2020 -- H 7127

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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. 2020

A N A C T

RELATING TO HEALTH AND SAFETY -- LICENSING OF HEALTH CARE FACILITIES

Introduced By: Representatives Ruggiero, Craven, Blazejewski, Marszalkowski, and Shanley
Date Introduced: January 16, 2020

Referred To: House Health, Education & Welfare

It is enacted by the General Assembly as follows:

SECTION 1. Section 23-17-4 of the General Laws in Chapter 23-17 entitled "Licensing of Health-Care Facilities" is hereby amended to read as follows:

23-17-4. License required for health-care facility operation.

(a) No person acting severally or jointly with any other person shall establish, conduct, or maintain a health-care facility in this state without a license under this chapter; provided, however, that any person, firm, corporation, or other entity that provides volunteer, registered and licensed practical nurses to the public shall not be required to have a license as a health-care facility.

(b) Each location at which a health-care facility provides services shall be licensed; provided, however, that a hospital or organized ambulatory-care facility shall be permitted to provide, solely on an ambulatory basis, limited physician services, other limited, professional health-care services, and/or other limited, professional mental-health-care services in conjunction with services provided by and at community health centers, community mental-health centers, organized ambulatory-care facilities or other licensed health-care facilities, physicians' offices, and facilities operated by the department of corrections without establishing such locations as additional licensed premises of the hospital or organized ambulatory-care facility; provided, that a health-care facility licensed as an organized ambulatory-care facility in the state, may provide services at other locations operated by that licensed organized ambulatory-care facility, without the requirement of a separate, organized ambulatory-care facility license for such other locations.

For purposes of this section, an organized ambulatory-care facility or other licensed health-care facility shall not include a freestanding, emergency-care facility. The department is further authorized to adopt rules and regulations to accomplish the purpose of this section, including, but not limited to, defining "limited physician services, other limited, professional health-care services, and/or other limited, professional mental-health-care services."

(c) The reimbursement rates for the services rendered in the settings listed in subsection (b) shall be subject to negotiations between the hospitals, organized, ambulatory-care facilities, and the payors, respectively~~, as defined in § 23-17.12-2~~ ; however, every health care facility shall provide notice in writing to any patient receiving non-emergency or elective care of all charges and expenses to include any services to be provided by an out-of-network physicians or provider prior to rendering that non-emergency or elective care.

(d) Failure of a health care facility to provide a patient of charges or expenses prior to providing non-emergency or elective services shall limit the health care facility charges and recovery to the amount of accident and sickness insurance, if any, providing coverage for the services. The director shall promulgate rules and regulations implementing the provisions of this section.

SECTION 2. 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) 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 § 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. 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 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~~ in-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-~~ in-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-~~ in-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 3. 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:

(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 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 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 plan or health insurance carrier is required to pay under subdivision (1) of this subsection. 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~~ in-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. 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 subdivision (B) 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).

(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-~~ in-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-~~ in-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 4. 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 plan or health insurance carrier is required to pay under subdivision (1) of this subsection. 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~~ in-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~~ in-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~~ in-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 5. 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:

(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 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 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 plan or health maintenance organization is required to pay under subdivision (1) of this subsection. 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-~~ in-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-~~ in-

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~~ in-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 6. This act shall take effect on January 1, 2021.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N A C T

RELATING TO HEALTH AND SAFETY -- LICENSING OF HEALTH CARE FACILITIES

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This act would mandate that a hospital providing a planned procedure to a patient provide notice of services proposed to be provided by out-of-network physician/provider. For emergency services the medical provider shall be limited to charging fees equal to services provided to in-network patients.

This act would take effect on January 1, 2021.

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