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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 -- INSURANCE COVERAGE FOR MENTAL ILLNESS AND
SUBSTANCE USE DISORDERS

Introduced By: Representatives Tanzi, Carson, Boylan, McGaw, Speakman, Cortvriend,
Kislak, Hull, Cotter, and Donovan

Date Introduced: March 04, 2024

Referred To: House Health & Human Services

It is enacted by the General Assembly as follows:

1 SECTION 1. Sections 27-38.2-2 and 27-38.2-3 of the General Laws in Chapter 27-38.2
2 entitled "Insurance Coverage for Mental Illness and Substance Use Disorders" are hereby amended
3 to read as follows:

4 **27-38.2-2. Definitions.**

5 For the purposes of this chapter, the following words and terms have the following
6 meanings:

7 (1) "Financial requirements" means deductibles, copayments, coinsurance, or out-of-
8 pocket maximums.

9 (2) "Group health plan" means an employee welfare benefit plan as defined in 29 U.S.C. §
10 1002(1) to the extent that the plan provides health benefits to employees or their dependents directly
11 or through insurance, reimbursement, or otherwise. For purposes of this chapter, a group health
12 plan shall not include a plan that provides health benefits directly to employees or their dependents,
13 except in the case of a plan provided by the state or an instrumentality of the state.

14 (3) "Health insurance plan" means health insurance coverage offered, delivered, issued for
15 delivery, or renewed by a health insurer.

16 (4) "Health insurers" means all persons, firms, corporations, or other organizations offering
17 and assuring health services on a prepaid or primarily expense-incurred basis, including but not
18 limited to, policies of accident or sickness insurance, as defined by chapter 18 of this title; nonprofit

1 hospital or medical service plans, whether organized under chapter 19 or 20 of this title or under
2 any public law or by special act of the general assembly; health maintenance organizations, or any
3 other entity that insures or reimburses for diagnostic, therapeutic, or preventive services to a
4 determined population on the basis of a periodic premium. Provided, this chapter does not apply to
5 insurance coverage providing benefits for:

- 6 (i) Hospital confinement indemnity;
- 7 (ii) Disability income;
- 8 (iii) Accident only;
- 9 (iv) Long-term care;
- 10 (v) Medicare supplement;
- 11 (vi) Limited benefit health;
- 12 (vii) Specific disease indemnity;
- 13 (viii) Sickness or bodily injury or death by accident or both; and
- 14 (ix) Other limited benefit policies.

15 (5) "Mental health or substance use disorder" means any mental disorder and substance
16 use disorder that is listed in the most recent revised publication or the most updated volume of
17 either the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American
18 Psychiatric Association or the International Classification of Disease Manual (ICO) published by
19 the World Health Organization; provided, that tobacco and caffeine are excluded from the
20 definition of "substance" for the purposes of this chapter.

21 (6) "Non-quantitative treatment limitations" means: (i) Medical management standards;
22 (ii) Formulary design and protocols; (iii) Network tier design; (iv) Standards for provider admission
23 to participate in a network; (v) Reimbursement rates and methods for determining usual, customary,
24 and reasonable charges; and (vi) Other criteria that limit scope or duration of coverage for services
25 in the treatment of mental health and substance use disorders, including restrictions based on
26 geographic location, facility type, and provider specialty.

27 (7) "Quantitative treatment limitations" means numerical limits on coverage for the
28 treatment of mental health and substance use disorders based on the frequency of treatment, number
29 of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration
30 of treatment.

31 (8) "Generally accepted standards of mental health and substance use disorder care" means
32 standards of care and clinical practice that are generally recognized by health care providers
33 practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology,
34 addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources

1 reflecting generally accepted standards of mental health and substance use disorder care include
2 peer-reviewed scientific studies and medical literature, recommendations of nonprofit health care
3 provider professional associations and specialty societies, including, but not limited to, patient
4 placement criteria and clinical practice guidelines, recommendations of federal government
5 agencies, and drug labeling approved by the United States Food and Drug Administration.

6 (9) "Medically necessary treatment of a mental health or substance use disorder" means a
7 service or product addressing the specific needs of that patient, for the purpose of screening,
8 preventing, diagnosing, managing or treating an illness, injury, condition, or its symptoms,
9 including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner
10 that is all of the following:

11 (i) In accordance with the generally accepted standards of mental health and substance use
12 disorder care;

13 (ii) Clinically appropriate in terms of type, frequency, extent, site, and duration; and

14 (iii) Not primarily for the economic benefit of the insurer, purchaser, or for the convenience
15 of the patient, treating physician, or other health care provider.

16 (10) "Mental health and substance use disorders" means a mental health condition or
17 substance use disorder that falls under any of the diagnostic categories listed in the mental and
18 behavioral disorders chapter of the most recent edition of the World Health Organization's
19 International Statistical Classification of Diseases and Related Health Problems, or that is listed in
20 the most recent version of the American Psychiatric Association's Diagnostic and Statistical
21 Manual of Mental Disorders. Changes in terminology, organization, or classification of mental
22 health and substance use disorders in future versions of the American Psychiatric Association's
23 Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization's
24 International Statistical Classification of Diseases and Related Health Problems shall not affect the
25 conditions covered by this section as long as a condition is commonly understood to be a mental
26 health or substance use disorder by health care providers practicing in relevant clinical specialties.

27 (11) "Utilization review" means either of the following:

28 (i) Prospectively, retrospectively, or concurrently reviewing and approving, modifying,
29 delaying, or denying, based, in whole or in part, on medical necessity, requests by health care
30 providers, insureds, or their authorized representatives for coverage of health care services prior to,
31 retrospectively or concurrent with the provision of health care services to insureds.

32 (ii) Evaluating the medical necessity, appropriateness, level of care, service intensity,
33 efficacy, or efficiency of health care services, benefits, procedures, or settings, under any
34 circumstances, to determine whether a health care service or benefit subject to a medical necessity

1 coverage requirement in an insurance policy is covered as medically necessary for an insured.

2 (12) "Utilization review criteria" means any criteria, standards, protocols, or guidelines
3 used by an insurer to conduct an utilization review.

4 **27-38.2-3. Medical necessity and appropriateness of treatment.**

5 ~~(a) Upon request of the reimbursing health insurers, all providers of treatment of mental~~
6 ~~illness shall furnish medical records or other necessary data that substantiates that initial or~~
7 ~~continued treatment is at all times medically necessary and appropriate. When the provider cannot~~
8 ~~establish the medical necessity and/or appropriateness of the treatment modality being provided,~~
9 ~~neither the health insurer nor the patient shall be obligated to reimburse for that period or type of~~
10 ~~care that was not established. The exception to the preceding can only be made if the patient has~~
11 ~~been informed of the provisions of this subsection and has agreed in writing to continue to receive~~
12 ~~treatment at his or her own expense.~~ Every insurance policy issued, amended, or renewed on or
13 after January 1, 2025, that provides hospital, medical, or surgical coverage shall provide coverage
14 for medically necessary treatment of mental health and substance use disorders.

15 ~~(b) The health insurers, when making the determination of medically necessary and~~
16 ~~appropriate treatment, must do so in a manner consistent with that used to make the determination~~
17 ~~for the treatment of other diseases or injuries covered under the health insurance policy or~~
18 ~~agreement.~~ An insurer shall not limit benefits or coverage for chronic or pervasive mental health
19 and substance use disorders to short-term or acute treatment at any level of care placement.

20 ~~(c) Any subscriber who is aggrieved by a denial of benefits provided under this chapter~~
21 ~~may appeal a denial in accordance with the rules and regulations promulgated by the department~~
22 ~~of health pursuant to chapter 17.12 [repealed] of title 23.~~ All medical necessity determinations made
23 by the insurer concerning service intensity, level of care placement, continued stay, and transfer or
24 discharge of insureds diagnosed with mental health and substance use disorders shall be conducted
25 in accordance with the requirements of this section.

26 (d) An insurer that authorizes a specific type of treatment by a provider pursuant to this
27 section shall not rescind or modify the authorization after the provider renders the health care
28 service in good faith and pursuant to this authorization for any reason, including, but not limited
29 to, the insurer's subsequent rescission, cancellation, or modification of the insured's or
30 policyholder's contract, or the insurer's subsequent determination that it did not make an accurate
31 determination of the insured's or policyholder's eligibility. This section shall not be construed to
32 expand or alter the benefits available to the insured or policyholder under an insurance policy.

33 (e) If services for the medically necessary treatment of a mental health or substance use
34 disorder are not available in network within the geographic and timeliness access standards set by

1 law or regulation, the insurer shall arrange coverage to ensure the delivery of medically necessary
2 out-of-network services and any medically necessary follow-up services that, to the maximum
3 extent possible, meet those geographic and timely access standards. As used in this subsection, to
4 "arrange coverage to ensure the delivery of medically necessary out-of-network services" includes,
5 but is not limited to, providing services to secure medically necessary out-of-network options that
6 are available to the insured within geographic and timely access standards. The insured shall pay
7 no more in total for benefits rendered than the cost sharing that the insured would pay for the same
8 covered services received from an in-network provider.

9 (f) An insurer shall not limit benefits or coverage for medically necessary services on the
10 basis that those services should be or could be covered by a public entitlement program, including,
11 but not limited to, special education or an individualized education program, Medicaid, Medicare,
12 Supplemental Security Income, or Social Security Disability Insurance, and shall not include or
13 enforce a contract term that excludes otherwise covered benefits on the basis that those services
14 should be or could be covered by a public entitlement program.

15 (g) An insurer shall not adopt, impose, or enforce terms in its policies or provider
16 agreements, in writing or in operation, that undermine, alter, or conflict with the requirements of
17 this section.

18 (h) If the insurance commissioner determines that an insurer has violated this section, the
19 commissioner may, after appropriate notice and opportunity for hearing in accordance with chapter
20 35 of title 42, by order, assess a civil penalty not to exceed five thousand dollars (\$5,000) for each
21 violation, or, if a violation was willful, a civil penalty not to exceed ten thousand dollars (\$10,000)
22 for each violation. The civil penalties available to the commissioner pursuant to this section are not
23 exclusive and may be sought and employed in combination with any other remedies available to
24 the commissioner under this section.

25 SECTION 2. Chapter 27-38.2 of the General Laws entitled "Insurance Coverage for Mental
26 Illness and Substance Use Disorders" is hereby amended by adding thereto the following section:

27 **27-38.2-7. Medical necessity determinations shall follow generally accepted**
28 **standards.**

29 (a) An insurer that provides hospital, medical, or surgical coverage shall base any medical
30 necessity determination or the utilization review criteria that the insurer, and any entity acting on
31 the insurer's behalf, applies to determine the medical necessity of health care services and benefits
32 for the diagnosis, prevention, and treatment of mental health and substance use disorders on current
33 generally accepted standards of mental health and substance use disorder care as defined in § 27-
34 38.2-2. All denials and appeals shall be reviewed by a professional with the same level of education

1 and experience of the provider requesting the authorization.

2 (b) In conducting a utilization review of all covered health care services and benefits for
3 the diagnosis, prevention, and treatment of mental health and substance use disorders in children,
4 adolescents, and adults, an insurer shall apply the level of care placement criteria and practice
5 guidelines set forth in the most recent versions of such criteria and practice guidelines, developed
6 by the nonprofit professional association for the relevant clinical specialty.

7 (c) In conducting a utilization review involving level of care placement decisions or any
8 other patient care decisions that are within the scope of the sources specified in subsection (b) of
9 this section, an insurer shall not apply different, additional, conflicting, or more restrictive
10 utilization review criteria than the criteria and guidelines set forth in those sources. For all level of
11 care placement decisions, the insurer shall authorize placement at the level of care consistent with
12 the insured's score using the relevant level of care placement criteria and guidelines as specified in
13 subsection (b) of this section. If that level of placement is not available, the insurer shall authorize
14 the next higher level of care. In the event of disagreement, the insurer shall provide full detail of its
15 scoring using the relevant level of care placement criteria and guidelines as specified in subsection
16 (b) of this section, to the provider of the service.

17 (d) To ensure the proper use of the criteria described in subsection (b) of this section, every
18 insurer shall do all of the following:

19 (1) Sponsor a formal education program by nonprofit clinical specialty associations to
20 educate the insurer's staff, including any third parties contracted with the insurer to review claims,
21 conduct utilization reviews, or make medical necessity determinations about the clinical review
22 criteria;

23 (2) Make the education program available to other stakeholders, including the insurer's
24 participating providers and covered lives;

25 (3) Provide, at no cost, the clinical review criteria and any training material or resources to
26 providers and insured patients;

27 (4) Track, identify, and analyze how the clinical review criteria are used to certify care,
28 deny care, and support the appeals process;

29 (5) Conduct interrater reliability testing to ensure consistency in utilization review decision
30 making covering how medical necessity decisions are made. This assessment shall cover all aspects
31 of an utilization review as defined in § 27-38.2-2.

32 (6) Run interrater reliability reports about how the clinical guidelines are used in
33 conjunction with the utilization management process and parity compliance activities; and

34 (7) Achieve interrater reliability pass rates of at least ninety percent (90%) and, if this

1 threshold is not met, immediately provide for the remediation of poor interrater reliability and
2 interrater reliability testing for all new staff before they can conduct an utilization review without
3 supervision.

4 (e) This section applies to all health care services and benefits for the diagnosis, prevention,
5 and treatment of mental health and substance use disorders covered by an insurance policy,
6 including prescription drugs.

7 (f) This section applies to an insurer that covers hospital, medical, or surgical expenses and
8 conducts an utilization review as defined in this section, and any entity or contracting provider that
9 performs utilization review or utilization management functions on an insurer's behalf.

10 (g) If the insurance commissioner determines that an insurer has violated this section, the
11 commissioner may, after appropriate notice and opportunity for hearing in accordance with section
12 35 of title 42, by order, assess a civil penalty not to exceed five thousand dollars (\$5,000) for each
13 violation, or, if a violation was willful, a civil penalty not to exceed ten thousand dollars (\$10,000)
14 for each violation. The civil penalties available to the commissioner pursuant to this section are not
15 exclusive and may be sought and employed in combination with any other remedies available to
16 the commissioner under this section.

17 (h) An insurer shall not adopt, impose, or enforce terms in its policies or provider
18 agreements, in writing or in operation, that undermine, alter, or conflict with the requirements of
19 this section.

20 **27-38.2-8. Discretionary clauses prohibited.**

21 (a) If an insurer contract offered, issued, delivered, amended, or renewed on or after
22 January 1, 2025, contains a provision that reserves discretionary authority to the insurer, or an agent
23 of the insurer, to determine eligibility for benefits or coverage, to interpret the terms of the contract,
24 or to provide standards of interpretation or review that are inconsistent with the laws of this state,
25 that provision is void and unenforceable.

26 (b) For purposes of this section, the term "discretionary authority" means a contract
27 provision that has the effect of conferring discretion on an insurer or other claims administrator to
28 determine entitlement to benefits or interpret contract language that, in turn, could lead to a
29 deferential standard of review by a reviewing court.

30 (c) This section does not prohibit an insurer from including a provision in a contract that
31 informs an insured that, as part of its routine operations, the plan applies the terms of its contracts
32 for making decisions, including making determinations regarding eligibility, receipt of benefits and
33 claims, or explaining policies, procedures, and processes, as long as the provision could not give
34 rise to a deferential standard of review by a reviewing court.

1 **27-38.2-9. Severability clause.**

2 The provisions of this chapter are severable. If any provision of this chapter or its
3 application is held invalid, that invalidity shall not affect other provisions or applications that can
4 be given effect without the invalid provision or application.

5 SECTION 3. 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 -- INSURANCE COVERAGE FOR MENTAL ILLNESS AND
SUBSTANCE USE DISORDERS

- 1 This act would outline the insurance coverage standards, protocols and guidelines for
- 2 medically necessary treatment of individuals with mental health or substance abuse use disorders.
- 3 This act would take effect upon passage.

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