering through each agency for those

31 determined eligible;

32 (C) Establishing a baseline understanding of reimbursement rates for all social and human

33 service programs including rates currently being paid, the date of the last increase, and a proposed

34 model that the state may use to conduct future studies and analyses;

1 (D) Ensuring accurate and adequate reimbursement to social and human service providers
2 that facilitate the availability of high-quality services to individuals receiving home and
3 community-based long-term services and supports provided by social and human service providers;
4 (E) Ensuring the general assembly is provided accurate financial projections on social and
5 human service program costs, demand for services, and workforce needs to ensure access to entitled
6 beneficiaries and services;
7 (F) Establishing a baseline and determining the relationship between state government and
8 the provider network including functions, responsibilities, and duties;
9 (G) Determining a set of measures and accountability standards to be used by EOHHS and
10 the general assembly to measure the outcomes of the provision of services including budgetary
11 reporting requirements, transparency portals, and other methods; and
12 (H) Reporting the findings of human services analyses and reports to the speaker of the
13 house, senate president, chairs of the house and senate finance committees, chairs of the house and
14 senate health and human services committees, and the governor.
15 (2) The analyses, reports, and studies required pursuant to this section shall be
16 accomplished and published as follows and shall provide:
17 (i) An assessment and detailed reporting on all social and human service program rates to
18 be completed by January 1, 2023, including rates currently being paid and the date of the last
19 increase;
20 (ii) An assessment and detailed reporting on eligibility standards and processes of all
21 mandatory and discretionary social and human service programs to be completed by January 1,
22 2023;
23 (iii) An assessment and detailed reporting on utilization trends from the period of January
24 1, 2017, through December 31, 2021, for social and human service programs to be completed by
25 January 1, 2023;
26 (iv) An assessment and detailed reporting on the structure of the state government as it
27 relates to the provision of services by social and human service providers including eligibility and
28 functions of the provider network to be completed by January 1, 2023;
29 (v) An assessment and detailed reporting on accountability standards for services for social
30 and human service programs to be completed by January 1, 2023;
31 (vi) An assessment and detailed reporting by April 1, 2023, on all professional licensed
32 and unlicensed personnel requirements for established rates for social and human service programs
33 pursuant to a contract or established fee schedule;
34 (vii) An assessment and reporting on access to social and human service programs, to

1 include any wait lists and length of time on wait lists, in each service category by April 1, 2023;

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

4 (ix) An assessment and reporting on usual and customary rates paid by private insurers and
5 private pay for similar social and human service providers, both nationally and regionally, by April
6 1, 2023;

7 (x) Completion of the development of an assessment and review process that includes the
8 following components: eligibility; scope of services; relationship of social and human service
9 provider and the state; national and regional rate comparisons and accountability standards that
10 result in recommended rate adjustments; and this process shall be completed by September 1, 2023,
11 and conducted biennially hereafter. The biennial rate setting shall be consistent with payment
12 requirements established in section 1902(a)(30)(A) of the Social Security Act, 42 U.S.C. §
13 1396a(a)(30)(A), and all federal and state law, regulations, and quality and safety standards. The
14 results and findings of this process shall be transparent, and public meetings shall be conducted to
15 allow providers, recipients, and other interested parties an opportunity to ask questions and provide
16 comment beginning in September 2023 and biennially thereafter; and

17 (xi) On or before September 1, 2026, the office shall publish and submit to the general
18 assembly and the governor a one-time report making and justifying recommendations for
19 adjustments to primary care services reimbursement and financing. The report shall include
20 consideration of Medicaid, Medicare, commercial, and alternative contracted payments.

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

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

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

1 (w) The office of the health insurance commissioner shall:

2 (1) Ensure that insurers minimize administrative burdens that may delay medically
3 necessary care, by promulgating rules and regulations and taking enforcement actions to implement
4 § 27-18.9-16; and

5 (2) Convene the payor/provider workgroup described in subsection (h) of this section, or a
6 similar taskforce, comprised of members with relevant experience and expertise, to serve as a
7 standing advisory steering committee (“committee”) to review and make recommendations
8 regarding:

9 (i) The continuous improvement and simplification of the prior authorization processes for
10 medical services and prescription drugs;

11 (ii) The facilitation of communication and collaboration related to volume reduction;

12 (iii) The establishment of a tracking method to improve the collection of baseline data from
13 commercial health insurers that does not create an administrative burden;

14 (iv) The assessment of prior authorizations that have been approved, those that have been
15 approved with modifications, and the utilization of MRI services in the emergency department; and

16 (v) The assessment of improvements to the access of primary care services and other
17 quality care measures related to the elimination of prior authorizations during this program,
18 including increase in staff availability to perform other office functions; increase in patient
19 appointments; and reduction in care delay.

20 (3) Submit such recommendations of the committee with a rationale, to the governor’s
21 office, speaker of the house of representatives, and the president of the senate, prior to the
22 implementation of any such recommendations and subsequently shall submit a full report to the
23 general assembly by July 1 of each year of the pilot program.

24 (x) The office of the health insurance commissioner shall have oversight and enforcement
25 authority over the requirements of this chapter, including the power to require disclosure of
26 information and documents, to clarify or simplify appeals procedures, and to limit step therapy
27 protocol use, to ensure delivery of medically necessary care, and to impose fines or other penalties
28 for noncompliance.

29 SECTION 3. This act shall take effect upon passage.

=====
LC004381
=====

EXPLANATION
BY THE LEGISLATIVE COUNCIL
OF
A N A C T
RELATING TO INSURANCE -- BENEFIT DETERMINATION AND UTILIZATION
REVIEW ACT

1 This act would limit the use by insurers of step therapy utilization management, a protocol
2 or program that establishes a specific sequence in which prescription drugs for a specified medical
3 condition are covered by an insurer by allowing medical providers to request step therapy
4 exceptions. This act would also require insurers to provide the office of the health insurance
5 commissioner with information and documents sufficient to evaluate whether step therapy
6 protocols delay or deny medically necessary care, including utilization and outcome data as
7 required by the commissioner.

8 This act would take effect upon passage.

=====
LC004381
=====