(b) A managed care organization shall:

(i) accept assignment of benefits from an enrollee for emergency services and post stabilization care provided by a non-network provider; and

(ii) send an explanation of benefits to the non-network provider with the information required under Subsection (5)(a).

(c) A managed care organization shall pay a non-network provider for emergency services the greater of the amount required in 45 C.F.R. Sec. 147.138 Ĥ→ **[~~, plus 5% of that amount~~]** ←Ĥ .

(d) Payment to a non-network provider for post stabilization care shall be the greater of:

(i) the payment required under the applicable provisions of 45 C.F.R. Sec. 147.138; or

(ii) 100% of the in-network allowed amount for the patient's managed care organization plan.

(3) Ĥ→ **[~~(a) Except as provided in Subsection (8), a non-network provider who receives payment directly from a payor may not balance bill that payor's enrollee in excess of the amount under this Subsection (3).~~**

~~(b) A non-network provider may balance bill an enrollee for emergency services in an amount that is the lesser of:~~

~~(i) 10% above the amount allowed under Subsection (2)(c) for the emergency services; or~~

~~(ii) $5,000.~~] **(a) As used in this Subsection (3), "allowed charges benchmark" means the 70th percentile of the distribution of payments made by insurers for an emergency service provided within a market area, as determined by a database of insurance claims designated by the commissioner.**

(b) Except as provided in Subsection (8), a non-network provider who is reimbursed under Subsection (2)(c) may not balance bill an enrollee in excess of the amount under this Subsection (3).

(c) A non-network provider may balance bill an enrollee for an emergency service in an amount not to exceed the allowed charges benchmark for the service for the market area in which the service was performed less any amounts already paid for the service by the managed care organization or the enrollee.

(d) The commissioner shall make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act:

(i) designating a database of insurance claims data to be used for determining allowed charges benchmarks, which shall be a database: ✪

(A) developed and maintained in accordance with sound methodologies; and

(B) provided by an independent nonprofit corporation that collects medical and dental insurance claims data nationwide and is able to provide allowed charges benchmarks for multiple market areas within Utah; and

(ii) specifying how market areas shall be determined for purposes of establishing allowed charges benchmarks for emergency services provided within Utah. ←Ĥ

(c) A non-network provider may not balance bill an enrollee for post stabilization care.

(4) (a) A managed care organization may elect to pay a non-network provider for emergency services or post stabilization care:

(i) as submitted by the provider;

(ii) in accordance with the benchmark established in Subsection (2)(c) or (2)(d); or

(iii) in an amount mutually agreed upon by the managed care organization and the provider.

(b) This section does not preclude a managed care organization and a non-network provider from agreeing to a different payment arrangement if:

(i) except as provided in Subsection (8), the enrollee is responsible for no more than:

(A) the applicable in-network cost-sharing amount; and