Office of the Attorney General

Regulatory Analysis for the Rules and Regulations for Fairness in Deductible Billing

110-RICR-40-00-6

I. Statement of Need

To protect consumers from financial harm associated with the premature and erroneous collection of estimated deductibles, the Office of the Attorney General (the "Office") is promulgating this Rule (110-RICR-40-00-6) pursuant to its consumer protection authority under the Deceptive Trade Practices Act, R.I. Gen. Laws § 6-13.1-7.

Pursuant to R.I. Gen. Laws Chapter 42-9.1, the Office of the Attorney General serves as the state's Health Care Advocate, an office established, in part, as a result of the "demanding business environment in which health care is delivered requir[ing] that the public have an advocate to assure that the policy and goal of assuring quality, affordable health care is achieved and maintained."[1] In furtherance of this goal, the Office reviews health care complaints submitted by Rhode Islanders and utilizes its statutory authority, including under the Deceptive Trade Practices Act, to remedy those complaints.

In the course of reviewing consumer complaints, the Office has identified concerns regarding overpayments for health care services beyond patients' actual deductible obligations, as well as subsequent delays in notification of such overpayments and issuing refunds. These concerns have highlighted the need for clear and enforceable standards governing the collection of estimated deductibles.

Accordingly, this Rule establishes clear requirements for patient notice and disclosure, proactive identification of overpayments, and timely refunds. Ultimately, the proposed Rule is intended to protect Rhode Islanders from financial harm resulting from the complex and often confusing nature of health care billing and insurance benefits by establishing clear, enforceable standards governing deductible collection practices.

a. Rising Health Care Costs and Lack of Affordability

Per-person healthcare spending in Rhode Island is 2.45 times higher today than it was in 2000.[2] As of 2020, Rhode Island spent more on healthcare per capita than 74% of states.[3] One important component of health care affordability is the amount of the

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[1] R.I. Gen. Laws § 42-9.1-1 (2)

[2] Rhode Island Office of the Health Insurance Commissioner, *Health Care Spending and Quality in Rhode Island*, OHIC ANNUAL REPORT, 5, https://ohic.ri.gov/sites/g/files/xkgbur736/files/2023-05/Health%20Care%20Spending%20and%20Quality%20in%20Rhode%20Island_FINAL%202023%2005.pdf

[3] KFF, *Health care expenditures per capita by state of residence,* https://www.kff.org/other/state-indicator/health-spending-per-capita/ (last visited May 8, 2025).

deductible imposed under a person's insurance policy. A deductible is the amount an enrollee must pay toward the cost of covered services before the health insurance plan begins paying for care.[4] Deductibles have surged in recent years. In 2026, average deductibles reached a record high of $3,786, representing a 37% increase over 2025.[5] This trend is also reflected in Rhode Island, where the average out-of-pocket spending per person increased from approximately $1,400-$1,800 between 2012 and 2020, to $2,500 in 2024.[6] Similarly, the percentage of enrollees with deductibles exceeding $4,000 increased from just 6 percent in 2012 to 33 percent in 2024.[7] $4,000 equates to roughly 5% of per capita income in Rhode Island.[8]

Rising health care costs have also coincided with increased enrollment in health insurance plans with lower actuarial values, which generally require consumers to pay a greater share of their health care expenses through higher deductibles and other cost-sharing requirements. Consumers may select these plans because they typically offer lower monthly premiums, despite exposing enrollees to greater out-of-pocket costs when they receive care. For the 2026 plan year, the federal government failed to extend the enhanced premium tax credits ("EPTC") that were included in the 2021 American Rescue Plan Act.[9] These tax credits substantially lowered premium costs for consumers, leading more consumers enrolling in higher valued plans that offered lower deductibles.[10] However, the EPTCs expired in 2025, contributing to a shift toward lower-value bronze-level plans, which generally offer lower premiums but higher deductibles.[11] This expiration of subsidies precipitated the steepest rise in deductibles for ACA Marketplace plans since the implementation of the ACA in 2014.[12]

As costs associated with health coverage become increasingly unaffordable, the number of consumers who choose to forego coverage increases. In 2024, Rhode Island enjoyed a very low uninsured rate of 2.2 percent.[13] However, recent enrollment data over the last two years suggests that coverage is declining. During open enrollment for 2026, there was a 10 percent decline in enrollment for family and individual plans, this includes a 20 percent decrease in new enrollees.[14] Overall plan enrollment decreased 20 percent between the start and the close of open enrollment in 2025.[15] Notably, enrollment of those under 200 percent of the Federal Poverty Level fell by 27 percent.[16] The data show that increasingly unaffordable health care is forcing Rhode Islanders to limit their interaction with the health care system or go uninsured altogether to save money.

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[4] Deductibles in ACA Marketplace Plans, 2014-2026 | KFF
[5] Id.
[6] *2026 Annual Report: Health Care Spending and Quality in Rhode Island
[7] He Premium Payments if Enhanced Premium Tax Credits Expire | KFFalth Care Spending and Quality in Rhode Island: Annual Report 2025 page 5
[8] https://fred.stlouisfed.org/series/RIPCPI
[9] Premium Payments if Enhanced Premium Tax Credits Expire | KFF
[10] Premium Payments if Enhanced Premium Tax Credits Expire | KFF
[11] What We Know So Far About 2026 ACA Marketplace Enrollment, Premiums, and Deductibles | KFF
[12] Id.
[13] https://healthsourceri.com/wp-content/uploads/OE2026-Report-FINAL-3-9-26.pdf page 3.
[14] Id at page 1-2.
[15] Id at 2
[16] Id at 2

b. Complexity Preventing Consumers from Monitoring Financial Obligations

In addition to rising costs, the complexity of health insurance makes it difficult for consumers to understand and monitor their financial obligations. Approximately 30 percent of adults report difficulty understanding how much they will have to pay out of pocket when using their health insurance, and a quarter of adults report difficulty understanding health insurance terms, including deductibles.[17] Consumers report struggling to determine how much they owe for a particular service, whether they have satisfied their annual deductible, or how much of their deductible remains outstanding. This lack of understanding leaves consumers particularly vulnerable to confusion regarding the amounts providers request at the point of service. Given these circumstances, health care providers and health insurance carriers have an important role in ensuring that patients are charged only the amounts they actually owe.

This Office has received a steady stream of consumer complaints reflecting these concerns. Rhode Islanders seeking medical care have consistently reported being asked to make payments before service are rendered and before the provider knows definitively what the patient will owe for the service. Until a claim is submitted to and adjudicated by the patient's health insurance carrier, the provider does not know the patient's actual financial responsibility. Faced with the prospect of delaying or foregoing medical care, consumers often make the requested payments under the assumption that they are required to do so It is only after payment has been made that a consumer may find out that payment at the time of service was not required or that the amount they paid was incorrect.

Payments can exceed the amount the patient actually owes toward their deductible. This can happen if the patient has already reached their deductible for the year or when there is a difference between the estimated deductible the provider referenced and the final amount that should have been billed to the patient. In the absence of specific requirements governing the identification and refund of these overpayments, consumers are often left responsible for contacting providers and seeking reimbursement themselves. Moreover, patients often find insurance carriers unable to assist them because the insurer often does not know – and does not monitor – what amount the provider charged the patient out of pocket.

Some health insurance carriers have attempted to address premature deductible collection through policies that attempt to bar such practices. As part of policy or plan design documents, or in agreements with providers, some carriers have announced that providers may not require payment toward estimated deductibles at the point of service or before services are rendered.[18] Rather, carriers require that providers submit the claim for reimbursement and receive affirmative notice that a consumer has not yet reached their deductible and thus the service is eligible for payment. Providers are entitled to receive all funds they are owed pursuant to their provider agreements with the carriers. However, based on the Office's review, carriers do not provide sufficient oversight or effective mechanisms to ensure that patients are not overpaying at point of

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service. Meanwhile, in the absence of clear information regarding their rights and obligations, consumers assume that payment requests made by providers are accurate and mandatory. This imbalance of information places consumers at a disadvantage and may increase the risk of improper collections, particularly as providers increasingly rely on pre-service billing practices to collect payments.[19]

When providers request payment toward estimated deductibles without adequately informing patients of their rights, including that they may refuse pre-adjudication payment without delaying or otherwise affecting their care, such practices create a risk of consumer confusion and may constitute unfair or deceptive acts or practices. [20]

The Office has an essential role in protecting Rhode Island consumers, including safeguarding access to quality and affordable health care. Accordingly, the proposed Rule establishes clear and enforceable requirements governing the collection of estimated deductibles, patient notice and disclosure, the identification and refund of overpayments, and the respective responsibilities of health care providers and health insurance carriers. These requirements are intended to prevent consumer financial harm, promote transparency and accountability in health care billing, and ensure that patients are not charged more than their actual financial responsibility.

II. Overview of the Proposed Rule

The Rule establishes statewide standards governing how health care providers may bill and collect deductible payments before insurance claims have been adjudicated. Specifically, the Rule prohibits providers from requiring payment toward a deductible before all claims for the services have been adjudicated by the carrier, unless the provider satisfies specified notice, disclosure, and refund requirements. The Rule further requires providers that accept voluntary pre-adjudication deductible payments to proactively identify and refund overpayments and erroneous payments, establish and maintain written refund policies and procedures, and conduct annual audits.

The Rule further requires providers that accept voluntary pre-adjudication deductible payments to proactively identify and refund any resulting overpayments or erroneous payments. Providers must establish and maintain written internal policies and procedures to identify potential overpayments without requiring a consumer complaint, including through routine reports comparing amounts billed to patients against deductible amounts established through carrier remittances. The Rule requires providers to process identified refunds within three to five business days, issue refunds through the original method of payment unless otherwise requested by the patient, and conduct annual audits of their refund policies and procedures. Providers must also maintain documentation of their audits and make such records available to the Attorney General upon request.

Additionally, the Rule establishes corresponding obligations for health insurance carriers to review complaints, identify potentially affected enrollees, notify providers of potential violations for corrective action, and retain records of such notifications. The following analyses demonstrate that the proposed Rule will provide a net benefit to the State of Rhode Island by strengthening consumer protections, promoting transparency

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[19] https://www.cbsnews.com/news/hospitals-upfront-payments-rising-deductibles/

[20] R.I. Gen. Laws § 6-13-1 (xii-xiv)

and accountability in health care billing, and minimizing the administrative and financial impact on health care providers and carriers.

The Rule also establishes corresponding obligations for health insurance carriers to ensure compliance with the rule and that no wrongfully collected funds are maintained by either entity. Upon receiving a complaint or other notification indicating that a provider may be violating the Rule or applicable carrier requirements concerning deductible billing and collection, carriers must, within 14 business days, review the matter to identify enrollees who have been or may have been billed for estimated deductibles before claim adjudication. Carriers must transmit the results of their review to the provider for corrective action, including notice of the provider's obligation to refund overpayments and erroneous deductible payments. Carriers must retain evidence of such notifications for at least three years and make those records available to the Attorney General upon request. Providers and carriers must also cooperate in good faith with one another in audits, investigations, and outreach concerning deductible overpayments and erroneous payments.

Finally, violations of the Rule constitute unfair or deceptive acts or practices and are enforceable under the Rhode Island Deceptive Trade Practices Act, R.I. Gen. Laws Chapter 6-13.1, and may include but not be limited to fines of up to $10,000 per violation as well as injunctive relief.

The Office is soliciting comments on several additional topics and may choose to incorporate additional language in the regulation to address such topics at the final rule stage:

- Whether consumers in Rhode Island have experienced providers requiring patients to pay “deposits” or other one-time fees before a service to cover the potential costs of the service. If so, the Office is soliciting comments on requirements providers should be required to fulfill before billing patients for such fees, how such fees are or are not consistent with insurance plan design, and reasonable limits to impose on the billing of such fees.
- Whether the regulation should include any provisions to ensure that consumers using Health Savings Accounts or Flexible Spending Accounts to cover their estimated deductible costs are protected from having to complete excessive paperwork in the runup to tax filing to correct for any overpayments they make.
- Whether the notice and disclosure language proposed in the regulation should be supplemented or revised in any way to promote clarity and ensure patients are properly notified of their rights

III. Assessment of the Proposed Rule’s Benefits and Costs to the State of Rhode Island

a. Benefits to the State of Rhode Island

The proposed Rule is expected to provide meaningful benefits to Rhode Island consumers while imposing relatively modest administrative costs on regulated health care providers and insurance carriers. Providers that accept voluntary pre-adjudication deductible payments will be required to establish written policies and procedures,

provide prescribed patient disclosures, proactively identify and process overpayments, and conduct annual audits of their refund practices. However, many providers already maintain billing, claims processing, and account reconciliation systems that can be utilized to satisfy these requirements. Accordingly, the proposed Rule is designed to leverage existing operational systems rather than require the development of entirely new administrative infrastructure.

With respect to patient notice, health care providers are already required to provide patients with various disclosures under existing state and federal laws. For example, the federal No Surprises Act requires that consumers be given a Surprise Billing Protection notice and form.[21] Consumers are entitled to receive notice of privacy practices for protected health information when they seek care.[22] As with the proposed rule, CMS provides guidance in the form of suggested and required language that these notices need to contain.[23] Although these existing notices address different subject matter and do not duplicate the proposed Rule's requirements, they demonstrate that providers generally have established processes for furnishing legally mandated patient disclosures. Because the proposed Rule prescribes the language that must be provided, providers should be able to incorporate the required disclosure into existing registration, intake, or billing processes without substantial additional expense.

Similarly, providers already maintain claims processing systems to submit claims to carriers and reconcile payments. The information generated through carrier remittances and existing billing systems can be leveraged to identify potential deductible overpayments, generate credit balances, and process refunds. By requiring providers to use information already available through their existing billing and claims reconciliation processes, the proposed Rule promotes more accurate collections and timely refunds without requiring substantial changes to existing business operations.

b. Costs to the State of Rhode Island

The proposed Rule provides a cost-effective means of ensuring that consumers receive adequate notice and protection against deductible overpayments without imposing unnecessary burdens on providers and carriers. Providers that do not require or collect payment toward estimated deductibles before claim adjudication are not subject to the additional notice, refund, and audit requirements applicable to providers that accept voluntary pre-adjudication payments. Providers that elect to accept such payments must provide the prescribed disclosures and establish procedures to ensure patients receive notice of their rights.

Although these requirements will involve some initial administrative effort, providers may incorporate the disclosures into existing patient registration and billing processes. Similarly, the audit and refund obligations impose a modest compliance burden to generate the necessary refund reports, and minimal required time per year conduct an internal audit of the provider’s refund system. The associated administrative

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costs are expected to decrease over time as providers incorporate these requirements into existing operations and automate reporting and refund processes where feasible. Moreover, providers that already maintain appropriate procedures for identifying overpayments and processing refunds may be able to satisfy many of the Rule's requirements through their existing practices. These costs are justified by the anticipated financial benefits to consumers and the prevention of improper deductible collections.

The proposed Rule imposes limited, targeted obligations on health insurance carriers. The core function of an insurance company is to process and pay claims made by providers. Carriers already process claims and maintain information necessary to determine whether an enrollee has satisfied their deductible. This functionality is occurring regardless of the Rule, thus there is no extra cost incurred. The rule simply builds upon these existing functions by requiring carriers to cooperate in good faith with provider audits and promptly review complaints made by consumers concerning improper collection of deductibles. The Office anticipates that these limited additional obligations will impose a minimal burden on carriers relative to the consumer protections achieved.

Although providers and carriers may incur initial administrative costs to establish or modify compliance procedures, the anticipated ongoing costs should be limited, particularly as reporting and refund processes are incorporated into existing systems and automated where feasible. Accordingly, the proposed Rule provides a greater net benefit to the State of Rhode Island and its consumers by promoting accurate deductible billing, ensuring timely refunds, and protecting patients from unnecessary financial harm.

c. Alternative Approaches

R.I. Gen Laws § 42-35-2.9(b)(2) requires the agency to demonstrate that there is no alternative approach among those considered that would be as effective and less burdensome to affected private persons. In evaluating the proposed rule, the Office considered taking no regulatory action, issuing non-regulatory guidance, and adopting the proposed rule.

Taking no regulatory action would leave Rhode Island consumers without clear and uniform protections against premature or erroneous deductible collections and the failure to promptly refund overpayments. Although some carriers have announced policies governing the collection of deductibles, the Office's research and engagement with stakeholders has revealed that carriers often lack access to the necessary billing data to effectively audit compliance with their policies, resulting in erroneous billing going undetected. The Office reviews healthcare complaints submitted by Rhode Islanders and must utilize its statutory authority to remedy those complaints. Accordingly, the Office determined that taking no regulatory action would not remedy the concerns raised by Rhode Island consumers or prevent the recurrence of these billing practices.

The Office also considered issuing non-regulatory guidance outlining the issues facing consumers and how providers should remedy those issues. The Office concluded that a non-regulatory guidance statement would not effectively address the concerns raised in health care complaints submitted by Rhode Islanders and could result in

inconsistent compliance practices among providers and carriers. A non-regulatory guidance statement would also lack the force of law necessary to ensure the proper remedies necessary to protect consumers against improper deductible collections, lack of notice and disclosure, and ensure timely refunds. Therefore, the Office concluded that promulgating a clear and enforceable regulation was necessary to establish uniform requirements and best protect consumers from these harms.

The Office determined through regulatory analysis, that adopting the proposed Rule strikes an appropriate balance between protecting Rhode Island consumers and minimizing the financial burden on health care providers and insurance carriers . Engagement with providers has revealed that some, but not all, health care providers already have adopted internal compliance policies to ensure accurate collection of deductibles and processing of refunds or, in accordance with policies released by certain carriers, already understand it to be their legal obligation to await adjudication of claims prior to billing. Accordingly, only providers without proper systems in place to monitor and correct erroneous deductible overpayments will be required to adopt new internal compliance processes.

Finally, because providers are already required to provide disclosures to patients related to data privacy and other matters, the Office determined that any administrative cost associated with the required deductible-billing disclosure proposed under the rule would be outweighed by the benefits delivered to consumers. The proposed rule will protect Rhode Islanders from financial harm by establishing clear, enforceable standards governing deductible collection practices.

IV. Conclusion: Benefits of the Proposed Rule Justify the Costs

The proposed Rule is expected to reduce the financial burden on Rhode Island consumers by protecting patients from improper deductible collections and ensuring timely refunds of overpayments. The primary stakeholders directly affected by the Rule include health care providers that collect estimated deductible payments, health insurance carriers operating in Rhode Island, and consumers who receive health care services and may be asked to make such payments. Consumers are expected to benefit from increased transparency, improved billing practices, and greater protections against overpayment. Providers and carriers may incur administrative costs associated with compliance.

The benefits of the Rule should endure indefinitely, however, for the purposes of analysis, benefits and costs are projected over the next two plan years, as they are representative of how the rule will save consumers money in years to come. Moreover, the rule requires upfront costs, such as creating an audit process and producing the required written notifications.