GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2025

H D

HOUSE BILL DRH10236-MR-97

Short Title:	Insurance Coverage Emergency Ambulance Trans.	(Public)
Sponsors:	Representative Loftis.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR A MINIMUM ALLOWABLE REIMBURSEMENT RATE UNDER HEALTH BENEFIT PLANS FOR EMERGENCY AMBULANCE SERVICES PROVIDED BY AN OUT-OF-NETWORK AMBULANCE SERVICE PROVIDER.

The General Assembly of North Carolina enacts:

SECTION 1.(a) G.S. 58-3-190 reads as rewritten:

"**§ 58-3-190. Coverage required for emergency care.**

(a) Every insurer shall provide coverage for emergency services to the extent necessary to screen and to stabilize the person covered under the plan or to transport the covered person to a medically appropriate location for screening and stabilization and shall not require prior authorization of the services if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. Payment of claims for emergency services shall be based on the retrospective review of the presenting history and symptoms of the covered person.

(b) With respect to emergency services provided by a health care provider who is not under contract with the insurer, the services shall be covered ~~if:~~if any of the following criteria are met:

(1) A prudent layperson acting reasonably would have believed that a delay would worsen the ~~emergency, or~~emergency.

(2) The covered person did not seek services from a provider under contract with the insurer because of circumstances beyond the control of the covered person.

(3) The covered person did not have a choice in the ground ambulance transportation service provider due to the emergency.

…

(d) Coverage of emergency services ~~shall~~ may be subject to coinsurance, co-payments, and deductibles applicable under the health benefit plan. An insurer shall not impose cost-sharing for emergency services provided under this ~~section~~ section, including emergency ambulance transportation services, that differs from the cost-sharing that would have been imposed if the physician or provider furnishing the services were a provider contracting with the insurer.

…

(g) ~~As used in this section, the term:~~The following definitions apply in this section:

(1) Covered person. – An individual who is enrolled in a health benefit plan and entitled to receive the benefits and services covered by that particular health benefit plan.

(1a) ~~"Emergency~~ Emergency medical ~~condition" means a~~ condition. – A medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, or by acute symptoms developing

from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following:

a. Placing the health of an individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

b. Serious impairment to bodily functions.

c. Serious dysfunction of any bodily organ or part.

(1b) Emergency medical transportation. – An emergency response, as defined under 42 C.F.R. § 414.605, and includes all of the following:

a. Transportation to a healthcare facility.

b. Ground ambulance transportation between two healthcare facilities "interfacility" transportation, when the transportation is being provided to the covered person because the needed medical care to treat the covered person's medical condition is not available at the current healthcare facility.

c. Emergency medical services that resulted with a medical evaluation being provided to the covered person without the covered person being transported to an emergency department.

(2) ~~"Emergency services" means health care~~ Emergency services. – Healthcare items and services furnished or required to screen for or treat an emergency medical condition until the condition is stabilized, including prehospital ~~care~~ care, ambulance transportation services, and ancillary services routinely available to the emergency department.

…

(4b) Out-of-network provider. – A provider that does not contract with the insurer of the health benefit plan under which a covered person is receiving services from that provider is enrolled.

(5) ~~"To stabilize" means to~~ Stabilize. – To provide medical care that is appropriate to prevent a material deterioration of the person's condition, within reasonable medical probability, in accordance with the ~~HCFA (Health Care Financing Administration)~~ Centers for Medicare and Medicaid Services interpretative guidelines, policies and regulations pertaining to responsibilities of hospitals in emergency ~~cases (as~~ cases, as provided under the Emergency Medical Treatment and Labor Act, section 1867 of the Social Security Act, ~~42 U.S.C.S. 1395dd), including medically necessary services and supplies to maintain stabilization until the person is transferred.~~42 U.S.C.S. 1395dd.

(h) The minimum allowable reimbursement rate under any health benefit plan for emergency medical transportation services provided by an ambulance service provider that shall be paid to an out-of-network ambulance service provider is one hundred percent (100%) of the rate set or approved, either by contract or in ordinance, by a local governmental entity established pursuant to G.S. 153A-250 in the jurisdiction in which the ambulance services originated. In the absence of a rate set or approved by a local governmental entity, the minimum allowable reimbursement rate under this subsection is the lesser of the following amounts:

(1) Four hundred percent (400%) of the most recent published Medicare rate for the ambulance service or services by the Centers for Medicare and Medicaid Services under Title XVIII of the Social Security Act for the same services provided in the same geographic area.

(2) The out-of-network ambulance service provider's billed charges.

(i) All of the following apply to emergency medical transportation services provided by an ambulance service provider:

(1) Payment by an insurer that is in compliance with subsection (h) of this section is considered payment in full by that insurer for the covered services. This subdivision does not preclude the billing for, or collection of, any copayment, coinsurance, deductible, and other cost-sharing feature amounts required to be paid by the covered person.

(2) An insurer shall promptly remit payment for emergency medical transportation services directly to the ambulance services provider, regardless of the network status of that provider. An insurer shall not send any payments for the reimbursement of these services to a covered person.

(3) An insurer shall not impose upon a covered person any cost-sharing requirement for emergency transportation services that exceeds the lesser of the following amounts:

a. One hundred dollars ($100.00).

b. Ten percent (10%) of the minimum allowable reimbursement rate amount required to be paid by the insurer established under subsection (h) of this section.

(j) Nothing in this section shall be construed to prevent a self-funded group plan regulated under the Employee Retirement Income Security Act (ERISA) from opting into the provisions of this section."

SECTION 1.(b) Subdivisions (3) and (4) of G.S. 58-3-190 are repealed.

SECTION 2. Section 1(a) of this act is effective October 1, 2025, applies to insurance contracts issued, renewed, or amended on or after that date and ambulance services provided on or after that date. The remainder of this act is effective when it becomes law.