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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. 2024

A N A C T

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

Introduced By: Senators Ujifusa, Miller, Murray, Mack, DiMario, Lawson, Valverde, Lauria, DiPalma, and Sosnowski
Date Introduced: February 12, 2024

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

SECTION 1. The general assembly hereby finds and declares as follows:

(1) About forty percent (40%) of Americans struggle to afford their regular prescription medicines, with one-third (1/3) skipping doses because of cost.

(2) Pharmacy benefit managers (PBMs) began in the 1970s as small independent middlemen between insurers and pharmacies, taking a set fee for processing claims, but today, have become part of large, vertically integrated conglomerates whose revenues exceed those of top pharmaceutical manufacturers making United Health Group, CVS and Cigna rank fifth, sixth and fifteenth, respectively, on the Fortune 500 list ranking largest corporations by revenues.

(3) PBMs drive revenues for their parent companies, e.g., CVS's PBM business made fifty-two percent (52%) of CVS's revenue in 2022 ($169.2 billion) - up 10% from $153 billion in 2021.

(4) Three (3) PBMs control about eighty percent (80%) of the market:

(i) CVS Caremark – thirty-three percent (33%) market share – parent company: CVS (Aetna);

(ii) Express Scripts – twenty-four percent (24%) market share – parent company: Cigna;

(iii) OptumRx – twenty-two percent (22%) market share – parent company: UnitedHealth.

(5) While middlemen PBMs are enjoying record profits, patients struggle to find health care providers, and health care providers in Rhode Island have been financially struggling, e.g., Memorial Hospital in Pawtucket closed, the state's largest Visiting Nurses Association closed,

multiple nursing homes have closed; Roger Williams Medical Center and Our Lady of Fatima hospitals were sold to a for-profit, out-of-state corporation and may be about to be sold again.

(6) A major problem caused by PBMs is that they charge "insurance sponsors" like Medicaid, more than what they reimburse pharmacies and pocket the difference (that is, keep "the spread"), e.g., annually PBMs kept spread pricing revenues of $123.5 million in Kentucky, $29 million in Virginia; and $72 million in Maryland.

(7) PBMs have been found to cause numerous additional problems including:

(i) Placing drugs on formularies to increase their legal kickbacks ("rebates") from manufacturers instead of choosing the most effective or affordable drugs for consumers.

(ii) Causing drug manufacturers to cover PBM rebates by raising list prices for drugs – adding an estimated thirty cents ($0.30) per dollar to the price consumers pay for prescriptions.

(iii) Causing independent pharmacies to go out of business by favoring PBM-affiliated retail, mail order and specialty pharmacies, such as by steering customers to their affiliates or paying less to non-affiliated pharmacies for the same drugs (e.g., in Florida, PBM-affiliated pharmacies got 18 to 109 times more profit than the typical community pharmacy for brand name drugs);

(8) PBMs make government oversight virtually impossible by hiding profits in multiple ways, including by designating rebates and discounts as confidential, renaming them as "fees" or "savings" and creating "Group Purchasing Organizations (GPOs)" that add another layer of middlemen to an already opaque and complex system;

(9) PBMs implement "utilization management" policies that can adversely affect clinical outcomes by making providers spend excessive time on administrative tasks, and delaying and discouraging patient care, including:

(i) "Prior authorizations," which require patients to get third-party approval prior to getting medicines prescribed by their health care provider;

(ii) "Step therapy," also known as "fail-first," "sequencing," and "tiering," which requires patients to start with lower-priced medications before being approved for originally prescribed medications; and

(iii) "Non-medical drug switching" which forces patients off their current therapies primarily to save insurers money, including by increasing out-of-pocket costs, moving treatments to higher cost tiers, or terminating coverage of a particular drug.

(10) PBMs can profit from a federal program ("Section 340B") meant to help low-income patients by engaging in "discriminatory reimbursement," e.g., offering 340B entities lower reimbursement rates than those offered to non-340B entities.

(11) Recently, more than one-half of all state legislation aimed at controlling prescription drug prices have focused on PBMs, and multiple states besides Rhode Island are aggressively taking actions:

(i) Ohio has gone to a single state PBM after its state auditor found that of the $2.5 billion spent annually through PBMs on Medicaid prescription drugs, PBMs pocketed $224.8 million through spread alone during a one-year period; and;

(ii) West Virginia passed a law requiring PBMs to share the savings they negotiate on medicines directly with West Virginia patients; and saved customers and taxpayers about $54 million in the first year (a little over $6 per individual prescription).

(12) A recent United States supreme court case, Rutledge v. PCMA, 141 S.Ct. 474 (2020), supports states taking actions to regulate PBMs.

(13) Rhode Island policymakers have not properly analyzed much less controlled PBMs and their effects on the cost of prescription drugs.

(14) Rhode Island Medicaid managed care organization (MCO) contracts which had an estimated cost to all taxpayers of over one billion seven hundred million dollars ($1,700,000,000) per year have not previously included adequate PBM oversight and controls;

(15) The state must prevent PBM actions that obfuscate the complex drug supply chain and cause prescription drug costs to rise without demonstrated benefits to Rhode Islanders.

SECTION 2. Legislative intent.

The intent of this legislation is to protect patients, healthcare providers, and taxpayers from high prescription drug costs by requiring greater pharmacy benefit manager transparency and accountability.

SECTION 3. Section 27-20.7-12 of the General Laws in Chapter 27-20.7 entitled "Third-Party Health Insurance Administrators" is hereby amended to read as follows:

27-20.7-12. Certificate of authority required.

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

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

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

documents;

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

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

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

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

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

(7) Information required by the office of health insurance commissioner (OHIC) pursuant to § 27-29.1-7; and

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

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

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

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

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

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

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

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

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

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

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

SECTION 4. Section 27-29.1-7 of the General Laws in Chapter 27-29.1 entitled "Pharmacy Freedom of Choice — Fair Competition and Practices" is hereby amended to read as follows:

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

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

(b) Pharmacy benefit managers shall:

(1) Cease activities that result in spread pricing;

(2) Implement pharmacy pass-through pricing;

(3) Not engage in discriminatory treatment of non-affiliated pharmacies and pharmacists;

(4) Cease utilization management, including prior authorization, step therapy and non-medical drug switching, that delays or discourages medically necessary care;

(5) Implement one hundred percent (100%) pass-through of manufacturer-derived revenues or discounts, including rebates and coupons, that shall be demonstrated to directly lower prescription drug prices for consumers;

(6) Prioritize benefits to consumers and not pharmacy benefit managers or affiliated company revenues in determining placement of drugs on formularies;

(7) Cease profiting from a federal program ("Section 340B") meant to help low-income patients by engaging in discriminatory reimbursement, e.g., offering 340B entities lower reimbursement rates than those offered to non-340B entities;

(8) Provide information and documents requested by the office of health insurance commissioner that relate to enforcement of this section, including those related to:

(i) Rebates, discounts or other compensation and benefits pharmacy benefit managers receive from drug manufacturers;

(ii) Payments from insurers to pharmacy benefit managers for prescription drugs and payments from pharmacy benefit managers on behalf of insurers to pharmacies for those drugs;

(iii) Payments to pharmacy benefit managers from pharmacies, including for administrative fees and claw backs;

(iv) Differences between what pharmacy benefit managers reimburse and charge affiliated and non-affiliated pharmacies for specific prescription drugs; and

(v) Reimbursement constructs utilized by the pharmacy benefit managers at any point in time for each prescription, including applicable lists for wholesale acquisition cost (WAC), maximum allowable cost (MAC), and average wholesale price (AWP).

(c) The office of health insurance commissioner shall promulgate rules and regulations, and hire independent contractors familiar with pharmacy benefit managers finances to allow implementation and enforcement of the terms of this section. The legislature shall approve funding for the office of health insurance commissioner staff and contractors necessary to ensure the requirements of this section are met and can be properly enforced.

(d) The office of health insurance commissioner may enforce the provisions of this section by imposing civil fines up to ten thousand dollars ($10,000) per violation, or by taking any other enforcement actions not prohibited by law. Nothing in this chapter shall preclude the attorney

general from also taking actions against PBMs to enforce any laws, including the provisions set forth in this chapter.

(e) Should any provision of this section be found unconstitutional, preempted, or otherwise invalid, that provision shall be severed and such decision shall not affect the validity of the other parts of this section.

SECTION 5. This act shall take effect upon passage.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N A C T

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

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This act would protect patients, healthcare providers, and taxpayers from high prescription drug costs by requiring greater pharmacy benefit manager transparency and accountability. It gives the office of health insurance commissioner (OHIC) authority to promulgate regulations and oversee implementation.

This act would take effect upon passage.

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