

2024 -- S 2715

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STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2024

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A N A C T

RELATING TO INSURANCE -- ACCIDENT AND SICKNESS INSURANCE POLICIES

Introduced By: Senators DiMario, and Pearson

Date Introduced: March 05, 2024

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

1 SECTION 1. Section 27-18-76 of the General Laws in Chapter 27-18 entitled "Accident
2 and Sickness Insurance Policies" is hereby amended to read as follows:

3 **27-18-76. Emergency services.**

4 (a) As used in this section:

5 (1) "Emergency medical condition" means a medical condition manifesting itself by acute
6 symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses
7 an average knowledge of health and medicine, could reasonably expect the absence of immediate
8 medical attention to result in a condition: (i) Placing the health of the individual, or with respect to
9 a pregnant woman her unborn child, in serious jeopardy; (ii) Constituting a serious impairment to
10 bodily functions; or (iii) Constituting a serious dysfunction of any bodily organ or part.

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

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

16 ~~(B)~~(ii) Such further medical examination and treatment, to the extent they are within the
17 capabilities of the staff and facilities available at the hospital, as are required under section 1867 of
18 the Social Security Act (42 U.S.C. § 1395dd) to stabilize the patient; ~~and~~

19 (iii) Transportation for emergency services by ambulance vehicles and ambulance service

1 entities licensed in accordance with chapter 4.1 of title 23 to provide emergency medical care,
2 transportation, and preventative care to mitigate loss of life or exacerbation of illness or injury.

3 (A) All copayment, coinsurance, deductible, and other cost-sharing feature amounts shall
4 not exceed the in-network copayment, coinsurance, deductible, and other cost-sharing features for
5 the covered health care services received by the enrollee.

6 (B) Nothing herein shall prevent the provider of ambulance services from pursuing
7 recompense for services from any non-enrollee third party liable to the enrollee at law.

8 (3) “Stabilize,” with respect to an emergency medical condition has the meaning given in
9 § 1867(e)(3) of the Social Security Act (42 U.S.C. § 1395dd(e)(3)).

10 (b) If a health insurance carrier offering health insurance coverage provides any benefits
11 with respect to services in an emergency department of a hospital, the carrier must cover emergency
12 services in compliance with this section.

13 (c) A health insurance carrier shall provide coverage for emergency services in the
14 following manner:

15 (1) Without the need for any prior authorization determination, even if the emergency
16 services are provided on an out-of-network basis;

17 (2) Without regard to whether the healthcare provider furnishing the emergency services is
18 a participating network provider with respect to the services;

19 (3) If the emergency services are provided out of network, without imposing any
20 administrative requirement or limitation on coverage that is more restrictive than the requirements
21 or limitations that apply to emergency services received from in-network providers;

22 (4) If the emergency services are provided out of network, by complying with the cost-
23 sharing requirements of subsection (d) of this section; and

24 (5) Without regard to any other term or condition of the coverage, other than:

25 ~~(A)~~(i) The exclusion of or coordination of benefits;

26 ~~(B)~~(ii) An affiliation or waiting period permitted under part 7 of federal ERISA, part A of
27 title XXVII of the federal PHS Act, or chapter 100 of the federal Internal Revenue Code; or

28 ~~(C)~~(iii) Applicable cost-sharing.

29 (d)(1) Any cost-sharing requirement expressed as a copayment amount or coinsurance rate
30 imposed with respect to a participant or beneficiary for out-of-network emergency services cannot
31 exceed the cost-sharing requirement imposed with respect to a participant or beneficiary if the
32 services were provided in-network; provided, however, that a participant or beneficiary may be
33 required to pay, in addition to the in-network cost-sharing, the excess of the amount the out-of-
34 network provider charges over the amount the health insurance carrier is required to pay under

1 subdivision (1) of this subsection. A health insurance carrier complies with the requirements of this
2 subsection if it provides benefits with respect to an emergency service in an amount equal to the
3 greatest of the three amounts specified in subdivisions (A), (B), and (C) of this subdivision (1)
4 (which are adjusted for in-network cost-sharing requirements).

5 ~~(A)~~(i) The amount negotiated with in-network providers for the emergency service
6 furnished, excluding any in-network copayment or coinsurance imposed with respect to the
7 participant or beneficiary. If there is more than one amount negotiated with in-network providers
8 for the emergency service, the amount described under this subdivision (A) is the median of these
9 amounts, excluding any in-network copayment or coinsurance imposed with respect to the
10 participant or beneficiary. In determining the median described in the preceding sentence, the
11 amount negotiated with each in-network provider is treated as a separate amount (even if the same
12 amount is paid to more than one provider). If there is no per-service amount negotiated with in-
13 network providers (such as under a capitation or other similar payment arrangement), the amount
14 under this subdivision (A) is disregarded.

15 ~~(B)~~(ii) The amount for the emergency service shall be calculated using the same method
16 the plan generally uses to determine payments for out-of-network services (such as the usual,
17 customary, and reasonable amount), excluding any in-network copayment or coinsurance imposed
18 with respect to the participant or beneficiary. The amount in this subdivision (B) is determined
19 without reduction for out-of-network cost-sharing that generally applies under the plan or health
20 insurance coverage with respect to out-of-network services.

21 ~~(C)~~(iii) The amount that would be paid under Medicare (part A or part B of title XVIII of
22 the Social Security Act, 42 U.S.C. § 1395 et seq.) for the emergency service, excluding any in-
23 network copayment or coinsurance imposed with respect to the participant or beneficiary.

24 (2) Any cost-sharing requirement other than a copayment or coinsurance requirement (such
25 as a deductible or out-of-pocket maximum) may be imposed with respect to emergency services
26 provided out of network if the cost-sharing requirement generally applies to out-of-network
27 benefits. A deductible may be imposed with respect to out-of-network emergency services only as
28 part of a deductible that generally applies to out-of-network benefits. If an out-of-pocket maximum
29 generally applies to out-of-network benefits, that out-of-pocket maximum must apply to out-of-
30 network emergency services.

31 (e) The provisions of this section apply for plan years beginning on or after September 23,
32 2010.

33 (f) This section shall not apply to grandfathered health plans. This section shall not apply
34 to insurance coverage providing benefits for: (1) hospital confinement indemnity; (2) disability

1 income; (3) accident only; (4) long term care; (5) Medicare supplement; (6) limited benefit health;
2 (7) specified disease indemnity; (8) sickness or bodily injury or death by accident or both; and (9)
3 other limited benefit policies.

4 SECTION 2. Section 27-19-66 of the General Laws in Chapter 27-19 entitled "Nonprofit
5 Hospital Service Corporations" is hereby amended to read as follows:

6 **27-19-66. Emergency services.**

7 (a) As used in this section:

8 (1) "Emergency medical condition" means a medical condition manifesting itself by acute
9 symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses
10 an average knowledge of health and medicine, could reasonably expect the absence of immediate
11 medical attention to result in a condition: (i) Placing the health of the individual, or with respect to
12 a pregnant woman her unborn child, in serious jeopardy; (ii) Constituting a serious impairment to
13 bodily functions; or (iii) Constituting a serious dysfunction of any bodily organ or part.

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

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

19 (ii) Such further medical examination and treatment, to the extent they are within the
20 capabilities of the staff and facilities available at the hospital, as are required under section 1867 of
21 the Social Security Act (42 U.S.C. § 1395dd) to stabilize the patient; ~~and~~

22 (iii) Transportation for emergency services by ambulance vehicles and ambulance service
23 entities licensed in accordance with chapter 4.1 of title 23 to provide emergency medical care,
24 transportation, and preventative care to mitigate loss of life or exacerbation of illness or injury.

25 (A) All copayment, coinsurance, deductible, and other cost-sharing feature amounts shall
26 not exceed the in-network copayment, coinsurance, deductible, and other cost-sharing features for
27 the covered health care services received by the enrollee.

28 (B) Nothing herein shall prevent the provider of ambulance services from pursuing
29 recompense for services from any non-enrollee third party liable to the enrollee at law.

30 (3) "Stabilize," with respect to an emergency medical condition has the meaning given in
31 section 1867(e)(3) of the Social Security Act (42 U.S.C. § 1395dd(e)(3)).

32 (b) If a nonprofit hospital service corporation provides any benefits to subscribers with
33 respect to services in an emergency department of a hospital, the plan must cover emergency
34 services consistent with the rules of this section.

1 (c) A nonprofit hospital service corporation shall provide coverage for emergency services
2 in the following manner:

3 (1) Without the need for any prior authorization determination, even if the emergency
4 services are provided on an out-of-network basis;

5 (2) Without regard to whether the healthcare provider furnishing the emergency services is
6 a participating network provider with respect to the services;

7 (3) If the emergency services are provided out of network, without imposing any
8 administrative requirement or limitation on coverage that is more restrictive than the requirements
9 or limitations that apply to emergency services received from in-network providers;

10 (4) If the emergency services are provided out of network, by complying with the cost-
11 sharing requirements of subsection (d) of this section; and

12 (5) Without regard to any other term or condition of the coverage, other than:

13 (i) The exclusion of or coordination of benefits;

14 (ii) An affiliation or waiting period permitted under part 7 of federal ERISA, part A of title
15 XXVII of the federal Public Health Service Act, or chapter 100 of the federal Internal Revenue
16 Code; or

17 (iii) Applicable cost sharing.

18 (d)(1) Any cost-sharing requirement expressed as a copayment amount or coinsurance rate
19 imposed with respect to a participant or beneficiary for out-of-network emergency services cannot
20 exceed the cost-sharing requirement imposed with respect to a participant or beneficiary if the
21 services were provided in-network. However, a participant or beneficiary may be required to pay,
22 in addition to the in-network cost sharing, the excess of the amount the out-of-network provider
23 charges over the amount the plan or health insurance carrier is required to pay under subsection
24 (d)(1). A group health plan or health insurance carrier complies with the requirements of this
25 subsection (d) if it provides benefits with respect to an emergency service in an amount equal to
26 the greatest of the three amounts specified in subsections (d)(1)(i), (d)(1)(ii), and (d)(1)(iii) of this
27 section (which are adjusted for in-network cost-sharing requirements).

28 (i) The amount negotiated with in-network providers for the emergency service furnished,
29 excluding any in-network copayment or coinsurance imposed with respect to the participant or
30 beneficiary. If there is more than one amount negotiated with in-network providers for the
31 emergency service, the amount described under this subsection (d)(1)(i) is the median of these
32 amounts, excluding any in-network copayment or coinsurance imposed with respect to the
33 participant or beneficiary. In determining the median described in the preceding sentence, the
34 amount negotiated with each in-network provider is treated as a separate amount (even if the same

1 amount is paid to more than one provider). If there is no per-service amount negotiated with in-
2 network providers (such as under a capitation or other similar payment arrangement), the amount
3 under this subsection (d)(1)(i) is disregarded.

4 (ii) The amount for the emergency service shall be calculated using the same method the
5 plan generally uses to determine payments for out-of-network services (such as the usual,
6 customary, and reasonable amount), excluding any in-network copayment or coinsurance imposed
7 with respect to the participant or beneficiary. The amount in this subsection (d)(1)(ii) is determined
8 without reduction for out-of-network cost sharing that generally applies under the plan or health
9 insurance coverage with respect to out-of-network services. Thus, for example, if a plan generally
10 pays seventy percent (70%) of the usual, customary, and reasonable amount for out-of-network
11 services, the amount in this subsection (d)(1)(ii) for an emergency service is the total, that is, one
12 hundred percent (100%), of the usual, customary, and reasonable amount for the service, not
13 reduced by the thirty percent (30%) coinsurance that would generally apply to out-of-network
14 services (but reduced by the in-network copayment or coinsurance that the individual would be
15 responsible for if the emergency service had been provided in-network).

16 (iii) The amount that would be paid under Medicare (part A or part B of title XVIII of the
17 Social Security Act, 42 U.S.C. § 1395 et seq.) for the emergency service, excluding any in-network
18 copayment or coinsurance imposed with respect to the participant or beneficiary.

19 (2) Any cost-sharing requirement other than a copayment or coinsurance requirement (such
20 as a deductible or out-of-pocket maximum) may be imposed with respect to emergency services
21 provided out of network if the cost-sharing requirement generally applies to out-of-network
22 benefits. A deductible may be imposed with respect to out-of-network emergency services only as
23 part of a deductible that generally applies to out-of-network benefits. If an out-of-pocket maximum
24 generally applies to out-of-network benefits, that out-of-pocket maximum must apply to out-of-
25 network emergency services.

26 (e) The provisions of this section apply for plan years beginning on or after September 23,
27 2010.

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

32 SECTION 3. Section 27-20-62 of the General Laws in Chapter 27-20 entitled "Nonprofit
33 Medical Service Corporations" is hereby amended to read as follows:

34 **27-20-62. Emergency services.**

1 (a) As used in this section:

2 (1) “Emergency medical condition” means a medical condition manifesting itself by acute
3 symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses
4 an average knowledge of health and medicine, could reasonably expect the absence of immediate
5 medical attention to result in a condition: (i) Placing the health of the individual, or with respect to
6 a pregnant woman her unborn child, in serious jeopardy; (ii) Constituting a serious impairment to
7 bodily functions; or (iii) Constituting a serious dysfunction of any bodily organ or part.

8 (2) “Emergency services” means, with respect to an emergency medical condition:

9 (i) A medical screening examination (as required under section 1867 of the Social Security
10 Act, 42 U.S.C. § 1395dd) that is within the capability of the emergency department of a hospital,
11 including ancillary services routinely available to the emergency department to evaluate the
12 emergency medical condition, ~~and~~;

13 (ii) Further medical examination and treatment, to the extent they are within the capabilities
14 of the staff and facilities available at the hospital, as are required under section 1867 of the Social
15 Security Act (42 U.S.C. § 1395dd) to stabilize the patient; ~~and~~

16 (iii) Transportation for emergency services by ambulance vehicles and ambulance service
17 entities licensed in accordance with chapter 4.1 of title 23 to provide emergency medical care,
18 transportation, and preventative care to mitigate loss of life or exacerbation of illness or injury.

19 (A) All copayment, coinsurance, deductible, and other cost-sharing feature amounts shall
20 not exceed the in-network copayment, coinsurance, deductible, and other cost-sharing features for
21 the covered health care services received by the enrollee.

22 (B) Nothing herein shall prevent the provider of ambulance services from pursuing
23 recompense for services from any non-enrollee third party liable to the enrollee at law.

24 (3) “Stabilize,” with respect to an emergency medical condition has the meaning given in
25 section 1867(e)(3) of the Social Security Act (42 U.S.C. § 1395dd(e)(3)).

26 (b) If a nonprofit medical service corporation offering health insurance coverage provides
27 any benefits with respect to services in an emergency department of a hospital, it must cover
28 emergency services consistent with the rules of this section.

29 (c) A nonprofit medical service corporation shall provide coverage for emergency services
30 in the following manner:

31 (1) Without the need for any prior authorization determination, even if the emergency
32 services are provided on an out-of-network basis;

33 (2) Without regard to whether the healthcare provider furnishing the emergency services is
34 a participating network provider with respect to the services;

1 (3) If the emergency services are provided out of network, without imposing any
2 administrative requirement or limitation on coverage that is more restrictive than the requirements
3 or limitations that apply to emergency services received from in-network providers;

4 (4) If the emergency services are provided out of network, by complying with the cost-
5 sharing requirements of subsection (d) of this section; and

6 (5) Without regard to any other term or condition of the coverage, other than:

7 (i) The exclusion of or coordination of benefits;

8 (ii) An affiliation or waiting period permitted under part 7 of federal ERISA, part A of title
9 XXVII of the federal Public Health Service Act, or chapter 100 of the federal Internal Revenue
10 Code; or

11 (iii) Applicable cost sharing.

12 (d)(1) Any cost-sharing requirement expressed as a copayment amount or coinsurance rate
13 imposed with respect to a participant or beneficiary for out-of-network emergency services cannot
14 exceed the cost-sharing requirement imposed with respect to a participant or beneficiary if the
15 services were provided in-network. However, a participant or beneficiary may be required to pay,
16 in addition to the in-network cost sharing, the excess of the amount the out-of-network provider
17 charges over the amount the plan or health insurance carrier is required to pay under subsection
18 (d)(1). A group health plan or health insurance carrier complies with the requirements of this
19 subsection (d) if it provides benefits with respect to an emergency service in an amount equal to
20 the greatest of the three amounts specified in subsections (d)(1)(i), (d)(1)(ii), and (d)(1)(iii) of this
21 section (which are adjusted for in-network cost-sharing requirements).

22 (i) The amount negotiated with in-network providers for the emergency service furnished,
23 excluding any in-network copayment or coinsurance imposed with respect to the participant or
24 beneficiary. If there is more than one amount negotiated with in-network providers for the
25 emergency service, the amount described under this subsection (d)(1)(i) is the median of these
26 amounts, excluding any in-network copayment or coinsurance imposed with respect to the
27 participant or beneficiary. In determining the median described in the preceding sentence, the
28 amount negotiated with each in-network provider is treated as a separate amount (even if the same
29 amount is paid to more than one provider). If there is no per-service amount negotiated with in-
30 network providers (such as under a capitation or other similar payment arrangement), the amount
31 under this subsection (d)(1)(i) is disregarded.

32 (ii) The amount for the emergency service shall be calculated using the same method the
33 plan generally uses to determine payments for out-of-network services (such as the usual,
34 customary, and reasonable amount), excluding any in-network copayment or coinsurance imposed

1 with respect to the participant or beneficiary. The amount in this subsection (d)(1)(ii) is determined
2 without reduction for out-of-network cost sharing that generally applies under the plan or health
3 insurance coverage with respect to out-of-network services.

4 (iii) The amount that would be paid under Medicare (part A or part B of title XVIII of the
5 Social Security Act, 42 U.S.C. § 1395 et seq.) for the emergency service, excluding any in-network
6 copayment or coinsurance imposed with respect to the participant or beneficiary.

7 (2) Any cost-sharing requirement other than a copayment or coinsurance requirement (such
8 as a deductible or out-of-pocket maximum) may be imposed with respect to emergency services
9 provided out of network if the cost-sharing requirement generally applies to out-of-network
10 benefits. A deductible may be imposed with respect to out-of-network emergency services only as
11 part of a deductible that generally applies to out-of-network benefits. If an out-of-pocket maximum
12 generally applies to out-of-network benefits, that out-of-pocket maximum must apply to out-of-
13 network emergency services.

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

19 SECTION 4. Section 27-41-79 of the General Laws in Chapter 27-41 entitled "Health
20 Maintenance Organizations" is hereby amended to read as follows:

21 **27-41-79. Emergency services.**

22 (a) As used in this section:

23 (1) "Emergency medical condition" means a medical condition manifesting itself by acute
24 symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses
25 an average knowledge of health and medicine, could reasonably expect the absence of immediate
26 medical attention to result in a condition: (i) Placing the health of the individual, or with respect to
27 a pregnant woman her unborn child in serious jeopardy; (ii) Constituting a serious impairment to
28 bodily functions; or (iii) Constituting a serious dysfunction of any bodily organ or part.

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

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

34 (ii) Such further medical examination and treatment, to the extent they are within the

1 capabilities of the staff and facilities available at the hospital, as are required under section 1867 of
2 the Social Security Act (42 U.S.C. § 1395dd) to stabilize the patient; and

3 (iii) Transportation for emergency services by ambulance vehicles and ambulance service
4 entities licensed in accordance with chapter 4.1 of title 23 to provide emergency medical care,
5 transportation, and preventative care to mitigate loss of life or exacerbation of illness or injury.

6 (A) All copayment, coinsurance, deductible, and other cost-sharing feature amounts shall
7 not exceed the in-network copayment, coinsurance, deductible, and other cost-sharing features for
8 the covered health care services received by the enrollee.

9 (B) Nothing herein shall prevent the provider of ambulance services from pursuing
10 recompense for services from any non-enrollee third party liable to the enrollee at law.

11 (3) “Stabilize,” with respect to an emergency medical condition has the meaning given in
12 section 1867(e)(3) of the Social Security Act (42 U.S.C. § 1395dd(e)(3)).

13 (b) If a health maintenance organization offering group health insurance coverage provides
14 any benefits with respect to services in an emergency department of a hospital, it must cover
15 emergency services consistent with the rules of this section.

16 (c) A health maintenance organization shall provide coverage for emergency services in
17 the following manner:

18 (1) Without the need for any prior authorization determination, even if the emergency
19 services are provided on an out-of-network basis;

20 (2) Without regard to whether the healthcare provider furnishing the emergency services is
21 a participating network provider with respect to the services;

22 (3) If the emergency services are provided out of network, without imposing any
23 administrative requirement or limitation on coverage that is more restrictive than the requirements
24 or limitations that apply to emergency services received from in-network providers;

25 (4) If the emergency services are provided out of network, by complying with the cost-
26 sharing requirements of subsection (d) of this section; and

27 (5) Without regard to any other term or condition of the coverage, other than:

28 (i) The exclusion of or coordination of benefits;

29 (ii) An affiliation or waiting period permitted under part 7 of federal ERISA, part A of title
30 XXVII of the federal Public Health Service Act, or chapter 100 of the federal Internal Revenue
31 Code; or

32 (iii) Applicable cost sharing.

33 (d)(1) Any cost-sharing requirement expressed as a copayment amount or coinsurance rate
34 imposed with respect to a participant or beneficiary for out-of-network emergency services cannot

1 exceed the cost-sharing requirement imposed with respect to a participant or beneficiary if the
2 services were provided in-network; provided, however, that a participant or beneficiary may be
3 required to pay, in addition to the in-network cost sharing, the excess of the amount the out-of-
4 network provider charges over the amount the plan or health maintenance organization is required
5 to pay under subsection (d)(1). A health maintenance organization complies with the requirements
6 of this subsection (d) if it provides benefits with respect to an emergency service in an amount
7 equal to the greatest of the three amounts specified in subsections (d)(1)(i), (d)(1)(ii), and (d)(1)(iii)
8 of this section (which are adjusted for in-network cost-sharing requirements).

9 (i) The amount negotiated with in-network providers for the emergency service furnished,
10 excluding any in-network copayment or coinsurance imposed with respect to the participant or
11 beneficiary. If there is more than one amount negotiated with in-network providers for the
12 emergency service, the amount described under this subsection (d)(1)(i) is the median of these
13 amounts, excluding any in-network copayment or coinsurance imposed with respect to the
14 participant or beneficiary. In determining the median described in the preceding sentence, the
15 amount negotiated with each in-network provider is treated as a separate amount (even if the same
16 amount is paid to more than one provider). If there is no per-service amount negotiated with in-
17 network providers (such as under a capitation or other similar payment arrangement), the amount
18 under this subsection (d)(1)(i) is disregarded.

19 (ii) The amount for the emergency service calculated using the same method the plan
20 generally uses to determine payments for out-of-network services (such as the usual, customary,
21 and reasonable amount), excluding any in-network copayment or coinsurance imposed with respect
22 to the participant or beneficiary. The amount in this subsection (d)(1)(ii) is determined without
23 reduction for out-of-network cost sharing that generally applies under the plan or health insurance
24 coverage with respect to out-of-network services.

25 (iii) The amount that would be paid under Medicare (part A or part B of title XVIII of the
26 Social Security Act, 42 U.S.C. § 1395 et seq.) for the emergency service, excluding any in-network
27 copayment or coinsurance imposed with respect to the participant or beneficiary.

28 (2) Any cost-sharing requirement other than a copayment or coinsurance requirement (such
29 as a deductible or out-of-pocket maximum) may be imposed with respect to emergency services
30 provided out of network if the cost-sharing requirement generally applies to out-of-network
31 benefits. A deductible may be imposed with respect to out-of-network emergency services only as
32 part of a deductible that generally applies to out-of-network benefits. If an out-of-pocket maximum
33 generally applies to out-of-network benefits, that out-of-pocket maximum must apply to out-of-
34 network emergency services.

1 (e) The provisions of this section apply for plan years beginning on or after September 23,
2 2010.

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

8 SECTION 5. This act shall take effect upon passage.

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EXPLANATION
BY THE LEGISLATIVE COUNCIL
OF
A N A C T
RELATING TO INSURANCE -- ACCIDENT AND SICKNESS INSURANCE POLICIES

1 This act would mandate health insurance coverage to include transportation for emergency
2 services by ambulance or rescue. It would prohibit any co-payments or deductibles from exceeding
3 the in-network covered health care services received by an enrollee. This act would further
4 authorize the provider of ambulance services to pursue payment for services from any non-enrollee
5 third party liable to the enrollee at law.

6 This act would take effect upon passage.

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