Blue Cross Blue Shield of Rhode Island

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March 12, 2026

The Honorable Susan Donovan, Chair, House Committee on Health and Human Services
Via email to: HouseHealthandHumanServices@rilegislature.gov

Re: House Bills 7943 7944 7945 7946, relating to insurance (behavioral health)

Dear Chairwoman Donovan and Members of the Committee:

On behalf of Blue Cross & Blue Shield of Rhode Island (Blue Cross), I am writing to share information and express concern about these proposals, all relating to health plans' coverage of behavioral health services.

Blue Cross shares the sponsors' and advocates' commitment to accessible, high-quality, affordable behavioral health services. We strongly support behavioral health providers and the patients they serve, and we have consistently invested in behavioral health services through increased payment rates, innovative payment arrangements, and collaborations designed to improve access, integration with medical care, and patient outcomes. **In dollar terms, the cost of care for fully insured members' treatment grew, from 2020 to 2025, from $42 million to $62 million**. This reflects increases in the amount of care delivered (utilization) and the prices paid for that care (reimbursement rates).

Based on our experience administering behavioral health benefits, we respectfully raise several concerns regarding the approaches reflected in these bills.

Utilization Management (H7943 and provisions in 7944, 7945, and 7946)

House Bill 7943 would prohibit, and related provisions of the other bills would restrict, "prior authorization" or other tools to review and manage behavioral health services. Blue Cross has direct experience in this area having ceased conducting utilization review for in-network behavioral health services in 2018.

While this step reduced administrative burden, our experience also demonstrated that eliminating utilization review alone did **not** achieve broader system goals, such as improved care coordination, stronger discharge planning, or reduced rehospitalization. We have consistently emphasized that easing or eliminating review processes is most effective when paired with **shared obligations** for providers and other stakeholders to collaborate on quality, integration, and continuity of care.

The Committee might consider the risks of adopting this policy, especially with no corresponding obligations on providers. Clinical reviews can be an important tool for safety and cost considerations. These reviews contribute to the appropriate level of care being delivered for some of the state's most vulnerable patients. The potential for reinstatement likely leads to a similar beneficial impact of members receiving the right care. Creating a statutory prohibition could lead to an undesirable change in behavior by sending an unwanted signal to the provider industry – one which is becoming increasingly influenced by corporately owned, private-equity backed practices. This could impair insurers' ability to provide affordable plans and support appropriate patient care.

Finally, this prohibition on prior authorization would follow last session's pilot removal of prior authorization for services ordered by primary care providers. It would compound a problematic precedent, with advocates and other providers petitioning for similar action on their preferred treatment, further eroding these safety and affordability provisions.

Criteria for coverage (7944, 7945, 7946)

State and federal rules guide how plans determine benefits and review care. The mental health parity law, which aims to ensure equal coverage for behavioral health and medical/surgical conditions, requires plans to cover treatment for behavioral health conditions comparably to medical/surgical conditions. This includes how plans determine which services to cover.

Determinations of which services to cover incorporate current clinical research and scientific evidence of effectiveness. These decisions are based on a range of sources centered on respected evidence-based assessments. These include national medical professional organizations and also peer-reviewed medical literature, guidance from Centers for Medicare and Medicaid (CMS), and reviews by experts at the Blue Cross Blue Shield Association. For substance use disorders specifically, plans base coverage determinations on the American Society of Addiction Medicine guidelines. Additionally, Blue Cross works with providers to develop new programs.[1]

These bills, however, impose overly narrow definitions of the criteria plans must use to determine what treatments to cover. This eliminates plans' ability to incorporate outcomes data or other considerations into coverage design. Litigation and regulatory risks would grow, as providers and members may perceive there is greater opportunity to dispute which guidelines establish a coverage obligation. Administrative burdens will increase as plans would need to continuously monitor an ill-defined universe of "generally recognized" practice guidelines that could conflict with clinical guidance. This new problematic framework will divert limited financial resources from access improvement to additional compliance activities.

The existing law appropriately relies on state and federally defined parity-based framework, with plans using comparable methods to review evidence-based, clinically appropriate, scientific evidence to determine what services to cover. This avoids reliance on specific provider-developed, and proprietary standards and instead promotes access and innovation.

Adopting rejected federal regulations (HB 7946)

Federal agencies have been issuing regulations, compliance guides, toolkits, and FAQs ever since the Parity law was adopted in 2008. However, employers challenged the most recent regulation, issued in late 2024, as exceeding the agencies' authority and because of its vague obligations. The 2024 rules are on hold while the litigation is pending and as the federal agencies reconsider the rule.

The existing legal framework continues to ensure coverage for behavioral health. Compliance is not optional: obligations exist under the 2008 Parity law, the 2013 regulations, compliance laws enacted in 2021, federal agency enforcement authority, as well as state law and regulatory authority.

Adopting the 2024 regulations into state law, in full or in part, while they are under active litigation and agency reconsideration would create a confusing and conflicting set of rules and obligations for health plans in Rhode Island. This would add complexity and cost, not clarity.

Taken together, these bills would fragment parity obligations and enforcement and the application of behavioral health coverage, with no clear gain. These burdensome state laws would add to the incentives for employers to move into self-funded arrangements, removing themselves from the state health insurance laws and regulations—and the premium tax—and undermine uniformity of coverage.

Blue Cross recognizes the concern of the sponsors and advocates and welcomes conversations on improving access to appropriate therapies. Please feel free to contact me with any questions.

Sincerely,
Richard Glucksman, Assistant General Counsel

[1] BCBSRI BH Resource Guide; RI Current, How providers and payers are collaborating to improve behavioral health care