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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. 2016

A N A C T

RELATED TO INSURANCE - SURPRISE BILLS FOR MEDICAL SERVICES

Introduced By: Representatives Craven, Fogarty, Ackerman, McEntee, and McKiernan

Date Introduced: March 25, 2016

Referred To: House Corporations

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 81

SURPRISE BILLS FOR MEDICAL SERVICES

27-81-1. Dispute resolution process established. -- The health insurance commissioner ("commissioner") shall establish a dispute resolution process by which a dispute for a bill for emergency services or a surprise bill may be resolved. The commissioner shall have the power to grant and revoke certifications of independent dispute resolution entities to conduct the dispute resolution process. The commissioner shall promulgate rules and regulations establishing standards for the dispute resolution process, including a process for certifying and selecting independent dispute resolution entities. An independent dispute resolution entity shall use licensed physicians in active practice in the same or similar specialty as the physician providing the service that is subject to the dispute resolution process of this chapter. To the extent practicable, the physician shall be licensed in this state.

27-81-2. Applicability. -- (a) This chapter shall not apply to health care services, including emergency services, where physician 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.

(b)(1) With regard to emergency services billed under American Medical Association

current procedural terminology (CPT) codes 99281 through 99285, 99288, 99291 through 99292, 99217 through 99220, 99224 through 99226, and 99234 through 99236, the dispute resolution process established in this chapter shall not apply when:

(i) The amount billed for any such CPT code meets the requirements set forth in subsection (b)(3) of this section, after any applicable co-insurance, co-payment and deductible; and

(ii) The amount billed for any such CPT code does not exceed one hundred twenty percent (120%) of the usual and customary cost for such CPT code.

(2) The health care plan shall ensure that an insured shall not incur any greater out-of-pocket costs for emergency services billed under a CPT code as set forth in this subsection than the insured would have incurred if such emergency services were provided by a participating physician.

(3) Beginning January 1, 2017 and each January 1 thereafter, the commissioner shall publish on a website maintained by the department of business regulation, and provide in writing to each health care plan, a dollar amount for which bills for the procedure codes identified in this subsection shall be exempt from the dispute resolution process established in this chapter. Such amount shall equal the amount from the prior year, beginning with six hundred dollars ($600) in 2016, adjusted by the average of the annual average inflation rates for the medical care commodities and medical care services components of the consumer price index. In no event shall an amount exceeding one thousand two hundred dollars ($1,200) for a specific CPT code billed be exempt from the dispute resolution process established in this chapter.

27-81-3. Definitions. -- For the purposes of this chapter:

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

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

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

(ii) Such further medical examinations and treatment required under said Section 1867 of

the Social Security Act 42 U.S.C. §1395dd, to stabilize such individual, that are within the capability of the hospital staff and facilities.

(3) "Health care plan" 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.

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

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

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

(7) "Non-participating" means not having a contract with a health care plan to provide health care services to an insured.

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

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

(10)(i) "Surprise bill" means a bill for health care services, other than emergency services, received by an insured for services rendered by an out-of-network health care provider, where such services were rendered by such 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;

(ii) "Surprise 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.

27-81-4. Billing and reimbursement. -- (a) No health carrier shall require prior authorization for rendering emergency services to an insured.

(b) No health carrier 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 may bill the health carrier directly and the health carrier shall reimburse such health care provider the greatest of the following amounts:

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

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

(3) The amount Medicare would reimburse for such services. "Usual, customary and reasonable rate" means 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 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 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) A health carrier shall reimburse the out-of-network health care provider or insured, as applicable, for health care services rendered at the in-network rate under the insured's health care plan as payment in full, unless such health carrier and health care provider agree otherwise.

(d) 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.

27-81-5. Criteria for determining a reasonable fee. -- In determining the appropriate amount to pay for a health care service, an independent dispute resolution entity shall consider all relevant factors, including:

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

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

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

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

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

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

(5) Individual patient characteristics; and

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

27-81-6. Dispute resolution for emergency services. -- (a) Emergency services for an insured:

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

(2) A non-participating physician or a health care plan may submit a dispute regarding a fee or payment for emergency services for review to an independent dispute resolution entity established by the commissioner.

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

(4) In determining a reasonable for the services rendered, the independent dispute resolution entity shall select either the health care plan's payment or the non-participating physician's fee. The independent dispute resolution entity shall determine which amount to select based upon the conditions and factors set forth in §27-81-5. If the independent dispute resolution entity determines, based on the health care plan's payment and the non-participating physician's fee, that a settlement between the health care plan and non-participating physician is reasonably likely, or that both the health care plan's payment and the non-participating physician's fee represent unreasonable extremes, then the independent dispute resolution entity may direct both parties to attempt a good faith negotiation for settlement. The health care plan and non-

participating physician may be granted up to ten (10) business days for this negotiation, which shall run concurrently with the thirty (30) day period for dispute resolution.

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

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

(2) The independent dispute resolution entity shall determine a reasonable fee for the services based upon the same conditions and factors set forth in §27-81-5.

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

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

27-81-7. Hold harmless and assignment of benefits for surprise bills for insureds. -- When an insured assigns benefits for a surprise bill in writing to a non-participating physician that knows the insured is insured under a health care plan, the non-participating physician shall not bill the insured except for any applicable co-payment, co-insurance or deductible that would be owed if the insured utilized a participating physician.

27-81-8. Dispute resolution for surprise bills. -- (a) Surprise bill received by an insured who assigns benefits:

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

(2) The non-participating physician may bill the health care plan for the health care services rendered, and the health care plan shall pay the non-participating physician the billed amount or attempt to negotiate reimbursement with the non-participating physician.

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

(4) Either the health care plan or the non-participating physician may submit the dispute regarding the surprise bill for review to an independent dispute resolution entity, provided

however, the health care plan may not submit the dispute unless it has complied with the requirements of subsections (a)(1) through (a)(3) of this section.

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

(6) When determining a reasonable fee for the services rendered, the independent dispute resolution entity shall select either the health care plan's payment or the non-participating physician's fee. An independent dispute resolution entity shall determine which amount to select based upon the conditions and factors set forth in §27-81-5. If an independent dispute resolution entity determines, based on the health care plan's payment and the non-participating physician's fee, that a settlement between the health care plan and non-participating physician is reasonably likely, or that both the health care plan's payment and the non-participating physician's fee represent unreasonable extremes, then the independent dispute resolution entity may direct both parties to attempt a good faith negotiation for settlement. The health care plan and non-participating physician may be granted up to ten (10) business days for this negotiation, which shall run concurrently with the thirty (30) day period for dispute resolution.

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

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

(2) The independent dispute resolution entity shall determine a reasonable fee for the services rendered based upon the conditions and factors set forth in §27-81-5.

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

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

27-81-9. Payment for independent dispute resolution entity.-- (a) For disputes involving an insured, when the independent dispute resolution entity determines the health care plan's payment is reasonable, payment for the dispute resolution process shall be the responsibility of the non-participating physician. When the independent dispute resolution entity determines the non-participating physician's fee is reasonable, payment for the dispute resolution

process shall be the responsibility of the health care plan. When a good faith negotiation directed by the independent dispute resolution entity pursuant to §27-81-6(a)(4), or §27-81-8(a)(6) results in a settlement between the health care plan and non-participating physician, the health care plan and the non-participating physician shall evenly divide and share the prorated cost for dispute resolution.

(b) For disputes involving a patient that is not an insured, when the independent dispute resolution entity determines the physician's fee is reasonable, payment for the dispute resolution process shall be the responsibility of the patient unless payment for the dispute resolution process would pose a hardship to the patient. The commissioner shall promulgate rules and regulations to determine payment for the dispute resolution process in cases of hardship. When the independent dispute resolution entity determines the physician's fee is unreasonable, payment for the dispute resolution process shall be the responsibility of the physician.

SECTION 2. This act shall take effect upon passage.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

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RELATED TO INSURANCE - SURPRISE BILLS FOR MEDICAL SERVICES

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

This act would take effect upon passage.

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