CHAPTER 435
FORMERLY
SENATE BILL NO. 207
AS AMENDED BY
SENATE AMENDMENT NO. 1

AN ACT TO AMEND TITLE 18 OF THE DELAWARE CODE RELATING TO THE REQUIRED COVERAGE FOR VOLUNTEER AMBULANCE COMPANY SERVICES.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE:

Section 1. Amend Chapter 33, Title 18 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 3349A. Required coverage for volunteer ambulance company services.

(a) For the purpose of this section:

(1) “Ambulance run” means a volunteer ambulance company response to dispatched calls for service.

(2) “Basic life support (BLS)” shall have the same meaning as set forth in § 9702 of Title 16.

(3) “Volunteer ambulance company” means a non-profit ambulance company that is certified by the State Fire Prevention Commission and is providing basic life support (BLS) services.

(b) Every individual health insurance policy, contract, certificate, or plan which is delivered or issued for delivery in this State by any health insurer, health service corporation, health maintenance organization, or managed care organization shall include coverage of not less than the cost of every ambulance run and associated basic life support (BLS) services provided by a volunteer ambulance company, inclusive of an allowance for uncompensated service, whether in the form of:

(1) An allowable charge;

(2) Through 100% payment; or

(3) Any combination of the foregoing.

(c) In the event that the volunteer ambulance company and the health insurer, health service corporation, health maintenance organization, or managed care organization cannot agree upon the allowable charge or the amount of payment to be made for an ambulance run and associated basic life support (BLS) services, then the volunteer ambulance company shall be entitled to those charges and rates allowed by the Insurance Commissioner or the Commissioner’s designee following an arbitration of the dispute.

(1) The Insurance Commissioner shall adopt regulations concerning the arbitration of such disputes.

(2) The Insurance Commissioner shall establish a schedule of fees for arbitration. The nonprevailing party at arbitration shall reimburse the Commissioner for the expenses related to the arbitration process. Funds paid to the Insurance Commissioner under this subsection shall be placed in the arbitration fund and shall be used exclusively for the payment of appointed arbitrators. The Insurance Commissioner may, in the Commissioner's discretion, impose a schedule of maximum fees that can be charged by an arbitrator for a given type of arbitration.

(d) Prior to the determination by the Insurance Commissioner, or the Commissioner’s designee, of the allowable charge or the amount of payment to be made for an ambulance run and associated basic life support (BLS) services, the health insurer, health service corporation, health maintenance organization, or managed care organization will pay directly to the volunteer ambulance company the charge assessed by the volunteer ambulance company for the run and basic life support (BLS) services provided, which shall not be subject to reimbursement after the Commissioner’s determination. The Insurance Commissioner is authorized to adopt regulations concerning the provisions of this subsection.

(e) Nothing in this section shall prevent the operation of policy provisions involving deductibles or copayments.

(f) This section shall not apply to policies that exclusively cover the following, and do not provide expense or reimbursement coverage for ambulance runs and associated basic life support (BLS) services provided by a volunteer ambulance company:

(1) Hospital confinement indemnity;

(2) Disability income;

(3) Long-term care;

(4) Medicare supplement;

(5) Specified disease indemnity;

(6) Individual and group supplemental health insurance; or

(7) Other limited benefit policies, to the extent the policies do not cover ambulance runs and associated basic life support (BLS) services provided by a volunteer ambulance company.

(g) Notwithstanding subsections (a)-(e) of this section, managed care organizations that contract with the State of Delaware shall be exempt from this section with regard to that portion of their plans that serve Medicaid and Delaware Health Children Program recipients.

(h) This section shall apply to all policies, contracts, certificates, or plans issued, renewed, modified, altered, amended, or reissued on or after January 1, 2015.

Section 2. Amend Chapter 35, Title 18 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 3565A. Required coverage for volunteer ambulance company services.

(a) For the purpose of this section:

(1) “Ambulance run” means a volunteer ambulance company response to dispatched calls for service.

(2) “Basic life support (BLS)” shall have the same meaning as set forth in § 9702 of Title 16.

(3) “Volunteer ambulance company” means a non-profit ambulance company that is certified by the State Fire Prevention Commission and is providing basic life support (BLS) services.

(b) Every individual health insurance policy, contract, certificate, or plan which is delivered or issued for delivery in this State by any health insurer, health service corporation, health maintenance organization, or managed care organization shall include coverage of not less than the cost of every ambulance run and associated basic life support (BLS) services provided by a volunteer ambulance company, inclusive of an allowance for uncompensated service, whether in the form of:

(1) An allowable charge;

(2) Through 100% payment; or

(3) Any combination of the foregoing.

(c) In the event that the volunteer ambulance company and the health insurer, health service corporation, health maintenance organization, or managed care organization cannot agree upon the allowable charge or the amount of payment to be made for an ambulance run and associated basic life support (BLS) services, then the volunteer ambulance company shall be entitled to those charges and rates allowed by the Insurance Commissioner or the Commissioner’s designee following an arbitration of the dispute.

(1) The Insurance Commissioner shall adopt regulations concerning the arbitration of such disputes.

(2) The Insurance Commissioner shall establish a schedule of fees for arbitration. The nonprevailing party at arbitration shall reimburse the Commissioner for the expenses related to the arbitration process. Funds paid to the Insurance Commissioner under this subsection shall be placed in the arbitration fund and shall be used exclusively for the payment of appointed arbitrators. The Insurance Commissioner may, in the Commissioner's discretion, impose a schedule of maximum fees that can be charged by an arbitrator for a given type of arbitration.

(d) Prior to the determination by the Insurance Commissioner, or the Commissioner’s designee, of the allowable charge or the amount of payment to be made for an ambulance run and associated basic life support (BLS) services, the health insurer, health service corporation, health maintenance organization, or managed care organization will pay directly to the volunteer ambulance company the charge assessed by the volunteer ambulance company for the run and basic life support (BLS) services provided, which shall not be subject to reimbursement after the Commissioner’s determination. The Insurance Commissioner is authorized to adopt regulations concerning the provisions of this subsection.

(e) Nothing in this section shall prevent the operation of policy provisions involving deductibles or copayments.

(f) This section shall not apply to policies that exclusively cover the following, and do not provide expense or reimbursement coverage for ambulance runs and associated basic life support (BLS) services provided by a volunteer ambulance company:

(1) Hospital confinement indemnity;

(2) Disability income;

(3) Long-term care;

(4) Medicare supplement;

(5) Specified disease indemnity;

(6) Individual and group supplemental health insurance; or

(7) Other limited benefit policies, to the extent the policies do not cover ambulance runs and associated basic life support (BLS) services provided by a volunteer ambulance company.

(g) Notwithstanding subsections (a)-(e) of this section, managed care organizations that contract with the State of Delaware shall be exempt from this section with regard to that portion of their plans that serve Medicaid and Delaware Healthy Children Program recipients.

(h) This section shall apply to all policies, contracts, certificates, or plans issued, renewed, modified, altered, amended, or reissued on or after January 1, 2015.

Section 3. Amend § 6309, Title 18 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 6309. Other provisions applicable.

(a) Such corporations shall be subject to this chapter and to the following chapters of this title, to the extent applicable and not in conflict with the express provisions of this chapter:

(1) Chapter 1 (General Definitions and Provisions).

(2) Chapter 3 (The Insurance Commissioner).

(3) Chapter 23 (Unfair Practices in the Insurance Business).

(4) Chapter 25 (Rates and Rating Organizations).

(5) Chapter 59 (Rehabilitation and Liquidation).

(6) Chapter 34 (Medicare Supplement Insurance Minimum Standards).

(7) Chapter 36 (Individual Health Insurance Minimum Standards).

(b) Such corporations shall also be subject to §§ 3349A, 3365, 3565A and 3571G of this title.

Approved September 24, 2014