The enacted legislation prohibits a health insurer from charging an insured patient a higher coinsurance, deductible or other out-of-pocket amount for emergency services provided by an out-of-network provider than would be charged if the services were provided by an in-network provider. In the event that an out-of-network provider renders emergency services to an insured person, this legislation requires the health insurer to reimburse such health care provider at the greater of (1) the in- network rate; (2) the usual, customary, and reasonable rate; or (3) the Medicare reimbursement rate. This legislation defines “usual, customary and reasonable rate” as the 80th percentile of all charges for the service provided in the same geographic region by a same or similar specialty, as determined by reference to a database designated by the insurance commissioner. This legislation does not prohibit the health care provider and health insurer from agreeing to a higher reimbursement amount. The balance billing ban applies to HMO’s and PPO’s. There is no dispute resolution process.

This comprehensive legislation addresses several other aspects of health care costs. It requires disclosure of actual contracted rates for the most common outpatient, inpatient, surgical, and imaging procedures and will make that information available to the public to compare prices by provider, service and payer. The legislation also bans certain facility fees, creates a statewide health information exchange, and requires that large hospital mergers and acquisitions be subject to appropriate market review in terms of costs and market power. Additionally, it creates a cabinet to study cost containment models in other states and requires a study on price disparity.