# Rhode Island

## Rhode Island - HB 7116

**Sponsor:** Representative John Lombardi (D)

**Actions:** 02/01/2022 Hearing Held; Held for further study
01/20/2022 Introduced, Referred to House Corporations Committee

**Summary:** Summary of 1/20/2022 Version

This measure amend the state's pharmaceutical cost transparency chapter, which requires the board of pharmacy to identify 15 drugs that the state spends money on and where the wholesale acquisition cost increased. The measure also establishes an advisory committee to develop all available options for health benefit plans to offer plans with both a higher out-of-pocket limit on prescription drug coverage and plans with an out-of-pocket limit at or below the limit already established.

This measure will require the state board of pharmacy annually identify up to fifteen prescription drugs on which the state spends a significant amount of money and for which the wholesale acquisition cost has increased by 50 percent or more over the past five years or by fifteen percent or more over the past twelve months. The drugs identified will represent different drug classes. The percentage increase of the WAC cost must be made available on the board’s website for the public.

The manufacturer must submit to the office of the attorney general all relevant information and supporting documentation necessary to justify the manufacturer's wholesale acquisition cost increase. They must list all factors that resulted in the increase. This section will not restrict the legal ability of a prescription drug manufacturer to change prices to the extent permitted under federal law.

A manufacturer that fails to provide the information will face a civil penalty of $10,000 per violation.

By January l, 2023, the insurance commissioner must adopt rules and regulations to require all health insurers that offer health benefit plans to Rhode Island residents through HealthSource RI or any successor health benefit exchange to provide information to enrollees, potential enrollees, and health care providers about the exchange plans' prescription drug formularies.

The formulary must include information about the prescription drugs covered, all applicable cost-sharing amounts, drug tiers, prior authorization, step therapy, and utilization management requirements.

The department must use the same dispensing fees in their reimbursement formula for 340B prescription drugs as it uses to pay for non 340 B prescription drugs under the Medicaid Program. The department will determine the advantages and disadvantages of using the same dispensing fee in their reimbursement formula for the 340B prescription program for 340B prescription drugs.

The measure also requires the department of health to form an advisory committee to develop all available options for health benefit plans to offer on the state exchange for the 2024 plan year including:
- Plans with a higher out of the pocket limit of prescription drug coverage
- Plans with an out-of-pocket limit at or below the limit established.

By February 1, 2023, the department must provide a report to the House and the Senate with an overview of the cost-sharing increase trend for all qualified health benefit plans offered on the Rhode Island health benefit exchange for 2017 through 2022 plan years that were subject to the out-of-pocket prescription drug limit. It must include information regarding lower cost-sharing amounts for selected services that will be available in all qualified health benefit plans in the 2023 plan year due to the flexibility to increase the out-of-pocket prescription drug limits. It must also include a comparison of the bronze-level qualified health benefit plans offered in the 2023 plan year in which there will be flexibility in the out-of-pocket prescription drug limit.

This measure will take effect once it is signed into law.

**Bill Links** 1/20/2022 Version

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# Rhode Island - SB 2465

**Sponsor:** Senator Walter Felag (D)

**Actions:** 03/01/2022 Introduced; Referred to the Senate Health and Human Services Committee

**Summary:** Summary of 3/1/2022 Version

This measure would impose a suspension on the issuance of new home care providers, home nursing care providers, and hospice provider licenses before July 1, 2027.

This measure requires the health services council to not review, and applicable state licensing agencies must not issue, any approvals for new home care provider, home nursing care provider, or hospice provider licenses prior to July 1, 2027; provided that any review by the health services council of the department of health and approval by state agencies may be conducted during the moratorium period in the case of an emergency circumstance. This includes certificate of need applications not previously approved.

This measure lays out the requirements for the study. If the study is not completed by July 1, 2027, the moratorium will remain in effect.

The number of home care providers, home nursing care providers, and hospice provider licenses in effect as of June 30, 2022, must be the maximum number of licenses issued in each licensure category. In the event of a 5% or more reduction of licenses within a calendar year, this new figure on December 31 of that year must be the new maximum number of licenses for that licensure category. All home and nursing-care providers, and hospice providers, must maintain a physical office location.

This measure takes effect immediately.

**Bill Links** 3/1/2022 Version

# Rhode Island - SB 2619

**Sponsor:** Senator Jeanine Calkin (D)

**Actions:** 03/10/2022 Introduced; Referred to Senate Health and Human Services Committee

**Summary:** Summary for 3/10/2022 Version

This measure requires PBMs to provide certain drug-cost information and prohibits PBMs from practicing in spread pricing and harmful utilization management practices.

This measure applies to pharmacy benefit managers. This measure requires PBMs to provide state authorities and the general public information enabling an accurate determination of the costs and benefits of PBMs for taxpayers and consumers on at least a quarterly basis.

This measure requires PBMs to be carved out from Medicaid managed care organization contracts.

PBMs are required to cease all activities that result in spread pricing profits, including creating multiple maximum acquisition cost lists that list higher prices for insurer to PBM reimbursement and lower prices for PBM to pharmacy reimbursements for the same drug.

PBMs must implement pharmacy pass-through pricing. Payers must reimburse no more than the actual amount the PBM pays to the dispensing pharmacy. Additionally, PBMs must implement 100% of pass-through of manufacturer-derived revenues. They are required to pay or credit payers 100% of all manufacturer-derived revenue including rebates. Payers cannot be charged for any management or administrative fees associated with obtaining or negotiating any manufacturer-derived revenue.

PBMs are required to cease the following activities:

- Taking money paid as co-pays to pharmacies in excess of what the pharmacies paid to acquire the drug
- Reimbursing affiliated pharmacies more than non-affiliated pharmacies for the same drugs
- Steering consumers to affiliated pharmacies by required a higher copay for drugs received by non-affiliated pharmacy
- Profiting from federal programs meant to assist low-income patients by offering 340B entities lower reimbursement rates than those offered to non-340B entities
- Utilizing strategies that delay and discourage patient care and adversely affect clinical outcomes, including prior authorizations, step therapy and non-medical drug switching.

Definitions:

"Other manufacturer revenue" means compensation or remuneration received or recovered, directly or indirectly, from a pharmaceutical manufacturer for administrative, educational, research, clinical program, or other services, product selection switching incentives, charge-

back fees, market share incentives, drug pull-through programs, or any payment amounts related to the number of covered lives, formularies, or the PBM’s relationship with the payer.

"Rebate" means all price concessions paid by a manufacturer or any other third party to PBMs including rebates, discounts, credits, fees, manufacturer administrative fees, or other payments that are based on actual or estimated utilization of a covered drug or price concessions based on the effectiveness of a covered drug.

This measure takes effect immediately.

**Bill Links** 3/10/2022 Version