2024 -- S 2715

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S T A T E O F R H O D E I S L A N D

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2024

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:

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

27-18-76. Emergency services.

(a) As used in this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(f) This section shall not apply to grandfathered health plans. 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.

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

27-19-66. Emergency services.

(a) As used in this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) The exclusion of or coordination of benefits;

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

(iii) Applicable cost sharing.

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

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

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

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

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

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

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

(f) 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.

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

27-20-62. Emergency services.

(a) As used in this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) The exclusion of or coordination of benefits;

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

(iii) Applicable cost sharing.

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

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

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

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

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

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

(f) The provisions of this section shall apply to grandfathered health plans. 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.

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

27-41-79. Emergency services.

(a) As used in this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) The exclusion of or coordination of benefits;

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

(iii) Applicable cost sharing.

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

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

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

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

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

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

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

(f) The provisions of this section shall apply to grandfathered health plans. 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.

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

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

This act would take effect upon passage.

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