# 2026 -- S 3088

========
LC006057
========

# 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. 2026**

---

A N  A C T

RELATING TO INSURANCE -- EQUITABLE FUNDING FOR HEALTHCARE PROVIDER BAD DEBT

Introduced By: Senators Dimitri, Patalano, LaMountain, Bissaillon, Quezada, McKenney, and Raptakis
Date Introduced: March 13, 2026

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 18.10

EQUITABLE FUNDING FOR HEALTHCARE PROVIDER BAD DEBT

**28-18.10-1. Definitions.**

When used in this chapter, the following words and phrases are construed as follows:

(1) "Co-insurance" means a percentage of the allowed amount, after a co-payment, if any, that an insured must pay for covered services received under a health benefit plan for healthcare services provided and billed by a healthcare provider.

(2) "Co-payment" means a fixed dollar amount that is owed by an insured as required under a health benefit plan for healthcare services provided and billed by a healthcare provider.

(3) "Deductible" means a specific dollar amount that an insured must pay for covered services before the health insurer's health benefit plan becomes obligated to pay for covered healthcare services provided and billed by a healthcare provider; such deductible does not include any portion of premiums paid by an insured.

(4) "Health insurance commissioner" means that individual appointed pursuant to § 42-14.5-1.

**28-18.10-2. Reimbursement.**

(a) Notwithstanding any other provision of the general laws to the contrary, a health insurer shall reimburse a healthcare provider no less than sixty-five percent (65%) of each co-payment, co-insurance and/or deductible amount due under an insured's health benefit plan which is unpaid after reasonable collection efforts have been made by the healthcare provider pursuant to subsection (b) of this section.

(b) Reimbursement for uncollected co-payment, co-insurance and/or deductible amounts due (each a "claim") under an insured's health benefit plan for covered services rendered shall be deemed an uncollectible bad debt, and a healthcare provider may submit a request for reimbursement to the health insurer under the following conditions:

(1) The claim must be derived from the wholly or partially uncollected co-payment, co-insurance and/or deductible amounts under an insured's health benefit plan;

(2) The reimbursement requested by the healthcare provider shall be for a claim where the co-payment, co-insurance, or deductible amount was at least two hundred fifty dollars ($250), and each claim reflects a unique covered service under the health benefit plan per insured;

(3) The healthcare provider must have made reasonable collection efforts for each claim filed for reimbursement under this section, such efforts including documentation that the claim has remained partially or fully unpaid and is not subject to an ongoing payment plan for more than one hundred twenty (120) days from the date the first bill was mailed, which may include such efforts as telephone calls, collection letters, or any other notification method that constitutes a genuine and continuous effort to contact the member. Said documentation shall include the date and method of contact;

(4) On or before May 1 of each year, the healthcare provider shall submit an aggregate request for reimbursement representing all claims that meet the criteria under this section in the prior calendar year. The request for reimbursement shall include documentation of the attempt to collect on the claim(s), the name and identification number of the insured, the date of service, the unpaid co-payment, co-insurance, or deductible, the amount that was collected, if any, and the date and general method of contact with the insured. For the purposes of this section, an insured co-payment, co-insurance, and/or deductible amount due shall be determined based on the date that the service is rendered; provided, further, that a health insurer shall not prohibit reimbursement if the insured is no longer covered by the plan on the date that the request is made;

(5) Nothing in this section shall prevent the health insurer from conducting an audit of the request for reimbursement of unpaid co-payment, co-insurance, and/or deductible amounts to verify that the insured was eligible for coverage at the time of service, that the service was a covered health benefit under the applicable health benefit plan, and to verify from the provider's internal

log that reasonable efforts were made to contact the insured following the criteria outlined in this section. The health insurer must complete any such audit of the submitted report from the healthcare provider and notify the healthcare provider of any disputes as to the request for reimbursement within one hundred twenty (120) days of receipt of the request for reimbursement from the healthcare provider. The health insurer shall pay the healthcare provider sixty-five percent (65%) of the undisputed amounts as submitted by the healthcare provider in the request for reimbursement in accordance with this section within one hundred twenty (120) days of receipt of such requests from the healthcare provider. Any dispute regarding contested claims shall be subject to a dispute resolution process applicable to the arrangement between the health insurer and the healthcare provider; and

(6) Any amounts attributable to co-payment, co-insurance, or deductible amounts collected by a healthcare provider after reimbursement has been made by the health insurer pursuant to this section shall be recorded by the healthcare provider and reported as an offset to future submissions to such health insurer.

(c) No health insurer shall prohibit a healthcare provider from collecting the amount of the insured's co-payment, co-insurance, and/or deductible, if any, at the time of service.

(d) The health insurance commissioner shall promulgate regulations, by January 1, 2027, that are consistent with the rules developed by the Centers for Medicare & Medicaid Services for reasonable collection efforts required by a healthcare provider prior to submission of a request of reimbursement to a carrier. Notwithstanding the foregoing, in the event that the health insurance commissioner fails to promulgate such regulations, the provisions of this chapter shall be self-implementing, and carriers shall make applicable payments to healthcare providers in accordance with the provisions of this chapter, utilizing the same process adopted by the Centers for Medicare & Medicaid Services' reasonable collection efforts for bad debt, as documented in the most recent Medicare Provider Reimbursement Manual, CMS Pub. 15-1 and 15-2 (HIM-15) in effect, within ninety (90) days of the effective date of this chapter. The health insurance commissioner shall further require each carrier to provide the health insurance commissioner with an annual report showing the total number and amount of uncollected co-payments, co-insurances, and deductibles that are reimbursed as well as those that are denied. The report shall be made publicly available on the health insurance commissioner's website.

SECTION 2. This act shall take effect upon passage.

========
LC006057
========

EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N  A C T

RELATING TO INSURANCE -- EQUITABLE FUNDING FOR HEALTHCARE PROVIDER BAD DEBT

***

This act would establish a procedure for a health insurer to reimburse a healthcare provider no less than sixty-five percent (65%) of each unpaid co-payment, co-insurance or deductible amount due, after reasonable collection efforts.

This act would take effect upon passage.

========
LC006057
========