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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. 2019**

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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, Nesselbush, Miller, Euer, and Satchell

Date Introduced: January 24, 2019

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

UNANTICIPATED OUT-OF-NETWORK BILLS FOR HEALTH CARE SERVICES

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

Notwithstanding any provisions to the contrary contained in §§ 27-18-76, 27-19-66, 27-20-62 and 27-41-79, this chapter shall govern any unanticipated out-of-network bills for health care services as further provided for by the provisions of this chapter; provided, however, this chapter shall 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 shall not preempt any such law.

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

For the purposes of this chapter:

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

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

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

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

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

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

(ii) Constituting a serious impairment to bodily functions; or

(iii) Constituting a serious dysfunction of any bodily organ or part.

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

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

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

(6) "Health care facility" or "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 or treatment centers; clinics; skilled nursing centers; residential treatment centers; an inpatient, outpatient or residential drug and alcohol treatment facility; outpatient surgery or care centers; diagnostic, laboratory and imaging centers; and specialized care centers, such as birthing centers, cancer-treatment centers and psychiatric care centers.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) No health insurance carrier shall 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 for such health care services if such services were rendered by an in-network health care provider.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) Binding resolution process.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) Cost allocations.

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

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

(i) Pay interest to the prevailing party.

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

(e) Alternative dispute resolution entity records.

An alternative dispute resolution entity shall comply with the following:

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

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

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

(iii) The award.

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

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

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

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

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

(iii) The total number of arbitrations concluded.

(iv) The breakdown of disposition for arbitrations concluded, with the details the arbitrators include in final binding awards issued, pursuant to § 27-82-6(c)(7). Any information shall be provided as de-identified data.

(4) Protect from disclosure, except as otherwise required by law, information specifically identifying the insured who received the health care services that were the subject of an arbitration decision. This information shall be protected and remain confidential in compliance with all applicable federal and state laws and regulations and shall be confidential as nonpublic personal health information.

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

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

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

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

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

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

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

SECTION 2. This act shall take effect on January 1, 2020.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

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

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

This act would take effect on January 1, 2020.

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