LIFE HEALTH & ACCIDENT
RHODE ISLAND

Stephen B. Lang, Esq.
Paul S. Callaghan, Esq.
HIGGINS, CAVANAGH & COONEY, LLP
10 Dorrance Street
Suite 400
Providence, Rhode Island 02903
Phone: (401)272-3500
Fax: (401)273-8780
Email: s_lang@hcc-law.com
p_callaghan@hcc-law.com
Website: www.hcc-law.com

I. REGULATORY LIMITS ON CLAIMS HANDLING

A. Timing for Responses and Determinations

R.I. Gen. Laws § 27-18-61 discussed this issue in the context of claims for covered health care service in which they must be processed promptly and get paid within forty (40) days of receipt of a written claim (or thirty (30) if the claim is made electronically). Denial of a claim must be made in writing within thirty (30) days of receipt of a claim, with the reasons for the denial given and a notification of what, if any, additional information is required to process the claim. Prompt claims processing is also required pursuant to Rhode Island Office of the Health Insurance Commissioner Regulation 7, see www.ohic.ri.gov. This regulation replaced Rhode Island Department of Business Regulation, Insurance Division, Regulation 102 which was repealed on January 1, 2007 and noted in a prior Compendium submission.

B. Standards for Determinations and Settlement


The "Unfair Claims Settlement Practices Act” mandates standards for the investigation and disposition of insurance claims. For instance, the insurer must conduct a "reasonable investigation" into the claims. § 27-9.1-4(a)(6). Also, the Act would be violated if an insurer did not attempt “in good faith to effectuate prompt, fair, and equitable settlement of claims submitted in which liability has become reasonably clear.” § 27-9.1-4(a)(4). “[I]n every case, an insurer must determine whether liability is reasonably clear by objective, measurable criteria, engage in settlement negotiations and attempt, in good faith, to resolve the claim so that its insured is relieved from the burden of instituting a suit to recover under the policy.” Skaling, 799 A.2d
II. PRINCIPLES OF CONTRACT INTERPRETATION

In Rhode Island, unambiguous contract terms will be given their "plain and ordinary meaning." Perry v. Garey, 799 A.2d 1018, 1023 (R.I. 2002). A contract is ambiguous "only when it is reasonably and clearly susceptible of more than one interpretation." 799 A.2d at 1023 (quoting Hilt on v. Fraio li, 763 A.2d 599, 602 (R.I. 2000)). Ultimately, where contract terms are found to be unambiguous, "the task of judicial construction is at an end and the parties are bound by the plain and ordinary meaning of the terms of the contract." Zarella v. Minn. Mut. Life Ins. Co., 824 A.2d 1249, 1259 (R.I. 2003). The Court considers "the intent expressed by the language of the contract." Botelho v. City of Pawtucket, 130 A.2d 172, 176 (R.I. 2016). Moreover, it is well settled under Rhode Island law that if there is an "ambiguity or omission, the agreement must be construed against the drafting party." A.C.Beales Co. v. R.I. Hosp., 292 A.2d 865, 872 (R.I. 1972). Finally, Rhode Island courts adhere to the parol evidence rule and will not consider "any previous or contemporaneous oral statements that attempt to modify an integrated written agreement." Nat’l Refrigeration, Inc. v. Standen Contracting Co., Inc., 942 A.2d 968, 972 (R.I. 2008).

III. CHOICE OF LAW

Rhode Island law provides that "[i]n the absence of a contractual stipulation about which law controls, Rhode Island’s conflict-of-laws doctrine provides that the law of the state where the contract was executed governs." 852 A.2d at 483-84. Under Rhode Island law, parties to a contract are generally free to stipulate which law will govern the terms of their agreement. DeCesare v. Lincoln Benefit Life Co., 852 A.2d 474, 481 (R.I. 2004). Further, courts have observed that "[c]hoice-of-law provisions are valid and enforceable in nearly all jurisdictions that have passed upon them." DeCesare, 852 A.2d at 481. Choice of law provisions are enforceable "if the intention of the parties to stipulate to the jurisdiction is made clear by express language or by the ‘facts and circumstances attending the making of the contract.’" 852 A.2d at 481 (quoting Owens v. Hagenbeck-Wallace Shows Co., 192 A. 158, 164 (R.I. 1937)). In order to ascertain the intent of the parties to “bind themselves to a particular forum or jurisdiction, courts employ the standard principles of contract law.” 852 A.2d at 481-82.

IV. EXTRACTIONAL CLAEMS AGAINST INSURERS: ELEMENTS AND REMEDIES

A. Bad Faith

R.I. Gen. Laws § 9-1-33 allows an insured to make a claim for bad faith by alleging that the insurer wrongfully and in bad faith "refused to pay or settle a claim made pursuant to the provisions of the policy, or otherwise wrongfully and in bad faith refused to timely perform its obligations under the contract of insurance." A plaintiff can claim compensatory and punitive damages, as well as reasonable attorney fees.

Asermely v. Allstate Ins. Co., 728 A.2d 461 (R.I. 1999) found that an insurer owes a fiduciary duty to its insured. This duty includes an obligation to seriously consider a reasonable offer to settle within the policy limits. The insurer assumes the risk of miscalculation even if it
believes it has a legitimate defense in good faith.

Skaling v. Aetna Ins. Co., 799 A.2d 997 (R.I. 2002) established what an insured must do to avoid a bad faith claim. The Court stated that an insurer must be able to show that (1) the claim was fairly debatable, and (2) the claim was evaluated in an appropriate and timely manner.

B. Fraud

In order to prove a claim of common law fraud in Rhode Island, the plaintiff must prove each of the following four elements: 1) false representation; 2) defendant's knowledge of the statement's falsity; 3) intent to induce reliance by defendant; and 4) plaintiff's detrimental reliance. See Women's Dev. Corp. v. City of Central Falls, 764 A.2d 151, 160 (R.I. 2001).

Rule 9(b) of the Rhode Island Superior Court Rules of Civil Procedure provides that "circumstances constituting fraud or mistake shall be stated with particularity."

C. Intentional and Negligent Infliction of Emotional Distress and/or Outrage

To hold a defendant liable for the tort of intentional infliction of emotional distress, sometimes known as the tort of outrage, a plaintiff is obligated to prove four elements: 1) the conduct must be intentional or in reckless disregard of the probability of causing emotional distress; 2) the conduct must be extreme and outrageous; 3) there must be a causal connection between the wrongful conduct and the emotional Distress; and 4) the emotional distress in question must be severe. The conduct at issue must be "so outrageous in character and so extreme in degree, as to go beyond all possible bounds of decency, and to be regarded as atrocious and utterly intolerable in a civilized community." Swerdlick v. Koch, 721 A.2d 849, 863 (R.I. 1998). Typically, Rhode Island requires proof of medically established physical symptoms for both intentional and negligent infliction of emotional distress. See Jalowy v. The Friendly Home, Inc., 818 A.2d 698 (R.I. 2003); Wright v. Zielinski, 824 A.2d 494 (R.I. 2003).

Recently, however, Rhode Island courts have recognized some exceptions to the requirement of physical symptoms. The use of that requirement to weed out exaggerated claims was found to be inappropriate for emotional distress claimed as a result of a humiliating arrest and loss of military privileges in Adams v. Uno Restaurants, Inc., 794 A.2d 489 (R.I. 2002), because of available objective facts.

Only two classes of people in Rhode Island may bring a claim for the negligent infliction of emotional distress: those within the "zone-of-danger" who are physically endangered by the acts of a negligent defendant, and bystanders related to a victim whom they witness being injured; negligent infliction of emotional distress also requires proof of medically established physical symptoms. Jalowy v. The Friendly Home, Inc., 818 A.2d 698 (R.I. 2003); DiBattista v. State, 808 A.2d 1081 (R.I. 2002).

D. State Consumer Protection Laws and Regulations
R.I. Gen. Laws § 6-13.1-1 et seq. is known as the "Unfair Trade Practice and Consumer Protection Act." The statutory scheme defines terms, prohibits general practices, as well as those particular to specific industries, and sets forth the penalties and enforcement procedures for unfair trade practices. The Rhode Island Department of the Attorney General also has a consumer protection unit, which can be reached at (401) 274-4400, or at http://www.riag.state.ri.us

R.I. Gen. Laws § 27-58-1 et seq. is known as the "Banking and Insurance Consumer Protection Act" and as the "Financial Institution Insurance Sales Act." According to R.I. Gen. Laws § 27-58-2, the purpose of the act is to "regulate financial institutions in the conduct of the business of insurance in this state."


Regulation 99, “Privacy of Consumer Financial Information,” “governs the treatment of nonpublic personal financial information about individuals by all insurance licensees of the Rhode Island Department of Business Regulation.” It “(1) Requires a licensee to provide notice to individuals about its privacy policies and practices; (2) Describes the conditions under which a licensee may disclose nonpublic personal financial information about individuals to affiliates and nonaffiliated third parties; and (3) Provides methods for individuals to prevent a licensee from disclosing that information.”

Regulation 100, “Privacy of Consumer Health Information,” “governs the treatment of individual’s nonpublic personal health information by all insurance licensees of the Rhode Island Department of Business Regulation.” It “(1) Describes the conditions under which a licensee may disclose nonpublic personal health information about individuals to affiliates and nonaffiliated third parties; and (2) Provides methods for individuals to prevent a licensee from disclosing that information.”

E. State Class Actions

Rule 23 of the Rhode Island Superior Court Rules of Civil Procedure details the requirements for certification of a class and the maintenance of a class action. Rule 23 (a) reads as follows: "One or more members of a class may sue or be sued as representative parties on behalf of all only if (1) the class is so numerous that joinder of all members is impracticable, (2) there are questions of law or fact common to the class, (3) the claims or defenses of the representative parties are typical of the claims or defenses of the class, and (4) the representative parties will fairly and adequately protect the interests of the class." A class action can also only be maintained if separate actions would create the risk of inconsistent adjudications or impaired ability to protect interests of non-members, or if the opposing party has acted on grounds generally applicable to the class, or the court finds that questions of fact or law common to the class predominate
over questions affecting individual members. See R.I. Super. Ct. R. Civ. P. 23 (b). The party pleading the action has the burden of proof, and though it is not overwhelming, it requires “more than mere conj ective and conclusory allegations.” Cabana v. Littler, 612 A.2d 678, 686 (R.I. 1992).

F. State Privacy Laws, Rules and Regulations

1. Criminal Sanctions

The Confidentiality of Health Care Communications and Information Act, pursuant to R.I. Gen. Laws § 5-37.3-1 et seq., prohibits the disclosure of a patient’s confidential health care information without the patient’s written consent. Violators will be subject to actual and punitive damages, attorneys fees, as well as criminal penalties. The Act protects “all information relating to a patient’s health care history, diagnosis, condition, treatment or evaluation obtained from a health care provider who has treated the patient.” § 5-37.3-3(3)(ii).

Pursuant to § 5-37.3-9(b) provides that “[a]ny one who intentionally and knowingly violates the provisions of this chapter shall, upon conviction, be fined not more than one thousand dollars ($1,000), or imprisoned for not more than six (6) months, or both.”

2. The Standards for Compensatory and Punitive Damages

Compensatory damages are awarded “in satisfaction of or in response to a loss or injury sustained.” Calise v. Hidden Valley Condo. Ass’n, Inc., 773 A.2d 834, 839 (R.I. 2001). Punitive damages are “awarded, not to compensate a plaintiff for his or her injuries but rather to punish the offender and to deter future misconduct.” Carrozza v. Voccola, 90 A.3d 142, 165 (R.I. 2014). The Rhode Island Supreme Court has “consistently held that “punitive damages are proper only in situations in which the defendant’s actions are so willful, reckless, or wicked that they amount to criminality and that the question of whether adequate facts exist to meet that standard and support an award of punitive damages is a question of law[.]” Id.

R.I. Gen. Laws § 9-1-33, “Insurer’s bad faith refusal to pay a claim made under any insurance policy” provides that “an insured under any insurance policy as set out in the general laws or otherwise may bring an action against the insurer issuing the policy when it is alleged the insurer wrongfully and in bad faith refused to pay or settle a claim made pursuant to the provisions of the policy, or otherwise wrongfully and in bad faith refused to timely perform its obligations under the contract of insurance.” Further, “[i]n any action brought pursuant to this section, an insured may also make claim for compensatory damages, punitive damages, and reasonable attorney fees.” § 9-1-33.

3. Insurance Regulations to Watch

Insurance Regulation 13, “Unfair Life, Accident and Health Claims Settlement Practices” creates “minimum standards for the investigation and disposition of life, accident, and health claims arising under policies or certificates issued pursuant to State law. It is not intended to cover claims involving workers’ compensation insurance.” This regulation intends “to define procedures and practices which constitute unfair claims practices.”
Relevant provisions provide that:

“A. Every insurer, upon receiving due notification of a claim shall, within fifteen (15) days of the notification, provide necessary claim forms, instructions and reasonable assistance so the insured can properly comply with company requirements for filing a claim.

B. Upon receipt of proof of loss from a claimant, the insurer shall begin any necessary investigation of the claim within fifteen (15) days.

C. The insurer’s standards for claims processing shall be such that notice of claim or proof of loss submitted against one policy issued by that insurer shall fulfill the insured’s obligation under any and all similar policies issued by that insurer and specifically identified by the insured to the insurer to the same degree that the same form would be required under any similar policy. If additional information is required to fulfill the insured’s obligation under similar policies, the insurer may request the additional information. When it is apparent to the insurer that additional benefits would be payable under an insured’s policy upon additional proofs of loss, the insurer shall communicate to and cooperate with the insured in determining the extent of the insurer’s additional liability.

D. The insurer shall affirm or deny liability on claims within a reasonable time and shall offer payment within thirty (30) days of affirmation of liability if the amount of the claim is determined and not in dispute. If portions of the claim are in dispute, the insurer shall tender payment for those portions that are not disputed within thirty (30) days.

E. With each claim payment, the insurer shall provide to the insured an Explanation of Benefits that shall include the name of the provider or services covered, dates of service, and a reasonable explanation of the computation of benefits.

F. An insurer may not impose a penalty upon any insured for noncompliance with insurer requirements for precertification unless such penalty is specifically and clearly set forth in the policy.

G. If a claim remains unresolved for thirty (30) days from the date proof of loss is received, the insurer shall provide the insured or, when applicable, the insured’s beneficiary, with a reasonable written explanation for the delay. In credit, mortgage and assigned accident/health claims, the notice shall be provided to the debtor/insured or medical provider in addition to the insured. If the investigation remains incomplete, the insurer shall, forty-five (45) days from the date of initial notification and every forty-five (45) days thereafter, send to the claimant a letter setting forth the reasons additional time is needed for investigation.

H. The insurer shall acknowledge and respond within fifteen (15) days to any written communications relating to a pending claim.

I. When a claim is denied, written notice of denial shall be sent to the claimant within fifteen (15) days of the determination. The
insurer shall reference the policy provision, condition or exclusion upon which the denial is based.

J. No insurer shall deny a claim upon information obtained in a telephone conversation or personal interview with any source unless the telephone conversation or personal interview is documented in the claim file.

K. Insurers offering cash settlements of first party long-term disability income claims, except in cases where there is a bona fide dispute as to the coverage for, or amount of, the disability, shall develop a present value calculation of future benefits (with probability corrections for mortality and morbidity) utilizing contingencies such as mortality, morbidity, and interest rate assumptions, etc. appropriate to the risk. A copy of the amount so calculated shall be given to the insured and signed by him/her at the time a settlement is entered into.

L. No insurer shall indicate to a first party claimant on a payment draft, check or in any accompanying letter that said payment is “final” or “a release” of any claim unless the policy limit has been paid or there has been a compromise settlement agreed to by the first party claimant and the insurer as to coverage and amount payable under the policy.

M. No insurer shall withhold any portion of any benefit payable as a result of a claim on the basis that the sum withheld is an adjustment or correction for an overpayment made on a prior claim arising under the same policy unless: (1) The insurer has in its files clear, documented evidence of an overpayment and written authorization from the insured permitting the withholding procedure, or (2) The insurer has in its files clear, documented evidence that: (a) The overpayment was clearly erroneous under the provisions of the policy and if the overpayment is not the subject of a reasonable dispute as to facts; (b) The error that resulted in the payment is not a mistake of the law; (c) The insurer has notified the insured within six (6) months of the date of the error, except that in instances of error prompted by representations or nondisclosures of claimants or third parties, the insurer notified the insured within fifteen (15) days after the date the evidence of discovery of such error is included in its file. For the purpose of this rule, the date of the error shall be the day on which the draft for benefits is issued; and (d) The notice stated clearly the nature of the error and the amount of the overpayment.

N. If, after an insurer rejects a claim, the claimant objects to such rejection, the insurer shall notify the claimant in writing that he or she may have the matter reviewed by the State of Rhode Island Insurance Division, 233 Richmond Street, Providence, RI 02903-4233.”

4. **State Arbitration and Mediation Procedures**

R.I. Gen. Laws § 10-3-1 et seq., the “Arbitration Act” provides the rules for arbitrations. Section 10-3-2 provides that “[w]hen clearly written and expressed, a provision in a written contract to settle by arbitration a controversy thereafter arising out of such contract, or out of the refusal to perform the whole or any part thereof, or an agreement in writing between two
(2) or more persons to submit to arbitration any controversy existing between them at the time of the agreement to submit shall be valid, irrevocable, and enforceable, save upon such grounds as exist at law or in equity for the revocation of any contract; provided, however, that the provisions of this chapter shall not apply to collective contracts between employers and employees, or between employers and associations of employees, in respect to terms or conditions of employment; and provided further, that in all contracts of primary insurance, wherein the provision for arbitration is not placed immediately before the testimonium clause or the signature of the parties, the arbitration procedure may be enforced at the option of the insured, and in the event the insured exercises the option to arbitrate, then the provisions of this chapter shall apply and be the exclusive remedy available to the insured.” The arbitrator’s award must be in writing and signed by the arbitrators or by a majority of the arbitrators. R.I. Gen. Laws § 10-3-10.

As for mediation, R.I. Gen. Laws § 9-19-44 provides that “[a]ll memoranda and other work product, including files, reports, interviews, case summaries, and notes, prepared by a mediator shall be confidential and not subject to disclosure in any subsequent judicial or administrative proceeding involving any of the parties to any mediation in which the materials are generated; nor shall a mediator be compelled to disclose in any subsequent judicial or administrative proceeding any communication made to him or her in the course of, or relating to the subject matter of, any mediation by a participant in the mediation process.”

5. State Administrative Entity Rule-Making Authority

The Rhode Island Administrative Procedures Act (“APA”), R.I. Gen. Laws § 42-35-1 et seq. governs state administrative rulemaking. Every state rulemaking entity is subject to the APA, with the exception of the legislature and the judiciary. State agencies must follow a specified process in order to create regulations. Agencies must designate a rules coordinator who manages the rulemaking process. § 42-35-2.1. Notice of the Proposed Rule and a Public Comment period of at least thirty (30) days is required. § 42-35-2.7-2.8. A Public Hearing is not required, but an agency may choose to hold a hearing or the public may request one, in which it should be held between the period of 10 days after the notice and 5 days before the end of the public comment period. During the regulatory finalization period, the state agencies must consider the submissions from the Public Comment period and will incorporate or reject the comments with the reasons behind their actions. The regulations are submitted to the Office of Regulatory Reform for a final review and then to the Office of the Secretary of State for finalization.

V. Defenses in Actions Against Insurers

A. Misrepresentations/Omissions: During Underwriting or During Claim

In the insurance context, in order to establish a prima facie case of negligent misrepresentation, the plaintiff must establish, “(1) a misrepresentation of a material fact; (2) the representor must either know of the misrepresentation, must make the misrepresentation without knowledge as to its truth or falsity or must make the representation under circumstances in which he ought to have known of its falsity; (3) the representor must intend the representation to induce another to act on it; and (4) injury must result to the party acting in justifiable reliance on

A material misrepresentation in an insurance application is any representation that induces the insurer to insure the applicant. Evora v. Henry, 559 A.2d 1038, 1040 (R.I. 1989). A material misrepresentation in an insurance application makes the policy voidable without a concomitant demonstration of fraud. Id.

B. Preexisting Illness or Disease Clause

In order to comport with the federal Patient Protection and Affordable Care Act, R.I. Gen. Laws 27-18.6-3(a)(1) provides that “a group health plan and a health insurance carrier offering group health insurance coverage shall not deny, exclude, or limit benefits with respect to a participant or beneficiary because of a preexisting condition exclusion.” The exceptions to this mandate are if

“(i) The exclusion relates to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six (6) month period ending on the enrollment date; (ii) The exclusion extends for a period of not more than twelve (12) months (or eighteen (18) months in the case of a late enrollee) after the enrollment date; and (iii) The period of the preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage, if any, applicable to the participant or the beneficiary as of the enrollment date. § 27-18.6-3(a)(1)(i)-(iii).

Additionally, R.I. Gen. Laws 27-41-81, “Prohibition on preexisting condition exclusion” provides that

“a) A health insurance policy, subscriber contract, or health plan offered, issued, issued for delivery, or issued to cover a resident of this state by a health insurance company licensed pursuant to this title and/or chapter:

(1) Shall not limit or exclude coverage for an individual under the age of nineteen (19) by imposing a preexisting condition exclusion on that individual.

(2) For plan or policy years beginning on or after January 1, 2014, shall not limit or exclude coverage for any individual by imposing a preexisting condition exclusion on that individual.

(b) As used in this section:

(1) "Preexisting condition exclusion" means a limitation or exclusion of benefits, including a denial of coverage, based on the fact that the condition (whether physical or mental) was present before the effective date of coverage, or if the coverage is denied, the date of denial, under a health benefit plan whether or not any medical advice, diagnosis, care or treatment was recommended or received before the effective date of coverage.

(2) "Preexisting condition exclusion" means any limitation or exclusion of benefits, including a denial of coverage, applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage, or if the coverage
is denied, the date of denial, under the health benefit plan, such as a condition (whether physical or mental) identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.

(c) This section shall not apply to grandfathered health plans providing individual health insurance coverage.

(d) This section shall not apply to insurance coverage providing benefits for: (1) Hospital confinement indemnity; (2) Disability income; (3) Accident only; (4) Long-term care; (5) Medicare supplement; (6) Limited benefit health; (7) Specified disease indemnity; (8) Sickness or bodily injury or death by accident or both; and (9) Other limited benefit policies.

C. Statutes of Limitations and Repose

R.I. Gen. Laws § 9-1-13 sets the statute of limitations for contract actions at ten (10) years from the alleged breach. R.I. Gen. Laws § 9-1-14 sets the statute of limitations for an action sounding in tort at three (3) years. Pursuant to R.I. Gen. Laws § 9-1-14.1, an action for insurance agent malpractice must be brought within three (3) years of the time that the act of malpractice should have been discovered in the exercise of reasonable diligence.

VI. BENEFICIARY ISSUES

A. Change of Beneficiary

As a general rule in Rhode Island, “[a]n insured may change the beneficiary of an insurance policy by complying substantially with the procedures required by the policy.” Souza v. R.I. Pub. Transit Auth., No. 92-3226, 1994 WL 930890, at *4 (R.I. Super.Ct. Jan. 6, 1994). Courts recognize that where the right to change the beneficiary is reserved to the insured, beneficiaries lack any vested interest and may not hinder the right of the insured to effect a change in beneficiaries in accordance with policy terms. See Metro. Life Ins. Co. v. Sandstrand, 82 A.2d 863, 865 (R.I. 1951). To “comply substantially” with the terms of an insurance policy, the insured must “do all do all that he [or she] reasonably could be expected to do in the circumstances in order to effectuate his [or her] intention to change the beneficiary in the policy.” 82 A.2d at 866.

B. Effect of Divorce on Beneficiary Designation

R.I. Gen. Laws § 15-5-14.1(f) provides that once a divorce complaint is served, an insured does not have the right as a sole policy owner to change the beneficiary during a pending divorce action. See Loppi v. United Investors Life Ins. Co., 126 A.3d 458, 462 (R.I. 2015).

VIII. INTERPLEADER ACTIONS
A. **Availability of Fee Recovery**

Although Rhode Island's Rules of Civil Procedure is silent on the issue, courts have held that they have discretion to award attorneys' fees. However, the court will deny costs and fees to a party who seeks to interplead without a sufficient basis for believing that it will be subject to multiple lawsuits. Courts will also refuse to grant attorneys' fees in circumstances where the party filing the interpleader action has a substantial interest in the litigation. In addition, courts will exercise their discretion in denying interpleader to a party whose interest in the underlying litigation is "substantial". See, e.g., DeMarco v. Travelers, 26 A.3d 585 (R.I. 2011).

B. **Difference in State vs. Federal**

R.I. Civ. P. 22 authorizes an interpleader action when claims of interpleader defendants are such that the plaintiff is or may be exposed to double or multiple liability, regardless of whether the claims of the interpleader defendant have a common origin, so long as they are adverse to and independent of each other. Interpleader is often used by insurers in circumstances where there are multiple claimants or a question as to the proper beneficiary of the proceeds of a policy. Rhode Island's statutory rule is the same as the Federal Rule.