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Sixty-seventh
Legislative Assembly
of North Dakota

HOUSE BILL NO. 1493

Introduced by

Representatives Weisz, Beltz, Fegley, Skroch

Senator Lee

A BILL for an Act to amend and reenact section 26.1-47-10 of the North Dakota Century Code and section 10 of chapter 194 of the 2017 Session Laws, relating to air ambulance services; and to provide for ambulance service operation funding.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-47-10 of the North Dakota Century Code is amended and reenacted as follows:

26.1-47-10. Preferred provider arrangements - Requirements for accessing air ambulance providers. ~~(Contingent effective date - See note)~~

1. In addition to the other preferred provider arrangement requirements under this chapter, a preferred provider arrangement must require the health care insurer and health care provider comply with this section.
2. Except as otherwise provided under this section, before a health care provider arranges for air ambulance services for an individual the health care provider knows to be a covered person, the health care provider shall request a prior authorization from the covered person's health care insurer for the air ambulance services to be provided to the covered person. If the health care provider is unable to request or obtain prior authorization from the covered person's health care insurer:
   a. The health care provider shall provide the covered person or the covered person's authorized representative an out-of-network services written disclosure stating the following:
      (1) Certain air ambulance providers may be called upon to render care to the covered person during the course of treatment;

(2) These air ambulance providers might not have contracts with the covered person's health care insurer and are, therefore, considered to be out of network;

(3) If these air ambulance providers do not have contracts with the covered person's health care insurer, the air ambulance services will be provided on an out-of-network basis;

(4) A description of the range of the charges for the out-of-network air ambulance services for which the covered person may be responsible;

(5) A notification the covered person or the covered person's authorized representative may agree to accept and pay the charges for the out-of-network air ambulance services, contact the covered person's health care insurer for additional assistance, or rely on other rights and remedies that may be available under state or federal law; and

(6) A statement indicating the covered person or the covered person's authorized representative may obtain a list of air ambulance providers from the covered person's health care insurer which are preferred providers and the covered person or the covered person's representative may request those participating air ambulance providers be accessed by the health care provider.

b. Before air ambulance services are accessed for the covered person, the health care provider shall provide the covered person or the covered person's authorized representative the written disclosure, as outlined by subdivision a and obtain the covered person's or the covered person's authorized representative's signature on the disclosure document acknowledging the covered person or the covered person's authorized representative received the disclosure document before the air ambulance services were accessed. If the health care provider is unable to provide the written disclosure or obtain the signature required under this subdivision, the health care provider shall document the reason, which may include the health and safety of the patient. The health care provider documentation satisfies the requirement under this subdivision.

3. ~~This section does not:~~

~~a. Preclude a covered person from agreeing to accept and pay the charges for the out-of-network services and not access the covered person's health care insurer's out-of-network air ambulance billing process described under this section.~~

~~b. Preclude a covered person from agreeing to accept and pay the bill received from the out-of-network air ambulance provider or from not accessing the air ambulance provider mediation process described under this section.~~

~~c. Regulate an out-of-network air ambulance provider's ability to charge certain fees for services or to charge any amount of fee for services provided to a covered person by the out-of-network air ambulance provider.~~

~~4. A health care insurer shall develop a program for payment of out-of-network air ambulance bills submitted under this section. A health benefit plan may not be issued in this state without the terms of the health benefit plan including the provisions of the health care insurer's program for payment of out-of-network air ambulance bills.~~

~~a. A health care insurer may elect to pay out-of-network air ambulance provider bills as submitted, or the health care insurer may elect to use the out-of-network air ambulance provider mediation process described in subsection 5.~~

~~b. This section does not preclude a health care insurer and an out-of-network facility air ambulance provider from agreeing to a separate payment arrangement.~~

~~5. A health care insurer shall establish an air ambulance provider mediation process for payment of out-of-network air ambulance provider bills. A health benefit plan may not be issued in this state if the terms of the health benefit plan do not include the provisions of the health care insurer's air ambulance provider mediation process for payment of out-of-network air ambulance provider bills.~~

~~a. A health care insurer's air ambulance provider mediation process must be established in accordance with mediation standards recognized by the department by rule.~~

~~b. If the health care insurer and the out-of-network air ambulance provider agree to a separate payment arrangement or if the covered person agrees to accept and pay the out-of-network air ambulance provider's charges for the out-of-network~~

~~services, compliance with the air ambulance provider mediation process is not required.~~

~~c. A health care insurer shall maintain records on all requests for mediation and completed mediation under this subsection for one year and, upon request of the commissioner, submit a report to the commissioner in the format specified by the commissioner.~~

~~6.~~ The rights and remedies provided under this section to covered persons are in addition to and may not preempt any other rights and remedies available to covered persons under state or federal law.

~~7.~~4. The department shall enforce this section and shall report a violation of this section by a facility to the state department of health.

~~8.~~5. This section does not apply to a policy or certificate of insurance, whether written on a group or individual basis, which provides coverage limited to:

a. A specified disease, a specified accident, or accident-only coverage;

b. Credit;

c. Dental;

d. Disability;

e. Hospital;

f. Long-term care insurance as defined by chapter 26.1-45;

g. Vision care or any other limited supplemental benefit;

h. A Medicare supplement policy of insurance, as defined by the commissioner by rule or coverage under a plan through Medicare;

i. Medicaid;

j. The federal employees health benefits program and any coverage issued as a supplement to that coverage;

k. Coverage issued as supplemental to liability insurance, workers' compensation, or similar insurance; or

l. Automobile medical payment insurance.

~~9.~~6. A health care provider is exempt from complying with this section if the health care provider determines and documents that due to emergency circumstances, compliance might jeopardize the health or safety of the patient.

7. The commissioner may adopt rules to implement this section.

SECTION 2. AMENDMENT. Section 10 of chapter 194 of the 2017 Session Laws is amended and reenacted as follows:

SECTION 10. EFFECTIVE DATE ~~- CONTINGENT EFFECTIVE DATE~~. Sections 2, 4, 5, and 6 of this Act become effective January 1, 2018. ~~If section 6 of this Act is declared invalid, sections~~Sections 3, 7, and 8 of this Act become effective on ~~the date the insurance commissioner certifies the invalidity of section 6 to the secretary of state and the legislative council~~August 1, 2021.

SECTION 3. AMBULANCE SERVICE OPERATION FUNDING DISTRIBUTION. Notwithstanding section 23-46-04, during the biennium beginning July 1, 2021, and ending June 30, 2023, the state department of health, in consultation with the emergency medical services advisory council, shall provide state financial assistance annually to each eligible ambulance service operation pursuant to the following calculation:

1. The minimum reasonable budget for each operation must be determined by adding the product of the operation's average number of runs for the two most recent ~~fiscal~~calendar years multiplied by the median cost of a run. The cost of a run is determined using statewide data. The minimum budget for each ambulance service operation may not be less than $60,000, or other base amount determined by the department.
2. The operation's grant amount must be determined by deducting the following amounts from the operation's budget calculated under subsection 1:
   a. The product of the operation's ~~median~~average number of runs for the two most recent ~~fiscal~~calendar years multiplied by the ~~average~~median amount of reimbursement for a run. The reimbursement amount for a run is determined using statewide data; and
   b. The product of the property tax valuation, as provided to the state department of health by the county auditor no later than July thirty-first of each year, of the operation's response area for the ~~most recent~~prior taxable year multiplied by five mills. If the response area covers multiple counties, the county auditor with the most response area is responsible for coordinating with the other county auditors.

3. The department shall distribute a prorated share of the operation's calculated grant amount if legislative appropriations for state financial assistance for emergency medical services is not sufficient to provide full grant funding calculated under this section.
4. An operation is not eligible to receive funding under this section if the operation's average number of runs for the two most recent fiscal years is more than seven hundred.