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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. 2017

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A N A C T

RELATING TO INSURANCE -- SURPRISE OUT-OF-NETWORK BILLS FOR EMERGENCY AND OTHER MEDICAL SERVICES

Introduced By: Senators Archambault, Satchell, Sheehan, Nesselbush, and Sosnowski

Date Introduced: March 02, 2017

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

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

CHAPTER 82

SURPRISE OUT-OF-NETWORK BILLS FOR EMERGENCY AND OTHER MEDICAL SERVICES

27-82-1. Short title.

This chapter shall be known and may be cited as the "Surprise Out-of-Network Bills for Emergency and other Medical Services".

27-82-2. Applicability.

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

27-82-3. Definitions.

As used in this chapter, the following words and terms shall have the following meanings unless the context shall clearly indicate another or different meaning or intent:

(1) "Alternative dispute resolution entity" means a person or organization, independent of the disputing parties, identified by the health insurance commissioner to resolve disputes pursuant to this chapter.

(2) "Emergency condition" means a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent person, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

(i) Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;

(ii) Serious impairment to such person's bodily functions;

(iii) Serious dysfunction of any bodily organ or part of such person;

(iv) Serious disfigurement of such person; or

(v) A condition described in §1867 of the Social Security Act, 42 U.S.C. §1395dd (e)(1)(A) (i), (ii), or (iii));

(3) "Emergency services" means, with respect to an emergency condition:

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

(ii) Within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under §1867 of the Social Security Act, 42 U.S.C. §1395dd, to stabilize the patient;

(4) "Facility" means any institution, place, building, or agency, or portion thereof, engaged in providing health care services. This includes, but is not limited to, hospitals, ambulatory surgical centers, clinics, outpatient surgery or care centers, laboratories and diagnostic centers, and specialized care centers, such as birthing centers and psychiatric care centers.

(5) "Health care plan", "health plan", "health benefits", or "health benefit plan" means health insurance coverage and a group health plan, pursuant to §§27-18-1.1, 27-19-1, 27-20-1 and 27-41-2.

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

(7) "Insured" means a patient covered under a health insurance carrier's policy or contract.

(8) "Out-of-network" or "nonparticipating" means not having a contract with a health

insurance plan to provide health care services to an insured.

(9) "In-network" or "participating" means having a contract with a health insurance plan to provide health care services to an insured.

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

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

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

27-82-4. Billing and reimbursement.

(a) No health insurance plan shall require prior authorization for rendering emergency services to an insured.

(b) No health insurance plan shall impose, for emergency services rendered to an insured by an out-of-network health care provider, a coinsurance, copayment, deductible, or other out-of-pocket expense that is greater than the coinsurance copayment, deductible, or other out-of-pocket expense that would be imposed if such emergency services were rendered by an in-network health care provider.

(c) If emergency services were rendered to an insured by an out-of-network health care provider, such health care provider shall bill the health carrier directly and the health carrier shall reimburse such health care provider the eightieth percentile of all charges for the particular health care service performed by a health care provider in the same or similar specialty and provided in the same geographical area, as reported in a benchmarking database maintained by a nonprofit organization specified by the health insurance commissioner. Such organization shall not be affiliated with any health carrier. Nothing in this subsection shall be construed to prohibit such health carrier and out-of-network health care provider from agreeing to a greater reimbursement amount.

(d) With respect to a surprise out-of-network bill:

(1) An insured shall only be required to pay the applicable coinsurance, copayment, deductible or other out-of-pocket expense that would be imposed for such health care services if

such services were rendered by an in-network health care provider; and

(2) The out-of-network health care provider shall bill the health carrier directly and the health carrier shall reimburse the out-of-network health care provider for health care services rendered at the eightieth percentile of all charges for the particular health care service performed by a health care provider in the same or similar specialty and provided in the same geographical area, as reported in a benchmarking database maintained by a nonprofit organization specified by the health insurance commissioner. Such organization shall not be affiliated with any health carrier. Nothing in this subsection shall be construed to prohibit such health carrier and out-of-network health care provider from agreeing to a greater reimbursement amount.

(e) If health care services were rendered to an insured by an out-of-network health care provider and the health carrier failed to inform such insured, if such insured was required to be informed, of the network status of such health care provider pursuant to the general laws, the health carrier shall not impose a coinsurance, copayment, deductible or other out-of-pocket expense that is greater than the coinsurance copayment, deductible or other out-of-pocket expense that would be imposed if such services were rendered by an in-network health care provider.

27-82-5. Hold harmless for surprise out-of-network bills for insureds.

When an insured is subject to a surprise out-of-network bill from a nonparticipating health care provider that knows the insured is insured under a health care plan, the nonparticipating health care provider shall not bill the insured except for any applicable copayment, coinsurance or deductible that would be owed if the insured utilized a participating health care provider.

27-82-6. Dispute resolution for emergency service.

Emergency services for an insured:

(1) When a health insurance carrier receives a bill for emergency services from a nonparticipating health care provider, the health insurance carrier shall reimburse the nonparticipating health care provider pursuant to §27-82-4(c).

(2) A nonparticipating health care provider or a health insurance carrier may submit a dispute regarding a fee or payment for emergency services for review to an alternative dispute resolution entity, provided that the disputed surprise out-of-network bill totals more than six hundred dollars ($600).

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

(4) The determination of the alternative dispute resolution entity shall be binding on the patient, health care provider and health insurance carrier, and shall be admissible in any court

proceeding between the patient or insured, health care provider or health insurance carrier, or in any administrative proceeding between this state and the health care provider.

27-82-7. Dispute resolution for surprise out-of-network bills.

(a) When a health insurance carrier receives a surprise out-of-network bill from nonparticipating health care provider, the health insurance carrier shall reimburse the nonparticipating health care provider pursuant to §27-82-4(d).

(b) Either the health insurance carrier or the nonparticipating health care provider may submit a dispute regarding a surprise out-of-network bill for review to an alternative dispute resolution entity, provided that the disputed surprise out-of-network bill totals more than six hundred dollars ($600).

(c) The alternative dispute resolution entity shall make a determination within thirty (30) days of receipt of the dispute for review.

(d) The determination of the alternative dispute resolution entity shall be binding on the patient, health care provider and health insurance carrier, and shall be admissible in any court proceeding between the patient or insured, health care provider or health insurance carrier, or in any administrative proceeding between this state and the health care provider.

27-82-8. Payment for alternative dispute resolution.

For disputes involving an insured, when the alternative dispute resolution entity makes a determination in favor of the health insurance carrier, payment for the dispute resolution process shall be the responsibility of the nonparticipating health care provider. When the alternative dispute resolution entity makes a determination in favor of the nonparticipating health care provider, payment for the dispute resolution process shall be the responsibility of the health insurance carrier. When a good faith negotiation directed by the alternative dispute resolution entity results in a settlement between the health insurance carrier and nonparticipating health care provider, the health insurance carrier and the nonparticipating health care provider shall evenly divide and share the prorated cost for dispute resolution.

SECTION 2. This act shall take effect upon passage.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

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RELATING TO INSURANCE -- SURPRISE OUT-OF-NETWORK BILLS FOR EMERGENCY AND OTHER MEDICAL SERVICES

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This act would protect people with health insurance from surprise medical bills for emergency and other services by requiring a nonparticipating health care provider to bill an insured party only for a copayment, or deductible. The nonparticipating health care provider would instead be required to directly bill the health insurance carrier for the remainder. This act would include detailed steps for billing and reimbursement as well as dispute resolution between the health care provide and the insurance carrier. This act would not apply to health care services, where health care provider fees are subject to fee schedules.

This act would take effect upon passage.

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