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STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2024

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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:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19 SECTION 2. Legislative intent.

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

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

25 **27-20.7-12. Certificate of authority required.**

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

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

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

1 documents;

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

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

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

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

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

22 (7) [Information required by the office of health insurance commissioner \(OHIC\) pursuant](#)  
23 [to § 27-29.1-7; and](#)

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

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

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

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

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

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

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

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

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

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

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

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

23 **27-29.1-7. Regulation of pharmacy benefits managers.**

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

34 (b) Pharmacy benefit managers shall:

- 1 (1) Cease activities that result in spread pricing;
- 2 (2) Implement pharmacy pass-through pricing;
- 3 (3) Not engage in discriminatory treatment of non-affiliated pharmacies and pharmacists;
- 4 (4) Cease utilization management, including prior authorization, step therapy and non-  
5 medical drug switching, that delays or discourages medically necessary care;
- 6 (5) Implement one hundred percent (100%) pass-through of manufacturer-derived  
7 revenues or discounts, including rebates and coupons, that shall be demonstrated to directly lower  
8 prescription drug prices for consumers;
- 9 (6) Prioritize benefits to consumers and not pharmacy benefit managers or affiliated  
10 company revenues in determining placement of drugs on formularies;
- 11 (7) Cease profiting from a federal program ("Section 340B") meant to help low-income  
12 patients by engaging in discriminatory reimbursement, e.g., offering 340B entities lower  
13 reimbursement rates than those offered to non-340B entities;
- 14 (8) Provide information and documents requested by the office of health insurance  
15 commissioner that relate to enforcement of this section, including those related to:
  - 16 (i) Rebates, discounts or other compensation and benefits pharmacy benefit managers  
17 receive from drug manufacturers;
  - 18 (ii) Payments from insurers to pharmacy benefit managers for prescription drugs and  
19 payments from pharmacy benefit managers on behalf of insurers to pharmacies for those drugs;
  - 20 (iii) Payments to pharmacy benefit managers from pharmacies, including for  
21 administrative fees and claw backs;
  - 22 (iv) Differences between what pharmacy benefit managers reimburse and charge affiliated  
23 and non-affiliated pharmacies for specific prescription drugs; and
  - 24 (v) Reimbursement constructs utilized by the pharmacy benefit managers at any point in  
25 time for each prescription, including applicable lists for wholesale acquisition cost (WAC),  
26 maximum allowable cost (MAC), and average wholesale price (AWP).
- 27 (c) The office of health insurance commissioner shall promulgate rules and regulations,  
28 and hire independent contractors familiar with pharmacy benefit managers finances to allow  
29 implementation and enforcement of the terms of this section. The legislature shall approve funding  
30 for the office of health insurance commissioner staff and contractors necessary to ensure the  
31 requirements of this section are met and can be properly enforced.
- 32 (d) The office of health insurance commissioner may enforce the provisions of this section  
33 by imposing civil fines up to ten thousand dollars (\$10,000) per violation, or by taking any other  
34 enforcement actions not prohibited by law. Nothing in this chapter shall preclude the attorney

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

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

6 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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1           This act would protect patients, healthcare providers, and taxpayers from high prescription  
2 drug costs by requiring greater pharmacy benefit manager transparency and accountability. It gives  
3 the office of health insurance commissioner (OHIC) authority to promulgate regulations and  
4 oversee implementation.

5           This act would take effect upon passage.

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