# 2026 -- S 2564

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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. 2026**

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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, Euer, Mack, Zurier, Murray, Acosta, DiMario, Valverde, Lauria, and Bell
Date Introduced: February 13, 2026

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

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

**27-38.2-1. Coverage for treatment of mental health and substance use disorders.**

(a) A group health plan and an individual or group health insurance plan shall provide coverage for the treatment of mental health and substance use disorders under the same terms and conditions as that coverage is provided for other illnesses and diseases.

(b) Coverage for the treatment of mental health and substance use disorders shall not impose any annual or lifetime dollar limitation.

(c) Financial requirements and quantitative treatment limitations on coverage for the treatment of mental health and substance use disorders shall be no more restrictive than the predominant financial requirements applied to substantially all coverage for medical conditions in each treatment classification.

(d) Coverage shall not impose non-quantitative treatment limitations for the treatment of mental health and substance use disorders unless the processes, strategies, evidentiary standards, or other factors used in applying the non-quantitative treatment limitation, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to

medical/surgical benefits in the classification.

(e) The following classifications shall be used to apply the coverage requirements of this chapter: (1) Inpatient, in-network; (2) Inpatient, out-of-network; (3) Outpatient, in-network; (4) Outpatient, out-of-network; (5) Emergency care; and (6) Prescription drugs.

(f) Medication-assisted treatment or medication-assisted maintenance services of substance use disorders, opioid overdoses, and chronic addiction, including methadone, buprenorphine, naltrexone, or other clinically appropriate medications, is included within the appropriate classification based on the site of the service.

(g) Payors shall ~~rely upon~~ provide coverage for substance use disorders, at a minimum, in accordance with the criteria of the American Society of Addiction Medicine ~~when developing coverage for levels of care for substance use disorder treatment~~.

(h) In conducting utilization review relating to service intensity or level of care placement for a mental health or substance use disorder, a payor shall exclusively apply the most recent version of the age-appropriate patient placement criteria developed by nonprofit professional provider associations of the relevant clinical specialty and shall authorize placement at the service intensity or level of care consistent with those criteria. If the payor's application of the relevant patient placement criteria is not consistent with the service intensity or level of care placement requested by the patient or their provider, any adverse benefit determination notice shall include full details of the payor's assessment under the relevant criteria to the provider and the patient.

(i) Mental health and substance use disorder coverage and clinical criteria shall not deviate from generally accepted standards of care.

~~(h)~~(j) Patients with substance use disorders shall have access to evidence-based, non-opioid treatment for pain, therefore coverage shall apply to medically necessary chiropractic care and osteopathic manipulative treatment performed by an individual licensed under § 5-37-2.

~~(i)~~(k) Parity of cost-sharing requirements. Regardless of the professional license of the provider of care, if that care is consistent with the provider's scope of practice and the health plan's credentialing and contracting provisions, cost sharing for behavioral health counseling visits and medication maintenance visits shall be consistent with the cost sharing applied to primary care office visits.

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

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

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

(2) "Generally accepted standards of care" means standards of care and clinical practice that are generally recognized by healthcare providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical social work, addiction medicine and counseling, and behavioral health treatment, as reflected in sources including, but not limited to, patient placement criteria, service intensity determination, and clinical practice guidelines developed by nonprofit professional provider associations including, but not limited to, the Level of Care Utilization System (LOCUS), the Child and Adolescent Level of Care/Service Intensity Utilization System (CALOCUS-CASII), and the Early Childhood Service Intensity Instrument.

~~(2)~~(3) "Group health plan" means an employee welfare benefit plan as defined in 29 U.S.C. § 1002(1) to the extent that the plan provides health benefits to employees or their dependents directly or through insurance, reimbursement, or otherwise. For purposes of this chapter, a group health plan shall not include a plan that provides health benefits directly to employees or their dependents, except in the case of a plan provided by the state or an instrumentality of the state.

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

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

(i) Hospital confinement indemnity;

(ii) Disability income;

(iii) Accident only;

(iv) Long-term care;

(v) Medicare supplement;

(vi) Limited benefit health;

(vii) Specific disease indemnity;

(viii) Sickness or bodily injury or death by accident or both; and

(ix) Other limited benefit policies.

~~(5)~~(6) "Mental health or substance use disorder" means any mental disorder and substance use disorder that is listed in the most recent revised publication or the most updated volume of:

~~either the~~

(i) The Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association or the International Classification of Disease Manual (ICO) published by the World Health Organization~~; provided, that tobacco and caffeine are excluded from the definition of "substance" for the purposes of this chapter~~, or The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood.

(7) "Nonprofit professional provider association" means a not-for-profit healthcare provider professional association or specialty society that is generally recognized by clinicians practicing in the relevant clinical specialty and issues peer-reviewed guidelines, criteria, or other clinical recommendations developed through a transparent process, including the American Psychiatric Association, American Psychological Association, American Society of Addiction Medicine, American Academy of Child and Adolescent Psychiatry, and the American Association for Community Psychiatry.

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

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

SECTION 2. This act shall take effect upon passage.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

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This act would provide that for insurance coverage for treatment of mental health and substance use disorders, payors would rely upon criteria which reflect generally accepted standards of care when developing coverage for levels of care for mental health treatment. This act would also provide that payors would not modify clinical criteria to reduce coverage for mental health treatment below the level established by the generally accepted standards of care upon which their clinical criteria are based. This act would also provide a definition for the term “generally accepted standards of care.”

This act would take effect upon passage.

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