2021 -- H 5461

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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. 2021

A N   A C T

RELATING TO INSURANCE -- ACCIDENT AND SICKNESS INSURANCE POLICIES

Introduced By: Representatives Edwards, Kennedy, and Tobon

Date Introduced: February 10, 2021

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

16 (B) 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.

19 (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 health care 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) The exclusion of or coordination of benefits;

(B) 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) 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~~ shall incur no greater out-of-pocket costs for the emergency services than the participant or beneficiary would have incurred with an in-network provider other than the in-network cost sharing. 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) 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

1 beneficiary. If there is more than one amount negotiated with in-network providers for the
2 emergency service, the amount described under this subdivision (A) is the median of these amounts,
3 excluding any in-network copayment or coinsurance imposed with respect to the participant or
4 beneficiary. In determining the median described in the preceding sentence, the amount negotiated
5 with each in-network provider is treated as a separate amount (even if the same amount is paid to
6 more than one provider). If there is no per-service amount negotiated with in-network providers
7 (such as under a capitation or other similar payment arrangement), the amount under this
8 subdivision (A) is disregarded.
9 (B) The amount for the emergency service shall be calculated using the same method the
10 plan generally uses to determine payments for out-of-network services (such as the usual,
11 customary, and reasonable amount), excluding any in-network copayment or coinsurance imposed
12 with respect to the participant or beneficiary. The amount in this subdivision (B) is determined
13 without reduction for out-of-network cost-sharing that generally applies under the plan or health
14 insurance coverage with respect to out-of-network services.
15 (C) The amount that would be paid under Medicare (part A or part B of title XVIII of the
16 Social Security Act, 42 U.S.C. § 1395 et seq.) for the emergency service, excluding any in-network
17 copayment or coinsurance imposed with respect to the participant or beneficiary.
18 (2) Any cost-sharing requirement other than a copayment or coinsurance requirement (such
19 as a deductible or out-of-pocket maximum) may be imposed with respect to emergency services
20 provided out of network if the cost-sharing requirement generally applies to out-of-network
21 benefits. A deductible may be imposed with respect to out-of-network emergency services only as
22 part of a deductible that generally applies to out-of-network benefits. If an out-of-pocket maximum
23 generally applies to out-of-network benefits, that out-of-pocket maximum must apply to out-of-
24 network emergency services.
25 (e) The provisions of this section apply for plan years beginning on or after September 23,
26 2010.
27 (f) This section shall not apply to grandfathered health plans. This section shall not apply
28 to insurance coverage providing benefits for: (1) hospital confinement indemnity; (2) disability
29 income; (3) accident only; (4) long term care; (5) Medicare supplement; (6) limited benefit health;
30 (7) specified disease indemnity; (8) sickness or bodily injury or death by accident or both; and (9)
31 other limited benefit policies.
32 SECTION 2. Section 27-19-66 of the General Laws in Chapter 27-19 entitled "Nonprofit
33 Hospital Service Corporations" is hereby amended to read as follows:
34 **27-19-66. 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 (A) 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 such
12 emergency medical condition, and
13 (B) Such further medical examination and treatment, to the extent they are within the
14 capabilities of the staff and facilities available at the hospital, as are required under section 1867 of
15 the Social Security Act (42 U.S.C. § 1395dd) to stabilize the patient.
16 (3) "Stabilize", with respect to an emergency medical condition has the meaning given in
17 section 1867(e)(3) of the Social Security Act (42 U.S.C. § 1395dd(e)(3)).
18 (b) If a nonprofit hospital service corporation provides any benefits to subscribers with
19 respect to services in an emergency department of a hospital, the plan must cover emergency
20 services consistent with the rules of this section.
21 (c) A nonprofit hospital service corporation shall provide coverage for emergency services
22 in the following manner:
23 (1) Without the need for any prior authorization determination, even if the emergency
24 services are provided on an out-of-network basis;
25 (2) Without regard to whether the health-care provider furnishing the emergency services
26 is a participating network provider with respect to the services;
27 (3) If the emergency services are provided out of network, without imposing any
28 administrative requirement or limitation on coverage that is more restrictive than the requirements
29 or limitations that apply to emergency services received from in-network providers;
30 (4) If the emergency services are provided out of network, by complying with the cost-
31 sharing requirements of subsection (d) of this section; and
32 (5) Without regard to any other term or condition of the coverage, other than:
33 (A) The exclusion of or coordination of benefits;
34 (B) An affiliation or waiting period permitted under part 7 of federal ERISA, part A of title

1 XXVII of the federal PHS Act, or chapter 100 of the federal Internal Revenue Code; or

2 (C) Applicable cost sharing.

3 (d)(1) Any cost-sharing requirement expressed as a copayment amount or coinsurance rate
4 imposed with respect to a participant or beneficiary for out-of-network emergency services cannot
5 exceed the cost-sharing requirement imposed with respect to a participant or beneficiary if the
6 services were provided in-network. However, a participant or beneficiary ~~may be required to pay,~~
7 ~~in addition to the in-network cost-sharing, the excess of the amount the out-of-network provider~~
8 ~~charges over the amount the health insurance carrier is required to pay under subdivision (1) of this~~
9 ~~subsection~~ shall incur no greater out-of-pocket costs for the emergency services than the participant
10 or beneficiary would have incurred with an in-network provider other than the in-network cost
11 sharing. A group health plan or health insurance carrier complies with the requirements of this
12 subsection if it provides benefits with respect to an emergency service in an amount equal to the
13 greatest of the three amounts specified in subdivisions (A), (B), and (C) of this subdivision (1)
14 (which are adjusted for in-network cost-sharing requirements).

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

25 (B) The amount for the emergency service shall be calculated using the same method the
26 plan generally uses to determine payments for out-of-network services (such as the usual,
27 customary, and reasonable amount), excluding any in-network copayment or coinsurance imposed
28 with respect to the participant or beneficiary. The amount in this subdivision (B) is determined
29 without reduction for out-of-network cost sharing that generally applies under the plan or health
30 insurance coverage with respect to out-of-network services. Thus, for example, if a plan generally
31 pays seventy percent (70%) of the usual, customary, and reasonable amount for out-of-network
32 services, the amount in this subdivision (B) for an emergency service is the total, that is, one
33 hundred percent (100%), of the usual, customary, and reasonable amount for the service, not
34 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).

(C) 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:

(A) 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) 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.

(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 health care 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) The exclusion of or coordination of benefits;

(B) 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) 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 health insurance carrier is required to pay under subdivision (1) of this subsection~~ shall incur no greater out-of-pocket costs for the emergency services than the participant or beneficiary would have incurred with an in-network provider other than the in-network cost sharing. A group health plan or 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) 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) 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) 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:

1 **27-41-79. Emergency services.**

2 (a) As used in this section:

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

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

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

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

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

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

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

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

26 (2) Without regard to whether the health care provider furnishing the emergency services
27 is a participating network provider with respect to the services;

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

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

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

34 (A) The exclusion of or coordination of benefits;

(B) 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) 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 ~~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~~ shall incur no greater out-of-pocket costs for the emergency services than the participant or beneficiary would have incurred with an in-network provider other than the in-network cost sharing. A health maintenance organization 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) 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) 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 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) 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.

1 (2) Any cost-sharing requirement other than a copayment or coinsurance requirement (such
2 as a deductible or out-of-pocket maximum) may be imposed with respect to emergency services
3 provided out of network if the cost-sharing requirement generally applies to out-of-network
4 benefits. A deductible may be imposed with respect to out-of-network emergency services only as
5 part of a deductible that generally applies to out-of-network benefits. If an out-of-pocket maximum
6 generally applies to out-of-network benefits, that out-of-pocket maximum must apply to out-of-
7 network emergency services.
8 (e) The provisions of this section apply for plan years beginning on or after September 23,
9 2010.
10 (f) The provisions of this section shall apply to grandfathered health plans. This section
11 shall not apply to insurance coverage providing benefits for: (1) Hospital confinement indemnity;
12 (2) Disability income; (3) Accident only; (4) Long-term care; (5) Medicare supplement; (6) Limited
13 benefit health; (7) Specified disease indemnity; (8) Sickness or bodily injury or death by accident
14 or both; and (9) Other limited benefit policies.
15 SECTION 5. This act shall take effect upon passage.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

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RELATING TO INSURANCE -- ACCIDENT AND SICKNESS INSURANCE POLICIES

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1 This act would require that a participant or beneficiary incur no greater out-of-pocket costs
2 for emergency services than they would have incurred with an in-network provider other than in-
3 network cost sharing.
4 This act would take effect upon passage.

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