

State of Rhode Island Office of the Health Insurance Commissioner
Administrative Simplification Workgroup
September 22, 2026 – 6:00pm – 7:00pm
Virtual Meeting Summary

Attendance

Co-Chair Dr. Victor Pinkes (BCBSRI), Co-Chair Dr. Peter Hollmann (Brown), Stacey Paterno (RIMS), Karen Labbe (BCBSRI), Brittany Lomond (CNE), Elena Nicolella (RIHCA), Robert Wascher (Cigna), Jerry Fingerut (EOHHS), Richard Glucksman (BCBSRI), Christina Pacheco (BVCHC), Alana Campbell (RIDOH), Elena Kwetowski, Jerry Bonner, Kristen Bennett, Dr. Christopher Ottiano (NHPRI), Christopher Furey, Darcey Gartner, Jocelyn Antonio (Brown), Almerinda Leclerc, Warren Licht, Tracey Wallace, Morgan Wieck (RIDOH), Sarah Fessler, Elizabeth McClaine (NHPRI), Susan Guerette (Aetna),

State of Rhode Island Office of the Health Insurance Commissioner Staff

Commissioner Cory King, Charles Estabrook, Taylor Travers

1. Call to Order and Introductions

Charlie Estabrook (OHIC) called the meeting to order. He explained that the purpose of the meeting is to hear directly from providers and staff completing the prior authorizations.

2. Presentation

Charlie provided an update on the progress of the pilot program thus far, including an overview of data. RIGL § 27-18.9-16 institutes a three-year pilot program whereby an insurer shall not impose a prior authorization requirement for any admission, item, service, treatment or procedure ordered by a primary care provider in the normal course of providing primary care treatment. This pilot program does not prohibit prior authorization requirements for prescription drugs. Data shared included aggregate primary care prior authorization requests. He added that the pilot program resulted in a moderate decline in prior authorization requests originating from PCPs. Administrative burden of PAs on PCPs is still high due to growing PA volume on pharmaceuticals. Due to the manual process some payers instituted the data reported to OHIC may represent an overcount. The ultimate goal of the pilot program is to reduce administrative burden on PCPs. If PCPs still believe they need to submit PAs, even if the requirements have been lifted/changed, the overall effect of the pilot program on administrative burden will be muted. Data also included PCP requests by individual payers. When excluding pharmaceuticals related requests, two insurers have shown a significant decline in reported PCP PA requests – BCBSRI and Point32 Health. Cigna and BCBSRI reported no PCP PA requests in Q2 of 2026, Cigna also reported no PCP PA requests in Q1 of 2026. NHPRI has reported a significant increase in PCP PA submissions.

Commissioner King added that Cigna and Aetna have very low enrollment in Rhode Island, and that the data only represents the commercial fully insured population only.

3. Provider Discussion

Charlie highlighted that this did not include Medicaid data.

Christina Pacheco (Blackstone Valley) is gratified to see the data. At Blackstone they deal with mostly NHPRI, and they have seen almost no difference.

Charlie added that they are working with NHPRI to understand the numbers.

Warren Licht asked if this included Medicare patients.

Charlie noted that for the purpose of the pilot program, it was instituted both in fully insured commercial and Medicaid populations but not Medicare because the legislature does not have authority over Medicare plans. It is also two separate parallel programs; one being run by OHIC and the other by Medicaid.

Warren added that was a frustration because Medicare wants a peer-to-peer to be done but the timeframe is very short. He also added that the burden is more on the staff completing the requests rather than on the providers themselves. He asked Kristen to comment on what the office staff had noticed.

Kristen Bennet added that the only big difference was the decline in need for BCBSRI because they stopped requiring prior authorizations for the primary care providers. There has been no change with any of the other insurers that she has noticed.

Sarah Fessler noted that the process has gotten more confusing, as they take a broad array of insurances. Some providers still need a prior authorization, and some do not, which in some cases has added more work.

Brittney added that a big change was seen in BCBSRI because they eliminated the prior authorization across the board. For NHPRI and UHC there is also no retro or backdating which can be troublesome especially when the guidance is not clear.

Commissioner King added that most of the Aetna presence is in the self-insured, and self-insured employers are not obligated to follow the pilot program. Because of that, there is a lot of fragmentation in it, and therefore little effect is being seen.

Brittney noted that because of the differences, they are checking every single request to make sure which doesn't relieve any burden.

Charlie asked if that is something, given a longer time span would there be an adjustment or is it because of the patchwork nature of the system and implementation that it would remain insurmountable.

Commissioner King commented that it was an existential question for the effectiveness of the program, which is due to sunset in October of 2028. By the end of the period, the office wants to be in the position to offer a recommendation as to whether the program should be continued or be allowed to sunset.

Brittney added that it is just not clear. If it was said that specific codes, such as these CTs, MRIs should be removed from fully insured commercial plans when ordered by a PCP across the board. That could then be electronically built into the EMR to auto authorize and wouldn't require them to manually check everyone. There is a gray area with the statement 'when ordered by a PCP and could have been ordered by a PCP in the normal course of care, it may not require a prior authorization.'

Christina echoed Brittney's comments as to needing more clarity.

Commissioner King added that when OHIC interpreted the statute, they did so in broadest manner possible. He felt that enumerating specific codes for which prior authorization should not be applied implies that there are codes where it should be required by a PCP. He added that maybe there is a need on the commercial side, for there to be additional specificity. On the Medicaid side, there is guidance that contains specific codes.

Christina added that she is not asking for OHIC for more specificity, but it is her recommendation for EOHHS to broaden.

Sarah added that if a patient is seen by a colleague, who is also a primary care provider but not the provider listed on the patient's insurance card, that provider is not being honored as the PCP. The primary care provider ordering the service must also be the one that is listed as that specific patient's primary care provider. The patient then has to request the change, which leads to a delay in processing.

Commissioner King noted that the feedback is helpful. He asked if the provider was credentialed as a PCP with that health plan. He assumed that if you are on the roster as a PCP with the health plan, it shouldn't matter if you were listed on the specific insurance card. It would be very restrictive for the law to require that you are also the selected PCP of the patient for the waiver to be triggered.

Charlie echoed that he doesn't think that follows either the spirit or the letter of the law or OHIC guidance.

Christopher Furey echoed the same concern as Sarah, as they have seen similar cases.

Co-Chair Dr. Peter Hollmann (Brown) added in the chat that it was not consistent with law, and thanked Charlie and Commissioner King for investigating the issue.

Dr. Ottiano echoed that there needed to be another look at that as it should be any provider who is involved in the practice that the patient is involved in. It may not apply to any PCP in the network but certainly should apply to any provider within the same practice. He also added to the data discussion, that it was NHPRI's first run at this and it didn't appear that much really changed but

they did not have automated system up and running until July 15 of this year. There were many cases where there were double requests being processed and received. There is some internal cleaning to do, but he is optimistic that when cutting away the double counts there is some notable improvement.

Commissioner King thanked Dr. Ottiano for his remarks. The plan is to have check-ins periodically to gage performance. Kinks are expected as this is the first time data is being collected from health plans at this level.

Charlie added that they would work on clarifying the ordering PCP issue. The specific statutory language states 'ordered by a primary care provider in the normal course of providing primary care treatment.'

Co-Chair Dr. Peter Hollmann (Brown) added that it is the first time they really had substantial statistics, and the data gives them an opportunity to work through the process. He noted that NHPRI and BCBSRI are local and always at the table.

4. Public Comment

No public comment was received.