

**2018 -- S 2077 SUBSTITUTE A AS AMENDED**

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LC003732/SUB A/5  
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**STATE OF RHODE ISLAND**

**IN GENERAL ASSEMBLY**

**JANUARY SESSION, A.D. 2018**

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A N A C T

RELATING TO INSURANCE - UNANTICIPATED OUT-OF-NETWORK BILLS FOR  
HEALTH CARE SERVICES

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

Date Introduced: January 18, 2018

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 UNANTICIPATED OUT-OF-NETWORK BILLS FOR HEALTH CARE SERVICES

5 **27-82-1. Applicability.**

6 Notwithstanding any provisions to the contrary contained in §§ 27-18-76, 27-19-66, 27-  
7 20-62 and 27-41-79, this chapter shall govern any unanticipated out-of-network bills for health  
8 care services as further provided for by the provisions of this chapter; provided, however, this  
9 chapter shall not apply to health care services, including emergency services, where health care  
10 provider fees are subject to schedules or other monetary limitations under any other law,  
11 including the workers' compensation law, and shall not preempt any such law.

12 **27-82-2. Definitions.**

13 For the purposes of this chapter:

14 (1) "Alternative dispute resolution entity" means a qualified third-party claim dispute  
15 resolution entity, which is independent of the disputing parties and is prepared to resolve disputes  
16 pursuant to this chapter.

17 (2) "Anticipated out-of-network care" means non-emergency services received by a  
18 patient when the patient voluntarily consents in writing to receive health care services from an

1 out-of-network health care provider prior to the provision of such services.

2 (3) "Cost-sharing" means a copayment, coinsurance, deductible or similar charge.

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

7 (i) Placing the health of the individual, or with respect to a pregnant woman her unborn  
8 child, in serious jeopardy, or in the case of a behavioral condition, placing the health of the  
9 individual or others in serious jeopardy;

10 (ii) Constituting a serious impairment to bodily functions; or  
11 (iii) Constituting a serious dysfunction of any bodily organ or part.

12 (5) "Emergency services" means, with respect to an emergency medical condition:

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

17 (ii) Such further clinical and medical examination and treatment, to the extent they are  
18 within the capabilities of the staff and facilities available at the health care facility, as are required  
19 under § 1867 of the Social Security Act (42 U.S.C. § 1395dd) to stabilize the patient;

20 (6) "Health care facility" or "facility" means any institution, place, building, or agency, or  
21 portion thereof, engaged in providing health care services. This includes, but is not limited to,  
22 hospitals; ambulatory surgical or treatment centers; clinics; skilled nursing centers; residential  
23 treatment centers; an inpatient, outpatient or residential drug and alcohol treatment facility;  
24 outpatient surgery or care centers; diagnostic, laboratory and imaging centers; and specialized  
25 care centers, such as birthing centers, cancer-treatment centers and psychiatric care centers.

26 (7) "Health care plan" or "plan" means health insurance coverage and a group health plan,  
27 defined pursuant to §§ 27-18-1.1, 27-19-1, 27-20-1 and 27-41-2 and any contract between the  
28 Rhode Island Medicaid program and any health insurance carrier, as defined under chapters 18,  
29 19, 20, and 41 of title 27.

30 (8) "Health care professional" or "professional" means a physician or other health care  
31 practitioner licensed, accredited or certified to perform specified health care services consistent  
32 with state law.

33 (9) "Health care provider" or "provider" means a health care professional or a health care  
34 facility.

1           (10) "Health care services" means services for the diagnosis, prevention, treatment, cure  
2 or relief of a medical or behavioral condition, illness, injury or disease.

3           (11) "Health insurance carrier" or "carrier" means an insurer licensed to write accident  
4 and sickness insurance policies pursuant to chapter 18 of title 27; a nonprofit hospital service  
5 corporation licensed to write insurance policies pursuant to chapter 19 of title 27; a nonprofit  
6 medical service corporation licensed to write insurance policies pursuant to chapter 20 of title 27;  
7 a health maintenance organization licensed to write insurance policies pursuant to chapter 41 of  
8 title 27.

9           (12) "Insured patient" or "insured" means a patient covered under a health care plan.

10          (13) "In-network," when it refers to cost-sharing amounts and benefits, means such  
11 amounts and benefits included in a health care plan.

12          (14) "In-network health care professional" means a health care professional and "in-  
13 network health-care provider" means a health care provider who has a contract with the health  
14 care plan that provides health care services to the plan's insured.

15          (15) "Out-of-network" refers to situations when health care providers or health care  
16 professionals do not have a contract with a particular health care plan to provide health care  
17 services to the insured.

18          (16) "Out-of-network health care professional" means a health care professional and "out-  
19 of-network health care provider" means a health care provider who does not have a contract with  
20 the health care plan that provides health care services to the plan's insured.

21          (17) "Patient" means a person who receives health care services, including emergency  
22 services.

23          (18) "Unanticipated out-of-network care" means emergency services or health care  
24 services rendered by an out-of-network health care provider for a patient in situations when the  
25 insured did not have the ability or control to select such services from an in-network health care  
26 provider. Such unanticipated out-of-network care may include health care services rendered by an  
27 out-of-network health care provider at the request of an in-network health care provider.

28          (19) "Uninsured patient" or "uninsured" means a patient not covered under a health care  
29 plan.

30          **27-82-3. Anticipated out-of-network care provided by out-of-network providers.**

31          (a) Health insurance carriers shall provide up-to-date information for patients about  
32 providers, pursuant to § 27-18.8-3(c)(4).

33          (b) Health care professionals who are not participants in health care plans shall post a  
34 notice pursuant to § 5-37-22.

1 (c) An insured patient shall make every reasonable effort to confirm before receiving  
2 health care services that each health care provider from whom the insured may receive non-  
3 emergency care is an in-network provider. It is the insured's responsibility to review with their  
4 health insurance carrier whether their health care plan offers any out-of-network benefit coverage  
5 and to inquire about potential payment the insured may be required to cover for out-of-network  
6 health care services.

7 (d) For scheduled, non-emergency, facility-based procedures or surgery, any patient may  
8 obtain from their health insurance carrier information about the insured's out-of-network benefits  
9 and payment obligations and may obtain from their out-of-network health care professional a  
10 written estimate, provided in good faith and with reasonable effort, of the cost for out-of-network  
11 health care services. The patient may further request that such estimates include the potential  
12 payment amount for which the patient may be liable and any amount that might be covered by the  
13 health insurance carrier.

14 **27-82-4. Written estimates for health care services for uninsured patients.**

15 Uninsured patients may obtain a written estimate from a health care professional for  
16 health care services, pursuant to § 27-82-3(d).

17 **27-82-5. Out-of-network professional billing and payment of unanticipated out-of-**  
18 **network care.**

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

21 (b) The office of the health insurance commissioner shall provide on its website a list of  
22 resources available to consumers, including its own consumer protection unit, the attorney  
23 general's office consumer protection unit and the department of health's Rhode Island Board of  
24 Medical Licensure & Discipline.

25 (c) Nothing in this subsection shall be construed to prohibit a patient's health insurance  
26 carrier and out-of-network health care professional from reaching agreement with each other  
27 about the payment for professional services.

28 (d) With respect to a bill for unanticipated out-of-network care:

29 (1) No health insurance carrier shall impose a coinsurance, copayment, deductible or  
30 other out-of-pocket expense that is greater than the coinsurance, copayment, deductible or other  
31 out-of-pocket expense that would be imposed for such health care services if such services were  
32 rendered by an in-network health care provider.

33 (2) No out-of-network health care provider may seek or accept any payment from a  
34 patient for unanticipated out-of-network care for services subject to this section, except for

1 copayments, deductibles, or other cost-sharing payments at in-network rates that are specifically  
2 permitted under the patient's arrangements with their health insurance carrier;

3 (3) The out-of-network health care professional shall send notice to the insured of the  
4 provider's out-of-network charges for the health care services provided and shall ask for the  
5 insured's health insurance information; provided, however, that this initial communication from  
6 the out-of-network professional to the insured shall include a notice in twelve (12)-point bold  
7 type stating that the communication is not a bill for unanticipated out-of-network care and that the  
8 insured shall not pay until they are informed by their health insurance carrier of any applicable  
9 cost sharing.

10 (4) The insured and/or the out-of-network health care professional shall then submit the  
11 professional's out-of-network charges as a claim to the insured's health insurance carrier. Such  
12 charges shall be determined by the health care professional in accordance with statutory standards  
13 of professional conduct, pursuant to chapter 37 of title 5. The health insurance carrier can request  
14 the Rhode Island department of health to make a determination whether the professional's billed  
15 charges comply with statutory standards, pursuant to § 5-37-5.1(16). The department of health  
16 shall respond with an advisory opinion before either party seeks arbitration for the unanticipated  
17 out-of-network charges.

18 (5) Upon receipt of a claim from the insured and/or the out-of-network health care  
19 professional for such out-of-network care, the health insurance carrier shall furnish to the out-of-  
20 network professional a statement of the applicable in-network cost-sharing amounts owed at the  
21 time of payment by the insured to the professional for the unanticipated out-of-network care.

22 (6) Within the time allowed pursuant to § 27-20-47(a), a health insurance carrier that has  
23 received an out-of-network claim from an insured and/or an out-of-network health care  
24 professional shall pay the insured the out-of-network charges billed, minus any amount of cost-  
25 sharing owed to the health care professional by the insured, or the health insurance carrier shall  
26 dispute the charges. If the health insurance carrier disputes the charges, the health insurance  
27 carrier and the health care professional may attempt to negotiate a payment that is acceptable to  
28 both parties.

29 (7) If there is no dispute over the charges at the end of the timeframe identified in § 27-  
30 20-47(a), the out-of-network health care professional shall bill the insured for the applicable in-  
31 network cost-sharing amounts owed by the insured to the professional for the unanticipated out-  
32 of-network care. The insured shall only pay the health care professional the deductibles and cost-  
33 sharing amounts that would correspond with deductible and cost-sharing amounts as described  
34 within this subsection that would be owed if the health insurance carrier were to pay the median

1 in-network rate for such health care services. When a health insurance carrier pays an insured the  
2 out-of-network charges billed, minus any amount of cost-sharing owed to the health care  
3 professional by the insured, that payment from the health insurance carrier shall be sent with a  
4 notice in twelve (12)-point bold type stating that the insured is obligated to pay the out-of-  
5 network professional the full amount of such payment from the health insurance carrier, within  
6 thirty (30) calendar days of receipt. This notice shall also inform the patient that they are  
7 responsible for paying the out-of-network professional all applicable cost-sharing amounts.

8 (8) The out-of-network professional shall not bill the patient while the claim is in  
9 negotiation, dispute, mediation or arbitration. If the health insurance carrier and health care  
10 professional reach a settlement for payment, that amount shall take into consideration the  
11 insured's cost-sharing amount and shall constitute payment in full for the health care services  
12 rendered.

13 (9) The health insurance carrier shall pay any settlement to the insured. With such  
14 payment, the health insurance carrier shall send a notice to the insured, of the insured's obligation  
15 to pay the health care professional, pursuant to § 27-82-5(7).

16 (10) In no case shall a health insurance carrier or professional go back to the patient  
17 seeking additional payment. However, the patient shall be responsible for paying the out-of-  
18 network professional any applicable cost-sharing amounts that would have been due to an in-  
19 network professional for such services. Such applicable cost-sharing amounts shall be treated by  
20 health insurance carriers as though they were paid to an in-network professional for purposes  
21 related to the insured's deductibles and annual out-of-pocket maximums.

22 (11) If the out-of-network professional has received more than the in-network cost-  
23 sharing amount from the insured for services subject to this section, the out-of-network  
24 professional shall refund any overpayment to the insured within thirty (30) calendar days after  
25 receiving payment from the insured or from the health insurance carrier. An out-of-network  
26 professional shall automatically include in their refund to the insured all interest that has accrued  
27 pursuant to this section without requiring the insured to submit a request for the interest amount.

28 (12) If the parties reach no resolution within the timeframe identified in § 27-20-47(a),  
29 either the professional or the health insurance carrier may notify the other that they dispute the  
30 out-of-network charge or the proposed payment by the health insurance carrier. When a health  
31 insurance carrier notifies an out-of-network professional that it disputes the out-of-network  
32 charges, the carrier shall include in its dispute notice the following: the claim code, the claim  
33 amount the carrier would pay to an in-network professional for the same health care services and  
34 the carrier's complete contact information.

1 (13) Within fourteen (14) calendar days after either party files a dispute notice, each party  
2 (out-of-network professional and health insurance carrier) shall submit to the other its best and  
3 final offer for the amount in dispute, with supporting documents, and they shall attempt to reach a  
4 negotiated settlement.

5 (14) If the parties negotiate a settlement, the health insurance carrier shall pay the insured  
6 the negotiated amount within thirty (30) calendar days.

7 (15) Once a year, by February 15, any health insurance carrier that has negotiated  
8 payments with any out-of-network professional shall report to the office of the health insurance  
9 commissioner the details about all settlements during the prior calendar year. That report shall  
10 include: the claim codes in dispute, the date of each dispute notice, each professional's billed  
11 charges, what the health insurance carrier would have paid for each service to an in-network  
12 professional and to an out-of-network professional, the dates the parties reached settlements and  
13 the settlement amounts for each case. Any information shall be provided as de-identified data.  
14 This report shall also include the number of times the health insurance carrier has paid the billed  
15 charges, without disputing the claim, for unanticipated out-of-network care.

16 (16) Either the health insurance carrier or the out-of-network professional may submit the  
17 dispute regarding the professional's out-of-network charges to an alternative dispute resolution  
18 entity, for the purpose of arbitrating the dispute, as provided for in § 27-82-6; provided, however,  
19 that both parties first attempt to negotiate the dispute within fourteen (14) calendar days, in  
20 accordance with the provisions of this subsection.

21 **27-82-6. Arbitrated dispute resolution for unanticipated out-of-network care.**

22 (a) This chapter establishes an independent dispute resolution process for the purpose of  
23 arbitrating payment disputes between a health insurance carrier and a health care professional for  
24 unanticipated out-of-network care covered by this chapter.

25 (b)(1) Nothing in this section shall be construed to preclude the parties from reaching a  
26 resolution of their dispute at any point before the arbitrator issues a final award.

27 (2)(i) The arbitrated dispute resolution process shall use the American Arbitration  
28 Association as the alternative dispute resolution entity. However, if the American Arbitration  
29 Association ceases to exist or ceases to be qualified or becomes unable to perform arbitrations in  
30 connection with this section, the office of the health insurance commissioner shall specify a  
31 similarly qualified organization.

32 (ii) Except as otherwise provided in this section, the arbitration shall follow the  
33 procedures of the American Arbitration Association Healthcare Payor Provider Arbitration Rules,  
34 Desk/Telephonic Track, with fees calculated under the Standard Fee Schedule and based on the

1 monetary amount in dispute, calculated as the difference between the out-of-network  
2 professional's best and final offer for out-of-network charges and the health insurance carrier's  
3 best and final offer for out-of-network payment, as provided for in § 27-82-5(13).

4 (3) An arbitrator appointed to administer a dispute shall be impartial and independent of  
5 the parties and shall perform the arbitrator's duties with diligence and in good faith.

6 (4) If either a health insurance carrier or an out-of-network professional submits the  
7 dispute for resolution, the other party shall also participate in the process as provided in this  
8 section.

9 (5) The award obtained through the resolution process shall be binding on both parties  
10 and not appealable. The award shall be binding on the health insurance carrier and out-of-network  
11 professional for any disputes between them involving the same claim code stated in the demand  
12 for arbitration for a period of one year from the date of the award.

13 (6) A payment made by a health insurance carrier to an out-of-network professional  
14 under an award obtained through the resolution process specified in this section, in addition to the  
15 applicable cost-sharing owed by the insured who received the health care service that is the  
16 subject of the resolution process, shall constitute payment in full for the health care services  
17 rendered.

18 (7) In all situations, the patient shall be held harmless. In no case shall a health insurance  
19 carrier or professional go back to the patient seeking additional payment. However, the patient  
20 shall be responsible for paying the out-of-network professional any applicable cost-sharing  
21 amounts that would have been due to an in-network professional for such services. Such  
22 applicable cost-sharing amounts shall be treated by health insurance carriers as though they were  
23 paid to an in-network professional for purposes related to the insured's deductibles and annual  
24 out-of-pocket maximums.

25 (c) Binding resolution process.

26 (1) The party initiating the process shall file a demand for arbitration with the alternative  
27 dispute resolution entity, shall pay the applicable administrative filing fee, and simultaneously  
28 send a copy of the demand to the other party. The initiating party shall include on the demand the  
29 claim code, claim amount and complete contact information for both parties and shall transmit the  
30 demand in accordance with the alternative dispute resolution entity's procedures.

31 (2) Within fourteen (14) calendar days after notice of the filing of the demand is sent by  
32 the alternative dispute resolution entity, the parties named in the demand shall each submit their  
33 best and final offer for the amount in dispute with supporting documents to each other and the  
34 alternative dispute resolution entity.



1           (i) During the fourteen (14) calendar day period after the notice of filing is sent, the  
2 parties may negotiate a settlement. If a settlement is reached, both parties shall advise in writing  
3 the alternative dispute resolution entity.

4           (ii) If, during the fourteen (14) calendar day period, the parties do not notify in writing  
5 the alternative dispute resolution entity that a settlement was reached, an arbitrator shall be  
6 appointed in accordance with the procedures established by the alternative dispute resolution  
7 entity.

8           (3) Upon appointment of the arbitrator, the alternative dispute resolution entity shall  
9 require the parties to deposit sums of money as the alternative dispute resolution entity deems  
10 necessary to cover the expense of arbitration, including the arbitrator's fees, if any, render an  
11 accounting to the parties and return any unexpended balance at the conclusion of the case. The  
12 deposit for arbitrator's fees shall be split evenly between the parties.

13           (4) After the arbitrator is appointed, the alternative dispute resolution entity shall transmit  
14 to the arbitrator the parties' previously submitted best and final offers with supporting documents.

15           (5) In making an award under this subsection, the arbitrator may consider the following  
16 criteria including, but not limited to:

17           (i) The level of training, education and experience of the professional.

18           (ii) The professional's usual charge and usual payment for comparable health care  
19 services provided in-network and out-of-network with respect to any health care plan.

20           (iii) The health insurance carrier's usual payment and fee schedules for comparable health  
21 care services provided in the service area.

22           (iv) The propensity of the professional to be included in networks and the propensity of  
23 the insurer to include professionals in networks.

24           (v) Payments made in prior disputes over unanticipated out-of-network care between the  
25 professional and the insurer.

26           (vi) The circumstances and complexity of the particular case, including the time and  
27 place of the health care service.

28           (vii) Any final award between the insurer and professional for the same claim code from  
29 a period of one year prior.

30           (6) The arbitrator's award shall be a dollar amount between the two (2) amounts  
31 submitted by the parties as their best and final offers and shall be binding on both parties.

32           (7) The arbitrator shall issue a final binding award in writing, within thirty (30) days after  
33 the arbitrator has received the parties' best and final offers and supporting documents. The award  
34 shall include the claim code for which the dispute was filed, the date of the written demand for

1 arbitration, the date the award was communicated to the parties, the final offers from each party  
2 and the award amount. Electronic copies of the final award shall be provided to both parties.

3 (8) The American Arbitration Association shall submit annually, by February 15, to the  
4 office of the health insurance commissioner the number of total cases that were filed for  
5 arbitration, the number of cases that were settled before an arbitrator issued an award and the  
6 number of awards issued. This report shall further include the details that arbitrators include in  
7 final binding awards, pursuant to § 27-82-6(c)(7). Any information shall be provided as de-  
8 identified data.

9 (d) Cost allocations.

10 (1) In the final award, the arbitrator shall determine which party is responsible for paying  
11 all administrative fees, arbitrator compensation and expenses, including any reimbursement of the  
12 initial filing fee that may be due to either party.

13 (2) A party that fails to pay all amounts due to the other party within thirty (30) days of  
14 receiving the final award shall:

15 (i) Pay interest to the prevailing party.

16 (ii) Be subject to a penalty of one hundred dollars (\$100) per day, payable to the  
17 prevailing party, until all payments are made in full.

18 (e) Alternative dispute resolution entity records.

19 An alternative dispute resolution entity shall comply with the following:

20 (1) Maintain for eighteen (18) months after a case is closed, by calendar year, all in an  
21 easily accessible and retrievable format, the following:

22 (i) The written demand filed by the initiating party establishing the date the alternative  
23 dispute resolution entity received a request for dispute resolution.

24 (ii) Case-related materials that are made a part of the alternative dispute resolution  
25 entity's electronic file.

26 (iii) The award.

27 (iv) The date the award was communicated to the parties.

28 (2) Document measures taken to appropriately safeguard the confidentiality of the  
29 records and prevent unauthorized use and disclosures under applicable federal and state law.

30 (3) Report annually to the office of the health insurance commissioner by February 15 for  
31 the prior calendar year's cases, with de-identified data, in the aggregate:

32 (i) The total number of demands for arbitrations received under this section.

33 (ii) The number of arbitrations withdrawn due to settlement before an arbitrator issued an  
34 award.

1 (iii) The total number of arbitrations concluded.  
2 (iv) The breakdown of disposition for arbitrations concluded, with the details the  
3 arbitrators include in final binding awards issued, pursuant to § 27-82-6(c)(7). Any information  
4 shall be provided as de-identified data.  
5 (4) Protect from disclosure, except as otherwise required by law, information specifically

6 identifying the insured who received the health care services that were the subject of an  
7 arbitration decision. This information shall be protected and remain confidential in compliance  
8 with all applicable federal and state laws and regulations and shall be confidential as nonpublic  
9 personal health information.

10 (5) Report immediately to the office of the health insurance commissioner a change in its  
11 status that would cause it to cease performing or being qualified to perform arbitrations under this  
12 act.

13 **27-82-7. Data collection regarding payment disputes that arise after unanticipated**  
14 **out-of-network care.**

15 (a) By March 31 each year, the office of the health insurance commissioner shall  
16 annually report to the president of the senate and to the speaker of the house of representatives, in  
17 the aggregate:

18 (1) The detailed information the office has received from health insurance carriers about  
19 the number of unanticipated out-of-network charges the carrier paid and the number of cases that  
20 were in dispute in the prior calendar year, pursuant to § 27-82-5(d)(15).

21 (2) The detailed information the office has received from the American Arbitration  
22 Association about how many cases were filed for arbitration and how such cases were resolved,  
23 with the information provided by arbitrators in final binding awards, pursuant to § 27-82-6(c)(7)  
24 and with the information provided pursuant to § 27-82-6(c)(8).

25 (b) Any information reported by the office of the health insurance commissioner shall be  
26 provided as de-identified data.

27 (c) As a result of data collected in its annual reports, if the office of the health insurance  
28 commissioner determines this statute has had a negative or inflationary impact on health  
29 insurance premiums, has resulted in increased consumer complaints and/or has led to a reduction  
30 of health care providers within health insurance networks, the commissioner may make  
31 recommendations to the governor, the president of the senate and to the speaker of the house of  
32 representatives regarding potential amendments to this statute.

33 SECTION 2. This act shall take effect on January 1, 2019.

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LC003732/SUB A/5  
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EXPLANATION  
BY THE LEGISLATIVE COUNCIL  
OF

A N A C T

RELATING TO INSURANCE - UNANTICIPATED OUT-OF-NETWORK BILLS FOR  
HEALTH CARE SERVICES

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1           This act would provide a method for the reimbursement to out-of-network professionals  
2 who provide unanticipated out-of-network care and would provide guidelines for what payment  
3 out-of-network professionals may seek or accept from a patient for unanticipated out-of-network  
4 care.

5           This act would take effect on January 1, 2019.

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