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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

A N A C T

RELATING TO INSURANCE -- ACCIDENT AND SICKNESS INSURANCE POLICIES

Introduced By: Representatives McGaw, Fogarty, Carson, Potter, Fellela, Furtado, Morales, Messier, Donovan, and Boylan
Date Introduced: January 28, 2026

Referred To: House 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:

27-18-96. Prior authorization restrictions 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 services for the first twelve (12) visits of each new episode of care. After the twelve (12) visits of each new episode of care, an individual or group health insurance plan may 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 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.

(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 may 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 for rehabilitative or habilitative services

within twenty-four (24) hours. If an individual or group health insurance plan requires more information to render 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 render a decision on the prior authorization request within twenty-four (24) hours of receiving the requested information.

(d) A prior authorization for rehabilitative or habilitative services 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 rehabilitative or habilitative services that are medically necessary covered benefits. An individual or group health insurance plan shall not deny coverage for medically necessary services for failure to obtain a prior authorization, if a medical necessity determination can be made after the rehabilitative or habilitative 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 rehabilitative or habilitative services or visits in a plan of care is subject to the same appeal rights as a denial under the health insurance commissioner's rule regarding health plan accountability and the provider's network agreement with the carrier, if any.

(g) Nothing in this section shall be construed 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:

27-19-88. Prior authorization restrictions 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 services for the first twelve (12) visits of each new episode of care. After the twelve (12) visits of each new episode of care, an individual or group health insurance plan may 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 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.

(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 may 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 for rehabilitative or habilitative services within twenty-four (24) hours. If an individual or group health insurance plan requires more information to render 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 render a decision on the prior authorization request within twenty-four (24) hours of receiving the requested information.

(d) A prior authorization for rehabilitative or habilitative services 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 rehabilitative or habilitative services that are medically necessary covered benefits. An individual or group health insurance plan shall not deny coverage for medically necessary services for failure to obtain a prior authorization, if a medical necessity determination can be made after the rehabilitative or habilitative 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 rehabilitative or habilitative services or visits in a plan of care is subject to the same appeal rights as a denial under the health insurance commissioner's rule regarding health plan accountability and the provider's network agreement with the carrier, if any.

(g) Nothing in this section shall be construed 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:

27-20-84. Prior authorization restrictions 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 services for the first twelve (12) visits of each new episode of care. After the twelve (12) visits of each new episode of care, an individual or group health insurance plan may 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 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.

(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 may 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 for rehabilitative or habilitative services within twenty-four (24) hours. If an individual or group health insurance plan requires more information to render 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 render a decision on the prior authorization request within twenty-four (24) hours of receiving the requested information.

(d) A prior authorization for rehabilitative or habilitative services 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 rehabilitative or habilitative services that are medically necessary covered benefits. An individual or group health insurance plan shall not deny coverage for medically necessary services for failure to obtain a prior authorization, if a medical necessity determination can be made after the rehabilitative or habilitative 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 rehabilitative or habilitative services or visits in a plan of care is subject to the same appeal rights as a denial under the health insurance commissioner's rule regarding health plan accountability and the provider's network agreement with the carrier, if any.

(g) Nothing in this section shall be construed 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:

27-41-101. Prior authorization restrictions 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 services for the first twelve (12) visits of each new episode of care. After the twelve (12) visits of each new episode of care, an individual or group health insurance plan may 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 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.

(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 may 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 for rehabilitative or habilitative services within twenty-four (24) hours. If an individual or group health insurance plan requires more information to render 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 render a decision on the prior authorization request within twenty-four (24) hours of receiving the requested information.

(d) A prior authorization for rehabilitative or habilitative services 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 rehabilitative or habilitative services that are medically necessary covered benefits. An individual or group health insurance plan shall not deny coverage for medically necessary services for failure to obtain a prior authorization, if a medical necessity determination can be made after the rehabilitative or habilitative 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 rehabilitative or habilitative services or visits in a plan of care is subject to the same appeal rights as a denial under the health insurance commissioner's rule regarding health plan accountability and the provider's network agreement with the carrier, if any.

(g) Nothing in this section shall be construed 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, 2027.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N A C T

RELATING TO INSURANCE -- ACCIDENT AND SICKNESS INSURANCE POLICIES

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This act would prohibit health insurance plans from requiring prior authorization for a new episode of rehabilitative care for twelve (12) visits, or from requiring prior authorization for rehabilitative care for chronic pain for ninety (90) days. This act would further mandate that where prior authorization is required, the health insurance plan would respond within twenty-four (24) hours. In addition, this act would require health insurance plans to provide a procedure for providers and insureds to obtain retroactive authorization for services that are medically necessary covered benefits.

This act would take effect on January 1, 2027.

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