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STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2017

A N A C T

RELATING TO INSURANCE -- SURPRISE BILLS FOR MEDICAL SERVICES

Introduced By: Senators Algieri, and Lombardi

Date Introduced: February 15, 2017

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

1 SECTION 1. Title 27 of the General Laws entitled "INSURANCE" is hereby amended  
2 by adding thereto the following chapter:

3 CHAPTER 82

4 SURPRISE BILLS FOR MEDICAL SERVICES

5 **27-82-1. Definitions.**

6 For the purposes of this chapter:

7 (1) "Emergency medical condition" means a medical condition manifesting itself by acute  
8 symptoms of sufficient severity, including severe pain, such that a prudent layperson with an  
9 average knowledge of health and medicine, acting reasonably, would have believed that the  
10 absence of immediate medical attention would result in serious impairment to bodily functions or  
11 serious dysfunction of a bodily organ or part, or would place the person's health or, with respect  
12 to a pregnant women, the health of the woman or her unborn child, in serious jeopardy.

13 (2) "Emergency services" means, with respect to an emergency medical condition:

14 (i) A medical screening examination as required under Section 1867 of the Social  
15 Security Act 42, U.S.C. §1395dd, as amended from time to time, that is within the capability of a  
16 hospital emergency department, including ancillary services routinely available to such  
17 department to evaluate such condition; and

18 (ii) Such further medical examinations and treatment required under Section 1867 of the  
19 Social Security Act 42, U.S.C. §1395dd, to stabilize an individual, that are within the capability

1 of the hospital staff and facilities.

2 (3) "Health care plan" means an insurer licensed to write accident and health insurance  
3 pursuant to chapter 18 of title 27; a nonprofit hospital service corporation licensed to write  
4 insurance pursuant to chapter 19 of title 27; a nonprofit medical service corporation licensed to  
5 write insurance pursuant to chapter 20 of title 27; and a health maintenance organization licensed  
6 to write insurance pursuant to chapter 41 of title 27.

7 (4) "Health care provider" means an individual licensed to provide health care services,  
8 pursuant to the general laws.

9 (5) "Health carrier" means an insurance company, health care center, hospital service  
10 corporation, medical service corporation, fraternal benefit society or other entity that delivers,  
11 issues for delivery, renews, amends or continues a health care plan in this state.

12 (6) "Insured" means a patient covered under a health care plan's policy or contract.

13 (7) "Nonparticipating" means not having a contract with a health care plan to provide  
14 health care services to an insured.

15 (8) "Participating" means having a contract with a health care plan to provide health care  
16 services to an insured.

17 (9) "Patient" means a person who receives health care services, including emergency  
18 services, in this state.

19 (10)(i) "Surprise bill" means a bill for health care services, other than emergency  
20 services, received by an insured for services rendered by an out-of-network health care provider,  
21 where such services were rendered by such out-of-network provider at an in-network facility,  
22 during a service or procedure performed by an in-network provider or during a service or  
23 procedure previously approved or authorized by the health carrier and the insured did not  
24 knowingly elect to obtain such services from such out-of-network provider; and

25 (ii) "Surprise bill" does not include a bill for health care services received by an insured  
26 when an in-network health care provider was available to render such services and the insured  
27 knowingly elected to obtain such services from another health care provider who was out-of-  
28 network.

29 **27-82-2. Applicability.**

30 This chapter shall not apply to health care services, including emergency services, where  
31 physician fees are subject to schedules or other monetary limitations under any other law,  
32 including the workers' compensation law, and shall not preempt any such law.

33 **27-82-3. Billing and reimbursement.**

34 (a) No health carrier shall require prior authorization for rendering emergency services to

1 an insured.

2 (b) No health carrier shall impose, for emergency services rendered to an insured by an  
3 out-of-network health care provider, a co-insurance, co-payment, deductible or other out-of-  
4 pocket expense that is greater than the co-insurance, co-payment, deductible or other out-of-  
5 pocket expense that would be imposed if such emergency services were rendered by an in-  
6 network health care provider.

7 (c) If emergency services were rendered to an insured by an out-of-network health care  
8 provider, such health care provider may bill the health carrier directly and the health carrier shall  
9 reimburse such health care provider the greatest of the following amounts:

10 (1) The amount the insured's health care plan would pay for such services if rendered by  
11 an in-network health care provider;

12 (2) The usual, customary and reasonable rate for such services; or

13 (3) The amount Medicare would reimburse for such services. "Usual, customary and  
14 reasonable rate" means the eightieth percentile of all charges for the particular health care service  
15 performed by a health care provider in the same or similar specialty and provided in the same  
16 geographical area, as reported in a benchmarking database maintained by a nonprofit organization  
17 specified by the commissioner. Such organization shall not be affiliated with any health carrier.  
18 Nothing in this subsection shall be construed to prohibit such health carrier and out-of-network  
19 health care provider from agreeing to a greater reimbursement amount.

20 (d) With respect to a surprise bill:

21 (1) An insured shall only be required to pay the applicable co-insurance, co-payment,  
22 deductible or other out-of-pocket expense that would be imposed for such health care services if  
23 such services were rendered by an in-network health care provider; and

24 (2) A health carrier shall reimburse the out-of-network health care provider or insured, as  
25 applicable, for health care services rendered at the in-network rate under the insured's health care  
26 plan as payment in full, unless such health carrier and health care provider agree otherwise.

27 (e) If health care services were rendered to an insured by an out-of-network health care  
28 provider and the health carrier failed to inform such insured of the network status of such health  
29 care provider, the health carrier shall not impose a co-insurance, co-payment, deductible or other  
30 out-of-pocket expense that is greater than the co-insurance, co-payment, deductible or other out-  
31 of-pocket expense that would be imposed if such services were rendered by an in-network health  
32 care provider.

33 **27-82-4. Dispute resolution process established.**

34 The health insurance commissioner ("commissioner") shall establish a dispute resolution

1 process by which a dispute for a bill for emergency services or a surprise bill may be resolved.  
2 The commissioner shall have the power to grant and revoke certifications of independent dispute  
3 resolution entities to conduct the dispute resolution process. The commissioner shall promulgate  
4 rules and regulations establishing standards for the dispute resolution process, including a process  
5 for certifying and selecting independent dispute resolution entities. An independent dispute  
6 resolution entity shall use licensed physicians in active practice in the same or similar specialty as  
7 the physician providing the service that is subject to the dispute resolution process of this chapter.  
8 To the extent practicable, the physician shall be licensed in this state.

9 **27-82-5. Criteria for determining a reasonable fee.**

10 In determining the appropriate amount to pay for a health care service, an independent  
11 dispute resolution entity shall consider all relevant factors, including:

12 (1) Whether there is a gross disparity between the fee charged by the physician for  
13 services rendered as compared to:

14 (i) Fees paid to the involved physician for the same services rendered by the physician to  
15 other patients in health care plans in which the physician is not participating; and

16 (ii) In the case of a dispute involving a health care plan, fees paid by the health care plan  
17 to reimburse similarly qualified physicians for the same services in the same region who are not  
18 participating with the health care plan;

19 (2) The level of training, education and experience of the physician;

20 (3) The physician's usual charge for comparable services with regard to patients in health  
21 care plans in which the physician is not participating;

22 (4) The circumstances and complexity of the particular case, including time and place of  
23 the service;

24 (5) Individual patient characteristics; and

25 (6) The usual and customary cost of the service.

26 **27-82-6. Dispute resolution for emergency services.**

27 (a) Emergency services for an insured:

28 (1) When a health care plan receives a bill for emergency services from a  
29 nonparticipating physician, the health care plan shall pay an amount that it determines is  
30 reasonable for the emergency services rendered by the nonparticipating physician, except for the  
31 insured's co-payment, co-insurance or deductible, if any, and shall ensure that the insured shall  
32 incur no greater out-of-pocket costs for the emergency services than the insured would have  
33 incurred with a participating physician;

34 (2) A nonparticipating physician or a health care plan may submit a dispute regarding a

1 fee or payment for emergency services for review to an independent dispute resolution entity  
2 established by the commissioner;

3 (3) The independent dispute resolution entity shall make a determination within thirty  
4 (30) days of receipt of the dispute for review;

5 (4) In determining a reasonable payment for the services rendered, the independent  
6 dispute resolution entity shall select either the health care plan's payment or the nonparticipating  
7 physician's fee. The independent dispute resolution entity shall determine which amount to select  
8 based upon the conditions and factors set forth in §27-82-5. If the independent dispute resolution  
9 entity determines, based on the health care plan's payment and the nonparticipating physician's  
10 fee, that a settlement between the health care plan and nonparticipating physician is reasonably  
11 likely, or that both the health care plan's payment and the nonparticipating physician's fee  
12 represent unreasonable extremes, then the independent dispute resolution entity may direct both  
13 parties to attempt a good faith negotiation for settlement. The health care plan and  
14 nonparticipating physician may be granted up to ten (10) business days for this negotiation, which  
15 shall run concurrently with the thirty (30) day period for dispute resolution.

16 (b) Emergency services for a patient who is not an insured:

17 (1) A patient who is not an insured or the patient's physician may submit a dispute  
18 regarding a fee for emergency services for review to an independent dispute resolution entity  
19 upon approval of the commissioner;

20 (2) The independent dispute resolution entity shall determine a reasonable fee for the  
21 services based upon the same conditions and factors set forth in §27-82-5;

22 (3) A patient that is not an insured shall not be required to pay the physician's fee in order  
23 to be eligible to submit the dispute for review to the independent dispute resolution entity.

24 (c) The determination of the independent dispute resolution entity shall be binding on the  
25 health care plan, physician and patient, and shall be admissible in any court proceeding between  
26 the health care plan, physician or patient, or in any administrative proceeding between this state  
27 and the physician.

28 **27-82-7. Hold harmless and assignment of benefits for surprise bills for insureds.**

29 When an insured assigns benefits for a surprise bill in writing to a nonparticipating  
30 physician that knows the insured is insured under a health care plan, the nonparticipating  
31 physician shall not bill the insured except for any applicable co-payment, co-insurance or  
32 deductible that would be owed if the insured utilized a participating physician.

33 **27-82-8. Dispute resolution for surprise bills.**

34 (a) Surprise bill received by an insured who assigns benefits.

1           (1) If an insured assigns benefits to a nonparticipating physician, the health care plan  
2 shall pay the nonparticipating physician in accordance with subsections (a)(2) and (a)(3) of this  
3 section.

4           (2) The nonparticipating physician may bill the health care plan for the health care  
5 services rendered, and the health care plan shall pay the nonparticipating physician the billed  
6 amount or attempt to negotiate reimbursement with the nonparticipating physician.

7           (3) If the health care plan's attempts to negotiate reimbursement for health care services  
8 provided by a nonparticipating physician does not result in a resolution of the payment dispute  
9 between the nonparticipating physician and the health care plan, the health care plan shall pay the  
10 nonparticipating physician an amount the health care plan determines is reasonable for the health  
11 care services rendered, except for the insured's co-payment, co-insurance or deductible.

12           (4) Either the health care plan or the nonparticipating physician may submit the dispute  
13 regarding the surprise bill for review to an independent dispute resolution entity; provided  
14 however, the health care plan may not submit the dispute unless it has complied with the  
15 requirements of subsections (a)(1) through (a)(3) of this section.

16           (5) The independent dispute resolution entity shall make a determination within thirty  
17 (30) days of receipt of the dispute for review.

18           (6) When determining a reasonable fee for the services rendered, the independent dispute  
19 resolution entity shall select either the health care plan's payment or the nonparticipating  
20 physician's fee. An independent dispute resolution entity shall determine which amount to select  
21 based upon the conditions and factors set forth in §27-82-5. If an independent dispute resolution  
22 entity determines, based on the health care plan's payment and the nonparticipating physician's  
23 fee, that a settlement between the health care plan and nonparticipating physician is reasonably  
24 likely, or that both the health care plan's payment and the nonparticipating physician's fee  
25 represent unreasonable extremes, then the independent dispute resolution entity may direct both  
26 parties to attempt a good faith negotiation for settlement. The health care plan and  
27 nonparticipating physician may be granted up to ten (10) business days for this negotiation, which  
28 shall run concurrently with the thirty (30) day period for dispute resolution.

29           (b) Surprise bill received by an insured who does not assign benefits or by a patient who  
30 is not an insured.

31           (1) An insured who does not assign benefits in accordance with subsection (a) of this  
32 section or a patient who is not an insured and who receives a surprise bill may submit a dispute  
33 regarding the surprise bill for review to an independent dispute resolution entity.

34           (2) The independent dispute resolution entity shall determine a reasonable fee for the

1 services rendered based upon the conditions and factors set forth in §27-82-5.

2 (3) A patient or insured who does not assign benefits in accordance with subsection (a) of  
3 this section shall not be required to pay the physician's fee to be eligible to submit the dispute for  
4 review to the independent dispute entity.

5 (c) The determination of an independent dispute resolution entity shall be binding on the  
6 patient, physician and health care plan, and shall be admissible in any court proceeding between  
7 the patient or insured, physician or health care plan, or in any administrative proceeding between  
8 this state and the physician.

9 **27-82-9. Payment for independent dispute resolution entity.**

10 (a) For disputes involving an insured, when the independent dispute resolution entity  
11 determines the health care plan's payment is reasonable, payment for the dispute resolution  
12 process shall be the responsibility of the nonparticipating physician. When the independent  
13 dispute resolution entity determines the nonparticipating physician's fee is reasonable, payment  
14 for the dispute resolution process shall be the responsibility of the health care plan. When a good  
15 faith negotiation directed by the independent dispute resolution entity pursuant to §27-82-6(a)(4)  
16 or §27-82-8(a)(6) results in a settlement between the health care plan and nonparticipating  
17 physician, the health care plan and the nonparticipating physician shall evenly divide and share  
18 the prorated cost for dispute resolution.

19 (b) For disputes involving a patient that is not an insured, when the independent dispute  
20 resolution entity determines the physician's fee is reasonable, payment for the dispute resolution  
21 process shall be the responsibility of the patient unless payment for the dispute resolution process  
22 would pose a hardship to the patient. "Hardship" means a household income below two hundred  
23 fifty percent (250%) of the federal poverty level as determined by the United States Department  
24 of Health and Human Services. The commissioner shall promulgate rules and regulations to  
25 determine payment for the dispute resolution process in cases of hardship. When the independent  
26 dispute resolution entity determines the physician's fee is unreasonable, payment for the dispute  
27 resolution process shall be the responsibility of the physician.

28 SECTION 2. Section 6-13.1-1 of the General Laws in Chapter 6-13.1 entitled "Deceptive  
29 Trade Practices" is hereby amended to read as follows:

30 **6-13.1-1. Definitions.**

31 As used in this chapter:

32 (1) "Documentary material" means the original or a copy of any book, record, report,  
33 memorandum, paper, communication, tabulation, map, chart, photograph, mechanical  
34 transcription, or other tangible document or recording wherever situated.

1 (2) "Examination" of documentary material includes the inspection, study, or copying of  
2 any documentary material, and the taking of testimony under oath or acknowledgment in respect  
3 of any documentary material or copy of any documentary material.

4 (3) "Person" means natural persons, corporations, trusts, partnerships, incorporated or  
5 unincorporated associations, and any other legal entity.

6 (4) "Rebate" means the return of a payment or a partial payment that serves as a discount  
7 or reduction in price.

8 (5) "Trade" and "commerce" mean the advertising, offering for sale, sale, or distribution  
9 of any services and any property, tangible or intangible, real, personal, or mixed, and any other  
10 article, commodity, or thing of value wherever situate, and include any trade or commerce  
11 directly or indirectly affecting the people of this state.

12 (6) "Unfair methods of competition and unfair or deceptive acts or practices" means any  
13 one or more of the following:

14 (i) Passing off goods or services as those of another;

15 (ii) Causing likelihood of confusion or of misunderstanding as to the source, sponsorship,  
16 approval, or certification of goods or services;

17 (iii) Causing likelihood of confusion or of misunderstanding as to affiliation, connection,  
18 or association with, or certification by, another;

19 (iv) Using deceptive representations or designations of geographic origin in connection  
20 with goods or services;

21 (v) Representing that goods or services have sponsorship, approval, characteristics,  
22 ingredients, uses, benefits, or quantities that they do not have or that a person has a sponsorship,  
23 approval, status, affiliation, or connection that he or she does not have;

24 (vi) Representing that goods are original or new if they are deteriorated, altered,  
25 reconditioned, reclaimed, used, or secondhand; and if household goods have been repaired or  
26 reconditioned, without conspicuously noting the defect that necessitated the repair on the tag that  
27 contains the cost to the consumer of the goods;

28 (vii) Representing that goods or services are of a particular standard, quality, or grade, or  
29 that goods are of a particular style or model, if they are of another;

30 (viii) Disparaging the goods, services, or business of another by false or misleading  
31 representation of fact;

32 (ix) Advertising goods or services with intent not to sell them as advertised;

33 (x) Advertising goods or services with intent not to supply reasonably expectable public  
34 demand, unless the advertisement discloses a limitation of quantity;



- 1 (xi) Making false or misleading statements of fact concerning the reasons for, existence  
2 of, or amounts of price reductions;
- 3 (xii) Engaging in any other conduct that similarly creates a likelihood of confusion or of  
4 misunderstanding;
- 5 (xiii) Engaging in any act or practice that is unfair or deceptive to the consumer;
- 6 (xiv) Using any other methods, acts, or practices that mislead or deceive members of the  
7 public in a material respect;
- 8 (xv) Advertising any brand name goods for sale and then selling substituted brand names  
9 in their place;
- 10 (xvi) Failure to include the brand name and or manufacturer of goods in any  
11 advertisement of the goods for sale, and, if the goods are used or secondhand, failure to include  
12 the information in the advertisement;
- 13 (xvii) Advertising claims concerning safety, performance, and comparative price unless  
14 the advertiser, upon request by any person, the consumer council, or the attorney general, makes  
15 available documentation substantiating the validity of the claim;
- 16 (xviii) Representing that work has been performed on or parts replaced in goods when the  
17 work was not in fact performed or the parts not in fact replaced; or
- 18 (xix) Failing to separately state the amount charged for labor and the amount charged for  
19 services when requested by the purchaser as provided for in § 44-18-12(b)(3).
- 20 (xx) Advertising for sale at a retail establishment the availability of a manufacturer's  
21 rebate by displaying the net price of the advertised item (the price of the item after the rebate has  
22 been deducted from the item's price) in the advertisement, unless the amount of the  
23 manufacturer's rebate is provided to the consumer by the retailer at the time of the purchase of the  
24 advertised item. It shall be the retailer's burden to redeem the rebate offered to the consumer by  
25 the manufacturer.
- 26 (xxi) For any health care provider (as such term is defined in chapter 82 of title 27) to  
27 request payment from an insured (as such term is defined in chapter 82 of title 27), other than co-  
28 insurance, co-payment, deductible, or other out-of-pocket expense, for:
- 29 (A) A surprise bill (as such term is defined in chapter 82 of title 27); or  
30 (B) Emergency services (as such term is defined in chapter 82 of title 27) covered under a  
31 health care plan and rendered by an out-of-network health care provider;
- 32 (xxii) For any health care provider (as such term is defined in chapter 82 of title 27) to  
33 report to a credit reporting agency an insured's (as such term is defined in chapter 82 of title 27)  
34 failure to pay a bill for:

1           (A) A surprise bill (as such term is defined in chapter 82 of title 27); or  
2           (B) Emergency services (as such term is defined in chapter 82 of title 27) covered under a  
3 health care plan and rendered by an out-of-network health care provider, when the health carrier  
4 (as such term is defined in chapter 82 of title 27) has primary responsibility for payment of such  
5 services, fees or bills; or  
6           (xxiii) For any health care provider (as such term is defined in chapter 82 of title 27) to  
7 otherwise willfully fail to comply with chapter 82 of title 27 with such frequency as to indicate a  
8 general business practice.

9           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 -- SURPRISE BILLS FOR MEDICAL SERVICES

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1           This act would provide for a dispute resolution process for emergency services and  
2 surprise bills for medical services performed by nonparticipating (out-of-network) health care  
3 providers.

4           This act would take effect upon passage.

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