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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: Senators Ujifusa, Kallman, Miller, Lauria, Lawson, Valverde, Murray,  
DiPalma, Pearson, and Quezada

Date Introduced: March 01, 2024

Referred To: Senate 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) "Generally accepted standards of mental health and substance use disorder care" means  
10          standards of care and clinical practice that are generally recognized by health care providers  
11          practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology,  
12          addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources  
13          reflecting generally accepted standards of mental health and substance use disorder care include  
14          peer-reviewed scientific studies and medical literature, recommendations of nonprofit health care  
15          provider professional associations and specialty societies, including, but not limited to, patient  
16          placement criteria and clinical practice guidelines, recommendations of federal government  
17          agencies, and drug labeling approved by the United States Food and Drug Administration.

18          (3) "Group health plan" means an employee welfare benefit plan as defined in 29 U.S.C. §

1 1002(1) to the extent that the plan provides health benefits to employees or their dependents directly  
2 or through insurance, reimbursement, or otherwise. For purposes of this chapter, a group health  
3 plan shall not include a plan that provides health benefits directly to employees or their dependents,  
4 except in the case of a plan provided by the state or an instrumentality of the state.

5 ~~(3)~~(4) "Health insurance plan" means health insurance coverage offered, delivered, issued  
6 for delivery, or renewed by a health insurer.

7 ~~(4)~~(5) "Health insurers" means all persons, firms, corporations, or other organizations  
8 offering and assuring health services on a prepaid or primarily expense-incurred basis, including  
9 but not limited to, policies of accident or sickness insurance, as defined by chapter 18 of this title;  
10 nonprofit hospital or medical service plans, whether organized under chapter 19 or 20 of this title  
11 or under any public law or by special act of the general assembly; health maintenance organizations,  
12 or any other entity that insures or reimburses for diagnostic, therapeutic, or preventive services to  
13 a determined population on the basis of a periodic premium. Provided, this chapter does not apply  
14 to insurance coverage providing benefits for:

- 15 (i) Hospital confinement indemnity;
- 16 (ii) Disability income;
- 17 (iii) Accident only;
- 18 (iv) Long-term care;
- 19 (v) Medicare supplement;
- 20 (vi) Limited benefit health;
- 21 (vii) Specific disease indemnity;
- 22 (viii) Sickness or bodily injury or death by accident or both; and
- 23 (ix) Other limited benefit policies.

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

- 29 (i) In accordance with the generally accepted standards of mental health and substance use  
30 disorder care;
- 31 (ii) Clinically appropriate in terms of type, frequency, extent, site, and duration; and
- 32 (iii) Not primarily for the economic benefit of the insurer, purchaser, or for the convenience  
33 of the patient, treating physician, or other health care provider.

34 (7) "Mental health and substance use disorders" means a mental health condition or

1 substance use disorder that falls under any of the diagnostic categories listed in the mental and  
2 behavioral disorders chapter of the most recent edition of the World Health Organization's  
3 International Statistical Classification of Diseases and Related Health Problems, or that is listed in  
4 the most recent version of the American Psychiatric Association's Diagnostic and Statistical  
5 Manual of Mental Disorders. Changes in terminology, organization, or classification of mental  
6 health and substance use disorders in future versions of the American Psychiatric Association's  
7 Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization's  
8 International Statistical Classification of Diseases and Related Health Problems shall not affect the  
9 conditions covered by this chapter as long as a condition is commonly understood to be a mental  
10 health or substance use disorder by health care providers practicing in relevant clinical specialties.

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

17 ~~(6)~~(8) "Non-quantitative treatment limitations" means: (i) Medical management standards;  
18 (ii) Formulary design and protocols; (iii) Network tier design; (iv) Standards for provider admission  
19 to participate in a network; (v) Reimbursement rates and methods for determining usual, customary,  
20 and reasonable charges; and (vi) Other criteria that limit scope or duration of coverage for services  
21 in the treatment of mental health and substance use disorders, including restrictions based on  
22 geographic location, facility type, and provider specialty.

23 ~~(7)~~(9) "Quantitative treatment limitations" means numerical limits on coverage for the  
24 treatment of mental health and substance use disorders based on the frequency of treatment, number  
25 of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration  
26 of treatment.

27 (10) "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; or

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 (11) "Utilization review criteria" means any criteria, standards, protocols, or guidelines  
3 used by an insurer to conduct 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 § 27-38.2-7.

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, by order, assess a civil  
20 penalty not to exceed five thousand dollars (\$5,000) for each violation, or, if a violation was willful,  
21 a civil penalty not to exceed ten thousand dollars (\$10,000) for each violation. The civil penalties  
22 available to the commissioner pursuant to this section are not exclusive and may be sought and  
23 employed in combination with any other remedies available to the commissioner.

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

26 **27-38.2-7. Medical necessity determinations shall follow generally accepted**  
27 **standards.**

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

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

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

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

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

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

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

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

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

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

33 (7) Achieve interrater reliability pass rates of at least ninety percent (90%) and, if this  
34 threshold is not met, immediately provide for the remediation of poor interrater reliability and

1 interrater reliability testing for all new staff before they can conduct an utilization review without  
2 supervision.

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

6 (f) This section applies to an insurer that covers hospital, medical, or surgical expenses and  
7 conducts an utilization review as defined in § 27-38.2-2, and any entity or contracting provider that  
8 performs utilization review or utilization management functions on an insurer's behalf.

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

15 (h) 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 **27-38.2-8. Discretionary clauses prohibited.**

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

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

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

33 **27-38.2-9. Severability clause.**

34 The provisions of this chapter are severable. If any provision of this chapter or its

1 [application is held invalid, that invalidity shall not affect other provisions or applications that can](#)  
2 [be given effect without the invalid provision or application.](#)

3 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

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1           This act would require that any insurance contract issued, amended or renewed on or after  
2 January 1, 2025, that provides hospital, medical or surgical coverage shall provide coverage for  
3 medically necessary treatment of mental health or substance use disorders. This act would further  
4 provide that out-of-network coverage shall be provided if in-network coverage is not available for  
5 medically necessary treatment of a mental health or substance use disorder. This act would further  
6 prohibit an insurer from limiting coverage for medically necessary services solely on the basis that  
7 such services would be covered by a public entitlement program.

8           This act would take effect upon passage.

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