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TITLE 110 – ATTORNEY GENERAL

CHAPTER 40 – CONSUMER PROTECTION UNIT

SUBCHAPTER 00 – N/A

PART 6 – Fairness in Deductible Billing

5.1 Purpose

A. These Rules and Regulations (“the Rules”) are promulgated to establish standards health care providers must follow when billing patients for deductibles.

5.2 Authority

A. These Rules have been promulgated pursuant to R.I. Gen. Laws Chapter 6-13.1, the Deceptive Trade Practices Act ("DTPA"), specifically R.I. Gen. Laws § 6-13.1-7. This Part has been prepared in accordance with the requirements of the Administrative Procedures Act, R.I. Gen. Laws Chapter 42-35

5.3 Severability

A. If any provision of this Part or the application thereof to any person or circumstance is held invalid by a court of competent jurisdiction, the validity of the remainder of this Part and the application of such provisions to other persons and circumstances shall not be affected thereby.

5.4 Definitions

A. For the purposes of this Part, the following terms shall have the following meanings:

1. "Audit" means a systematic review of relevant claims data, billing records and other internal documentation, or any other data necessary to determine whether the provider has satisfied the requirements of this Part.

2. "Deductible" means the amount of funds a consumer is required under a health insurance plan administered by a health insurance carrier to pay out of pocket before the carrier covers the costs of services.

3. "Health care provider" or "provider" means a physician, hospital, professional provider, pharmacy, laboratory, dental, medical, or behavioral health provider, or other state-licensed or other state-recognized provider of health care or behavioral health services or supplies.

4. "Health insurance carrier" or "carrier" means any entity subject to the insurance laws and regulations of this state, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services, including, without limitation, an insurance company offering accident and sickness insurance, a health maintenance organization, a nonprofit hospital, medical or dental service corporation, or any other entity providing a plan of health insurance or health benefits by which healthcare services are paid or financed for an eligible individual or his or her dependents by such entity on the basis of a periodic premium, paid directly or through an association, trust, or other intermediary, and issued, renewed, or delivered within or without Rhode Island to cover a natural person who is a resident of this state, including a certificate issued to a natural person that evidences coverage under a policy or contract issued to a trust or association.

5. "Service" means services and items furnished for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

5.5 Prohibition on Deductible Billing Prior to Claims Processing

A. It shall be an unfair and deceptive act or practice for any health care provider to require payment towards a deductible prior to the point at which all claims for the provider's service have been adjudicated by the carrier, unless the provider has fully complied with the requirements of § 5.6 and § 5.7 of this Part.

5.6 Notice and Disclosure Requirements

A. Health care providers shall provide notice and disclosure to all patients that the patient is not legally obligated to pay any amount toward their deductible at the point of service and prior to adjudication of any claim for the service. The notice shall explain that any deductible costs quoted to the patient before claim adjudication are estimates of what the patient’s financial responsibility may be once the patient’s carrier has adjudicated the claim. The notice and disclosure shall further notify the patient that refusal to pay an estimated deductible prior to claim adjudication shall not prevent the patient from receiving services and that their care will not be in any way delayed or otherwise affected as a result of any such refusal.

B. Such notice and disclosure shall include, at a minimum, the following language, which must be prominently and conspicuously displayed to all patients in writing at the same time as any estimated deductible amount that is communicated to the patient: “YOU ARE NOT LEGALLY OBLIGATED TO PAY ANY AMOUNT TOWARDS YOUR DEDUCTIBLE AT THIS TIME. YOU ARE NOT REQUIRED TO PAY FOR ANY DEDUCTIBLE UNTIL THE CLAIM IS PROCESSED BY YOUR INSURER AND YOU RECEIVE A BILL. REVIEW YOUR EXPLANATION OF BENEFITS TO CONFIRM THE AMOUNT DUE.”

C. The health care provider shall retain a copy of the notice given to the patient for a period no less than three (3) years.

D. If notice and disclosure is provided and documented pursuant to this section and the patient voluntarily chooses to make payment based on estimated deductible costs, the provider may receive such payment and shall comply with all refund obligations set forth in § 5.7 of this Part.

5.7 Affirmative Obligation to Refund Overpayments Associated with Estimated Deductibles

A. If a health care provider receives payment from a patient towards a deductible that is later identified to have been an overpayment or an erroneous deductible payment, it shall be the affirmative obligation of the provider to refund the full amount of the overpayment or erroneous payment to the patient.

B. The provider shall establish and maintain a satisfactory written internal policy and procedure to proactively identify and process any such refunds. Such internal policies and procedures shall not require receipt of a consumer complaint in order to identify and process refunds.

1. A satisfactory internal policy and procedure is one that identifies potential overpayments by generating routine reports at least weekly comparing amounts billed to the patient against adjudicated deductible costs documented by carrier remittances, automatically generates credit balances for particular accounts, and completes a refund for such accounts within 3-5 business days.

C. All refunds shall be issued to the patient via the original method of payment, unless otherwise requested by the patient. If a refund to the original method of payment is not possible, the provider may issue a check to the patient for the full amount of the overpayment.

D. Any provider that chooses to bill patients based on estimated deductibles prior to claim adjudication shall conduct an audit of its refund policies and procedures at least annually to ensure that overpayments and erroneous deductible payments are appropriately identified and refunds are timely issued. Providers shall maintain documentation regarding the methodology and results of such audits and shall make such records available to the Attorney General upon request.

E. Providers shall cooperate in good faith with carriers in any audit, investigation, or outreach regarding overpayment of deductibles or erroneous deductible payments, which cooperation shall include timely response to inquiries and production of reasonably requested documentation.

5.8 Requirements for Health Insurance Carriers

A. Upon receiving a complaint from an enrollee or notification from any other source indicating that a provider may be violating the provisions of this Part or any carrier requirements relating to the appropriate billing or collection of deductibles, the carrier shall, within 14 business days, conduct a review to identify all enrollees who have been billed or may have billed by the provider for estimated deductibles prior to claim adjudication. The carrier shall transmit the results of such review to the provider for corrective action.

B. The transmission set forth in this section shall include notice of the provider's affirmative obligation to refund patients for overpayments of deductibles or erroneous deductible payments accordance with this Part.

C. The carrier shall retain evidence of such transmission on file for a period not less than three (3) years and make it available to the Attorney General upon request.

D. Carriers shall cooperate in good faith with providers in any audit, investigation, or outreach regarding overpayment of deductibles or erroneous deductible payments, which cooperation shall include timely response to inquiries and production of reasonably requested documentation

5.9 Violations

A. It shall be an unfair and deceptive act or practice for a health care provider or carrier subject to these rules and regulations to violate or fail to comply with any provision of this Part.

B. These rules and regulations are enforceable to the same extent as would be any violation of the provisions of the Rhode Island Deceptive Trade Practices Act, R.I. Gen. Laws § 6-13.1-1, et. seq. Specifically, enforcement remedies include injunctive and/or monetary relief pursuant to R.I. Gen. Laws § 6-13.1-5 and civil penalties pursuant to R.I. Gen. Laws § 6-13.1-8.

5.10 Interaction with Other Laws and Regulations

A. Nothing in this regulation shall be interpreted to modify or in any way interfere with carrier or provider obligations under state and federal law or regulation.