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S T A T E O F R H O D E I S L A N D

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2025

A N A C T

RELATING TO INSURANCE -- ACCIDENT AND SICKNESS INSURANCE POLICIES -- REGULATE HEALTH INSURANCE PRIOR AUTHORIZATION REQUIREMENTS FOR REHABILITATIVE AND HABILITATIVE SERVICES ACT

Introduced By: Senators Mack, Lauria, Acosta, Valverde, Thompson, Kallman, DiMario, Pearson, and Ujifusa
Date Introduced: February 26, 2025

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

SECTION 1. Chapter 27-18 of the General Laws entitled "Accident and Sickness Insurance Policies" is hereby amended by adding thereto the following section:

27-18-95. Prior authorization for rehabilitative and habilitative services.

(a) An individual or group health insurance plan shall not require prior authorization for rehabilitative or habilitative services, including, but not limited to, physical therapy or occupational therapy services for the first twelve (12) visits of each new episode of care. For purposes of this section, "new episode of care" means treatment for a new or recurring condition for which an insured has not been treated by the provider within the previous ninety (90) days. After the twelve (12) visits of each new episode of care, an individual or group health insurance plan shall not require prior authorization more frequently than every six (6) visits or every thirty (30) days, whichever time period is longer.

(b) An individual or group health insurance plan shall not require prior authorization for physical medicine or rehabilitation services provided to patients with chronic pain for the first ninety (90) days following diagnosis in order to provide the necessary nonpharmacologic management of the pain. After the first ninety (90) days following a chronic pain diagnosis, an individual or group health insurance plan shall not require prior authorization more frequently than every six (6) visits or every thirty (30) days, whichever time period is longer. For purposes of this subsection, "chronic pain" means pain that persists or recurs for more than three (3) months.

(c) An individual or group health insurance plan shall respond to a prior authorization request for services or visits in an ongoing plan of care under this section within twenty-four (24) hours. If an individual or group health insurance plan requires more information to make a decision on the prior authorization request, the individual or group health insurance plan shall notify the patient and the provider within twenty-four (24) hours of the initial request with the information that is needed to complete the prior authorization request including, but not limited to, the specific tests and measures needed from the patient and provider. An individual or group health insurance plan shall make a decision on the prior authorization request within twenty-four (24) hours of receiving the requested information.

(d) With regard to circumstances in which a prior authorization for covered services under this section is deemed to be approved by an individual or group health insurance plan, a prior authorization is deemed to be approved if an individual or group health insurance plan:

(1) Fails to timely answer a prior authorization request in accordance with subsection (c) of this section, including due to a failure of the individual or group health insurance plan’s prior authorization platform or process; or

(2) Informs a provider that prior authorization is not required orally, via an online platform or program, through the patient's health plan documents or by any other means.

(e) An individual or group health insurance plan shall provide a procedure for providers and insureds to obtain retroactive authorization for services under this section that are medically necessary covered benefits. An individual or group health insurance plan shall not deny coverage for medically necessary services under this section only for failure to obtain a prior authorization, if a medical necessity determination can be made after the services have been provided and the services would have been covered benefits if prior authorization had been obtained.

(f) An individual or group health insurance plan’s failure to approve a prior authorization for all services or visits in a plan of care under this section is subject to the same appeal rights as a denial under the office of the health insurance commissioner's rule or regulation regarding health plan accountability and the provider's network agreement with the carrier, if any.

(g) Nothing in this section is intended to prohibit an individual or group health insurance plan from performing a retrospective medical necessity review.

SECTION 2. Chapter 27-19 of the General Laws entitled " Nonprofit Hospital Service Corporations " is hereby amended by adding thereto the following section:

27-19-87. Prior authorization for rehabilitative and habilitative services.

(a) An individual or group health insurance plan shall not require prior authorization for rehabilitative or habilitative services, including, but not limited to, physical therapy or occupational

therapy services for the first twelve (12) visits of each new episode of care. For purposes of this section, "new episode of care" means treatment for a new or recurring condition for which an insured has not been treated by the provider within the previous ninety (90) days. After the twelve (12) visits of each new episode of care, an individual or group health insurance plan shall not require prior authorization more frequently than every six (6) visits or every thirty (30) days, whichever time period is longer.

(b) An individual or group health insurance plan shall not require prior authorization for physical medicine or rehabilitation services provided to patients with chronic pain for the first ninety (90) days following diagnosis in order to provide the necessary nonpharmacologic management of the pain. After the first ninety (90) days following a chronic pain diagnosis, an individual or group health insurance plan shall not require prior authorization more frequently than every six (6) visits or every thirty (30) days, whichever time period is longer. For purposes of this subsection, "chronic pain" means pain that persists or recurs for more than three (3) months.

(c) An individual or group health insurance plan shall respond to a prior authorization request for services or visits in an ongoing plan of care under this section within twenty-four (24) hours. If an individual or group health insurance plan requires more information to make a decision on the prior authorization request, the individual or group health insurance plan shall notify the patient and the provider within twenty-four (24) hours of the initial request with the information that is needed to complete the prior authorization request including, but not limited to, the specific tests and measures needed from the patient and provider. An individual or group health insurance plan shall make a decision on the prior authorization request within twenty-four (24) hours of receiving the requested information.

(d) With regard to circumstances in which a prior authorization for covered services under this section is deemed to be approved by an individual or group health insurance plan, a prior authorization is deemed to be approved if an individual or group health insurance plan:

(1) Fails to timely answer a prior authorization request in accordance with subsection (c) of this section, including due to a failure of the individual or group health insurance plan’s prior authorization platform or process; or

(2) Informs a provider that prior authorization is not required orally, via an online platform or program, through the patient's health plan documents or by any other means.

(e) An individual or group health insurance plan shall provide a procedure for providers and insureds to obtain retroactive authorization for services under this section that are medically necessary covered benefits. An individual or group health insurance plan shall not deny coverage for medically necessary services under this section only for failure to obtain a prior authorization,

if a medical necessity determination can be made after the services have been provided and the services would have been covered benefits if prior authorization had been obtained.

(f) An individual or group health insurance plan's failure to approve a prior authorization for all services or visits in a plan of care under this section is subject to the same appeal rights as a denial under the office of the health insurance commissioner's rule or regulation regarding health plan accountability and the provider's network agreement with the carrier, if any.

(g) Nothing in this section is intended to prohibit an individual or group health insurance plan from performing a retrospective medical necessity review.

SECTION 3. Chapter 27-20 of the General Laws entitled " Nonprofit Medical Service Corporations " is hereby amended by adding thereto the following section:

27-20-83. Prior authorization for rehabilitative and habilitative services.

(a) An individual or group health insurance plan shall not require prior authorization for rehabilitative or habilitative services, including, but not limited to, physical therapy or occupational therapy services for the first twelve (12) visits of each new episode of care. For purposes of this section, "new episode of care" means treatment for a new or recurring condition for which an insured has not been treated by the provider within the previous ninety (90) days. After the twelve (12) visits of each new episode of care, an individual or group health insurance plan shall not require prior authorization more frequently than every six (6) visits or every thirty (30) days, whichever time period is longer.

(b) An individual or group health insurance plan shall not require prior authorization for physical medicine or rehabilitation services provided to patients with chronic pain for the first ninety (90) days following diagnosis in order to provide the necessary nonpharmacologic management of the pain. After the first ninety (90) days following a chronic pain diagnosis, an individual or group health insurance plan shall not require prior authorization more frequently than every six (6) visits or every thirty (30) days, whichever time period is longer. For purposes of this subsection, "chronic pain" means pain that persists or recurs for more than three (3) months.

(c) An individual or group health insurance plan shall respond to a prior authorization request for services or visits in an ongoing plan of care under this section within twenty-four (24) hours. If an individual or group health insurance plan requires more information to make a decision on the prior authorization request, the individual or group health insurance plan shall notify the patient and the provider within twenty-four (24) hours of the initial request with the information that is needed to complete the prior authorization request including, but not limited to, the specific tests and measures needed from the patient and provider. An individual or group health insurance plan shall make a decision on the prior authorization request within twenty-four (24) hours of

receiving the requested information.

(d) With regard to circumstances in which a prior authorization for covered services under this section is deemed to be approved by an individual or group health insurance plan, a prior authorization is deemed to be approved if an individual or group health insurance plan:

(1) Fails to timely answer a prior authorization request in accordance with subsection (c) of this section, including due to a failure of the individual or group health insurance plan's prior authorization platform or process; or

(2) Informs a provider that prior authorization is not required orally, via an online platform or program, through the patient's health plan documents or by any other means.

(e) An individual or group health insurance plan shall provide a procedure for providers and insureds to obtain retroactive authorization for services under this section that are medically necessary covered benefits. An individual or group health insurance plan shall not deny coverage for medically necessary services under this section only for failure to obtain a prior authorization, if a medical necessity determination can be made after the services have been provided and the services would have been covered benefits if prior authorization had been obtained.

(f) An individual or group health insurance plan's failure to approve a prior authorization for all services or visits in a plan of care under this section is subject to the same appeal rights as a denial under the office of the health insurance commissioner's rule or regulation regarding health plan accountability and the provider's network agreement with the carrier, if any.

(g) Nothing in this section is intended to prohibit an individual or group health insurance plan from performing a retrospective medical necessity review.

SECTION 4. Chapter 27-41 of the General Laws entitled " Health Maintenance Organizations " is hereby amended by adding thereto the following section:

27-41-100. Prior authorization for rehabilitative and habilitative services.

(a) An individual or group health insurance plan shall not require prior authorization for rehabilitative or habilitative services, including, but not limited to, physical therapy or occupational therapy services for the first twelve (12) visits of each new episode of care. For purposes of this section, "new episode of care" means treatment for a new or recurring condition for which an insured has not been treated by the provider within the previous ninety (90) days. After the twelve (12) visits of each new episode of care, an individual or group health insurance plan shall not require prior authorization more frequently than every six (6) visits or every thirty (30) days, whichever time period is longer.

(b) An individual or group health insurance plan shall not require prior authorization for physical medicine or rehabilitation services provided to patients with chronic pain for the first

ninety (90) days following diagnosis in order to provide the necessary nonpharmacologic management of the pain. After the first ninety (90) days following a chronic pain diagnosis, an individual or group health insurance plan shall not require prior authorization more frequently than every six (6) visits or every thirty (30) days, whichever time period is longer. For purposes of this subsection, "chronic pain" means pain that persists or recurs for more than three (3) months.

(c) An individual or group health insurance plan shall respond to a prior authorization request for services or visits in an ongoing plan of care under this section within twenty-four (24) hours. If an individual or group health insurance plan requires more information to make a decision on the prior authorization request, the individual or group health insurance plan shall notify the patient and the provider within twenty-four (24) hours of the initial request with the information that is needed to complete the prior authorization request including, but not limited to, the specific tests and measures needed from the patient and provider. An individual or group health insurance plan shall make a decision on the prior authorization request within twenty-four (24) hours of receiving the requested information.

(d) With regard to circumstances in which a prior authorization for covered services under this section is deemed to be approved by an individual or group health insurance plan, a prior authorization is deemed to be approved if an individual or group health insurance plan:

(1) Fails to timely answer a prior authorization request in accordance with subsection (c) of this section, including due to a failure of the individual or group health insurance plan’s prior authorization platform or process; or

(2) Informs a provider that prior authorization is not required orally, via an online platform or program, through the patient's health plan documents or by any other means.

(e) An individual or group health insurance plan shall provide a procedure for providers and insureds to obtain retroactive authorization for services under this section that are medically necessary covered benefits. An individual or group health insurance plan shall not deny coverage for medically necessary services under this section only for failure to obtain a prior authorization, if a medical necessity determination can be made after the services have been provided and the services would have been covered benefits if prior authorization had been obtained.

(f) An individual or group health insurance plan’s failure to approve a prior authorization for all services or visits in a plan of care under this section is subject to the same appeal rights as a denial under the office of the health insurance commissioner's rule or regulation regarding health plan accountability and the provider's network agreement with the carrier, if any.

(g) Nothing in this section is intended to prohibit an individual or group health insurance plan from performing a retrospective medical necessity review.

SECTION 2. This act shall take effect on January 1, 2026.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N A C T

RELATING TO INSURANCE -- ACCIDENT AND SICKNESS INSURANCE POLICIES -- REGULATE HEALTH INSURANCE PRIOR AUTHORIZATION REQUIREMENTS FOR REHABILITATIVE AND HABILITATIVE SERVICES ACT

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This act would limit prior authorization requirements for rehabilitative and habilitative services. This act would prohibit prior authorization for the first twelve (12) visits of a new episode of care and for ninety (90) days following a chronic pain diagnosis. This act would also require that insurers must respond to requests within twenty-four (24) hours, and delays result in automatic approval. This act would further allow retroactive authorization for medically necessary services and provides appeal rights for denied requests.

This act would take effect on January 1, 2026.

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