HOUSE BILL REPORT
SSB 5986

As Reported by House Committee On:
Health Care & Wellness
Appropriations

Title: An act relating to protecting consumers from charges for out-of-network health care services by prohibiting balance billing for ground ambulance services and addressing coverage of transports to treatment for emergency medical conditions.

Brief Description: Protecting consumers from out-of-network health care services charges.

Sponsors: Senate Committee on Ways & Means (originally sponsored by Senators Cleveland, Muzzall, Hasegawa, Kuderer, Mullet, Nobles, Randall, Salomon, Valdez and Wellman).

Brief History:
Committee Activity:
Health Care & Wellness: 2/14/24, 2/21/24 [DPA];
Appropriations: 2/23/24, 2/26/24 [DPA(HCW)].

Brief Summary of Substitute Bill
(As Amended by Committee)

- Establishes balance billing protections for certain ground ambulance services and the allowed amount paid to a nonparticipating ground ambulance services organization for covered ground ambulance services.
- Requires health carriers to provide coverage for ground ambulance transport services to behavioral health emergency services providers for enrollees who are experiencing an emergency medical condition.
- Requires the Office of the Insurance Commissioner to review the reasonableness of the percentage of the Medicare rate and any trends in changes to ground ambulance service rates and billed charges.
- Requires the Washington State Institute for Public Policy to conduct a study on the extent to which other states fund or have considered funding

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This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not part of the legislation nor does it constitute a statement of legislative intent.

emergency medical services (EMS) substantially or entirely through federal, state, or local governmental funding and the current landscape of EMS in Washington.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: Do pass as amended. Signed by 15 members: Representatives Riccelli, Chair; Bateman, Vice Chair; Schmick, Ranking Minority Member; Hutchins, Assistant Ranking Minority Member; Bronoske, Davis, Graham, Macri, Maycumber, Mosbrucker, Orwall, Simmons, Stonier, Thai and Tharinger.

Minority Report: Do not pass. Signed by 1 member: Representative Harris.

Minority Report: Without recommendation. Signed by 1 member: Representative Caldier.

Staff: Kim Weidenaar (786-7120).

Background:

Balance Billing Protection Act.
In 2019 the Legislature passed the Balance Billing Protection Act (BBPA), which prohibited balance billing for emergency services and certain nonemergency services. In 2020 Congress passed the federal No Surprises Act (NSA), which establishes federal protections against balance billing for emergency services, including air ambulance services, and certain other services provided at in-network facilities beginning January 1, 2022. In 2022 the Legislature amended the BBPA to align provisions with the NSA. Under the BBPA as amended, a nonparticipating provider or facility may not balance bill an enrollee for:

- emergency services provided to an enrollee;
- nonemergency health care services performed by a nonparticipating provider at certain participating facilities; or
- air ambulance services.

This includes covered services provided by a behavioral health emergency services provider. A behavioral health emergency services provider means emergency services provided in the following settings: a crisis stabilization unit, an evaluation and treatment facility, an agency certified to provide outpatient crisis services, a triage facility, an agency certified to provide medically managed or monitored withdrawal management services, and a mobile rapid response crisis team contracted with a behavioral health administrative services organization (BHASO) to provide crisis response services in the BHASO's area.

Nonemergency health care services performed by nonparticipating providers at certain participating facilities are the covered items or services other than emergency services with respect to a visit at a participating facility as provided in the NSA.

A health care provider, health care facility, or air ambulance service may not request or require a patient at any time, for any procedure, service, or supply to sign or otherwise execute any document that would attempt to avoid, waive, or alter the balance billing provisions. If an enrollee pays a nonparticipating provider, facility, or air ambulance service more than the in-network cost-sharing amount determined under the NSA and the implementing regulations, the provider must refund the excess amount within 30 days. If an enrollee receives emergency services from a behavioral health emergency services provider, the enrollee satisfies the obligation to pay if the enrollee pays the in-network cost-sharing amount specified in the enrollee's group health plan contract.

Payment and dispute resolution between carriers and providers for services covered by the balance billing prohibitions, except for emergency services provided by behavioral health emergency services providers, are governed by the NSA and implementing regulations. For covered services provided by a behavioral health emergency services provider the payment must be a commercially reasonable amount based on the same or similar service provided in a similar geographic region. If the parties fail to agree to a commercially reasonable amount, the dispute must be resolved under the state's arbitration process.

The Office of the Insurance Commissioner (OIC) must develop a template to notify consumers of their rights under the BBPA, and the NSA and its implementing federal regulations. Hospitals, ambulatory surgical facilities, and behavioral health emergency service providers must post a list of the carrier health plan networks with which they are in-network on the facility's website, and if they do not have a website this information must be available upon request.

Ground Ambulance Balance Billing Report.
The amended BBPA directed the OIC, in collaboration with the Health Care Authority (HCA) and the Department of Health (DOH), to submit a report and any recommendations to the appropriate legislative committees detailing how balance billing for ground ambulance services can be prevented and if ground ambulance services should be subject to the balance billing prohibitions.

Ground Ambulance Balance Billing Advisory Group.
As part of its work, the OIC convened an advisory group of stakeholders to review the types of ground ambulance providers in the state, the funding structures, and issues that would need to be addressed to eliminate balance billing. In October 2023 the OIC released its report, which included the following policy recommendations:

- a prohibition on balance billing for emergency and nonemergency transports and applying the prohibition to public and private providers;
- reimbursing ground ambulance services at applicable local jurisdiction fixed rate, or

if no local rate exists, at the lesser of a fixed percentage of Medicare or billed charges; and
- requiring coverage for emergency transport to alternative sites, which are behavioral health emergency services providers, including crisis stabilization facilities, evaluation and treatment facilities, medical withdrawal management facilities, and other crisis providers.

Summary of Amended Bill:

Ground Ambulance Balance Billing.
For health plans issued or renewed on or after January 1, 2025, a nonparticipating ground ambulance services organization may not balance bill an enrollee for covered ground ambulance services. For the purposes of this act, ground ambulance services mean:
- the rendering of medical treatment and care at the scene of a medical emergency or while transporting a patient from the scene to an appropriate health care facility or behavioral health emergency services provider when the services are provided by one or more ground ambulance vehicles; and
- ground ambulance transport between hospitals or behavioral health emergency services providers, hospitals or behavioral health emergency providers and other health care facilities or locations, and between health care facilities when the services are medically necessary and are provided by one or more ground ambulance vehicles.

A ground ambulance services organization is a public or private organization licensed by the DOH to provide ground ambulance services.

If an enrollee receives covered ground ambulance services, the enrollee satisfies their obligation to pay for the ground ambulance services if they pay the in-network cost-sharing amount specified in the enrollee's or applicable group's health plan contract. The amount paid by the enrollee must be applied toward the enrollee's maximum out-of-pocket payment obligation.

The allowed amount paid to a nonparticipating ground ambulance services organization for covered ground ambulance services must be one of the following amounts:
- the rate established by the local governmental entity where the covered health care services originated for the provision of ground ambulance services by ground ambulance services organizations owned or operated by the local governmental entity and submitted to the OIC;
- where the ground ambulance service was provided by a private ground ambulance services organization under contract with the local governmental entity where the covered health care services originated, the amount set by the contract and submitted to the OIC; or
- if a rate has not been established or contracted for as described above, the rate will be

the lesser of:

- 325 percent of the current published rate for ambulance services as established by the Centers for Medicare and Medicaid Services for the same service provided in the same geographic area; or
- the ground ambulance services organization's billed charges.

The carrier must make payments for ground ambulance services provided by nonparticipating ground ambulance services organizations directly to the organization, rather than the enrollee. A ground ambulance services organization may not request or require a patient at any time, for any procedure, service, or supply, to sign or otherwise execute any document that would attempt to avoid, waive, or alter any of these requirements. Carriers must make available through electronic and other methods of communication used by a ground ambulance services organization to verify enrollee eligibility and benefits information regarding whether an enrollee's health plan is subject to these requirements.

Behavioral health emergency services providers and ground ambulance services organizations are added to the providers that OIC must consult with when developing a template to notify consumers of their rights under the BBPA. Ground ambulance service organizations are also added to the list of providers that must post a list of the carrier health plan networks with which they are in-network and the notice of consumer rights developed by the OIC on the provider's website, if the provider has a website, and if they do not have a website this information must be available upon request.

A carrier must provide enrollees with a notification that if the enrollee receives services from an out-of-network ground ambulance service organization for services not covered under this act, the enrollee will have financial responsibility for those services.

Self-funded group health plans may opt in to the provisions of this act.

Each local governmental entity that has established or contracted for rates for ground ambulance services provided in their geographic service area must submit the rates to the OIC in the form and manner prescribed by the Insurance Commissioner (Commissioner). The Commissioner must establish and maintain a publicly accessible database for the rates. A carrier may rely in good faith on the rates shown on the website. Local governmental entities are solely responsible for submitting any updates to their rates to the Commissioner.

If the Commissioner has cause to believe that any ground ambulance services organization has engaged in a pattern of unresolved violations of the balance billing requirements, the Commissioner may submit information to the DOH. If the report is substantiated after investigation, the DOH may levy a fine upon the ground ambulance services organization up to $1,000 per violation and take other formal or informal disciplinary action as authorized.

Health Insurance Coverage.
For health plans issued or renewed on or after January 1, 2025, a health carrier must provide coverage for ground ambulance transports to behavioral health emergency services providers for enrollees who are experiencing an emergency medical condition. A health carrier may not require prior authorization of ground ambulance services if a prudent layperson acting reasonably would have believed that an emergency medical condition existed.

Reports and Analyses.
The Commissioner must undertake a process to review the reasonableness of the percentage of the Medicare rate and any trends in changes to ground ambulance service rates set by local governmental entities and ground ambulance services organizations' billed charges. The Commissioner should consider the relationship between the rates of the cost of providing ground ambulance services and any impacts on health plan enrollees. The results of the review must be submitted to the Legislature the earlier of October 1, 2026, or October 1 following:

- any significant trend of increasing rates for ground ambulance services established or contracted for a local governmental entity increasing billed charges or increasing consumer cost sharing;
- any significant reduction in access to ground ambulance services; or
- any update on Medicare ground ambulance services rates.

The report must also include:

- health carrier spending on ground ambulance transports for fully insured health plans and for public and school employee programs during plan years 2024 and 2025;
- individual and small group health plan premium trends and cost-sharing trends for ground ambulance services for plan years 2024 and 2025;
- trends in coverage of ground ambulance services for fully insured health plans and for public and school employee programs for plan years 2024 and 2025;
- a description of current emergency medical services training, equipment, and personnel standards for emergency medical services licensure; and
- a description of emergency medical services interfacility transport capabilities in Washington.

The OIC, in consultation with the HCA, must contract for an actuarial analysis of the cost, potential cost savings, and total net costs or savings of covering services provided by ground ambulance services organizations when a ground services ambulance organization is dispatched to the scene of an emergency and the patient is treated but not transported. The analysis must calculate costs or savings for different health plan markets and consider the proportion of dispatches that do not result in transport, appropriate payment rates for these services, any potential impact of covering these services on the number or types of transports, and costs or savings. The report must be submitted to the Legislature by October 1, 2025, and must include the findings of the analysis and recommendations on whether the services should be covered.

The Washington State Institute for Public Policy (WSIPP), in collaboration with the DOH, the HCA, and the OIC, must conduct a study on the extent to which other states fund or have considered funding emergency medical services (EMS) substantially or entirely through federal, state, or local governmental funding and the current landscape of EMS in Washington. The WSIPP must consider:

- trends in the number and types of EMS available, the volume of 911 responses, and interfacility transports provided by EMS organizations in Washington;
- projections of the need for EMS over the next two years;
- geographic disparities in emergency medical services access and average response times, including identification of geographic areas without access to EMS within an average 25-minute response time;
- estimates for the cost to address gaps in EMS;
- models for funding EMS in other states; and
- existing research and literature related to funding models for EMS.

In conducting the study, the WSIPP must consult with EMS organizations, local governmental entities, hospitals, labor organizations, and other interested entities in consultation with the other state agencies. A report of the study's results must be submitted to the DOH and the Legislature by June 1, 2026.

The statutory provision requiring a report on ground ambulance balance billing, which has been completed, is repealed.

Amended Bill Compared to Substitute Bill:

The striking amendment:

- modifies the allowed amount paid to nonparticipating ground ambulance services organizations to include the amount contracted for between a private ground ambulance services organization and a local governmental entity and makes other technical language changes;
- expires the established allowed amount paid to nonparticipating ground ambulance services organizations under the act on December 31, 2027;
- requires local governmental entities to submit any established or contracted rate for ground ambulance services to the OIC;
- modifies the review the Commissioner must undertake to review the reasonableness of the Medicare rate and any changes in ground ambulance services rates, by:
    - moving up the date one year to October 1, 2026, or October 1 following any significant trend of increasing rates established or contracted for by ground ambulance services organizations, increasing billed charges, or increasing consumer cost-sharing, or any significant reduction in access to ground ambulance services in Washington; and
    - requiring the report to also include: any trends in changes to ground ambulance services organizations' billed charges; health carrier spending on ground

ambulance transports; individual and small group health plans premium trends and cost-sharing trends; trends in coverage of ground ambulance services; and a description of current emergency medical services training, equipment and personnel standards, and a description of emergency medical services interfacility transport capabilities;
- adds an examination of geographic disparities in emergency medical service access and average response times to the WSIPP study;
- removes the requirement that the DOH develop recommendations on whether emergency medical services should be treated as an essential health service provided and funded by governmental entities as a public health service;
- modifies the definition of "ground ambulance services" to include defined terms; and
- defines "local governmental entity."

Appropriation: None.

Fiscal Note: Available.

Effective Date of Amended Bill: The bill takes effect 90 days after adjournment of the session in which the bill is passed.

Staff Summary of Public Testimony:

(In support) This bill fixes a problem that has been a real issue for patients and providers. This bill sets a series of rate methodologies. It ensures that patients are protected from too high out-of-pocket expenses, while also protecting emergency medical services. The fees for private ambulance organizations are often set around 329 percent of the Medicare rate and these agencies do not have local rates set so they will see a small decrease, not an increase. This bill does a good job of establishing balance.

This bill is the final piece of the balance billing bills. There will be some questions about the rate and some amendments have been suggested to better monitor what is happening with respect to ground ambulance services rates so that the OIC can report back to the Legislature.

It is critical that ambulance services remain viable. The Legislature should support ambulance services so that they can continue to operate.

There are concerns from consumers and insurance providers that all public providers would adjust their rates, but they could do that today. Ambulance transport rates are set by boards based on budget demands. Proper funding of ambulance services helps make sure that help is available at a fair and equitable cost.

If the Legislature reduces the rates to anything less than 325 percent of Medicare, they will

rob small communities of their ambulance services. Ambulance services have been leaving rural areas because of reimbursement rates. Please make sure that people can still have service when they call 911.

When you have an emergency, you have no choice in what ambulance company is called or whether the ambulance is public or private. Often individuals do not have a choice to not take an ambulance in emergency circumstances. Many cannot afford the bills that come following an ambulance transport since insurance often does not pay a large portion of the bill.

The rate of 325 percent of the Medicare rate seems high based on the data that has been presented.

(Opposed) None.

(Other) There is support for balance billing prohibitions for ground ambulance services and the general premise of the bill. However, the 325 percent of the Medicare rate is 100 percent higher than the current average reimbursement. This would raise median rates. While the ground ambulance balance billing advisory process was robust, the advisory group did not recommend a specific percentage. Additionally, the response from providers was minimal and so the report lacks sufficient data to provide a helpful view of current rates. A decision should not be made until there is more information.

Actuarial assumptions are also based on how they expect consumers to behave. Ground ambulance services providers described the uncertainty for ground ambulance services providers but also stated that they do not expect that they will receive less under the bill. Is this bill protecting consumers from subsidizing ground ambulance providers?

The default rate for where local jurisdictions do not have a set rate is too high. The rate data provided was questionably high. At a minimum, the data collection and look back under the bill should be expanded.

Persons Testifying: (In support) Shawn Baird, Cascade Ambulance; Mike Battis, Ballard Ambulance and Washington Ambulance Association; Dwight Worden, Teamsters Local 231; Jane Beyer, Office of the Insurance Commissioner; Shaun Ford, Washington Fire Chiefs Association; Chris Cato, Pend Oreille County Fire District; Lena Qiu; and Jim Freeburg, Patient Coalition of Washington.

(Other) Jennifer Ziegler, Association of Washington Health Care Plans; Jane Douthit, Regence; Samuel Wilcoxson, Premera; and Emily Brice, Northwest Health Law Advocates.

Persons Signed In To Testify But Not Testifying: None.

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: Do pass as amended by Committee on Health Care & Wellness. Signed by 25 members: Representatives Ormsby, Chair; Bergquist, Vice Chair; Gregerson, Vice Chair; Macri, Vice Chair; Corry, Ranking Minority Member; Connors, Assistant Ranking Minority Member; Berg, Callan, Chopp, Davis, Fitzgibbon, Lekanoff, Pollet, Riccelli, Ryu, Sandlin, Schmick, Senn, Simmons, Slatter, Springer, Stokesbary, Stonier, Tharinger and Wilcox.

Minority Report: Without recommendation. Signed by 4 members: Representatives Chambers, Assistant Ranking Minority Member; Couture, Assistant Ranking Minority Member; Harris and Rude.

Staff: Meghan Morris (786-7119).

Summary of Recommendation of Committee On Appropriations Compared to Recommendation of Committee On Health Care & Wellness:

No new changes were recommended.

Appropriation: None.

Fiscal Note: Available.

Effective Date of Amended Bill: The bill takes effect 90 days after adjournment of the session in which the bill is passed.

Staff Summary of Public Testimony:

(In support) This bill is based on the extensive work of a broad advisory group. The bill uses a rate formula for out-of-network ambulance services because there are 300 providers in Washington that vary in size including some tiny rural fire districts. Because of this, the advisory group found that it does not make sense to use the Balance Billing Protection Act's (BBPA) dispute resolution process for these services. There is appreciation for the Health Care and Wellness Committee amendment because it strengthens the Office of the Insurance Commissioner's (OIC) ability to monitor exactly what is happening with respect to rates and cost-sharing.

Some areas have regulated rates and other do not, but the average rate over these is 329 percent of Medicare, which is close to the maximum of 325 percent. This bill is striking a balance between protecting patients and maintaining emergency response services. There is a sunset on the rate, which will require it to be reviewed.

The mission of emergency medical services is to help patients. This bill protects patients by protecting them from balance billing, and the 325 percent rate of Medicare protects patient access to emergency medical services. These rates are within the national average for

ambulance services.

The advisory group agreed balance billing for ground ambulance services should be ended as soon as possible. However, the group did not agree on a default rate. There were previously some concerns that 325 percent of Medicare is too high, but the striking amendment takes some steps to address these concerns by expiring the rate and giving the OIC tools to monitor rates in the meantime.

(Opposed) None.

(Other) Fundamentally there is support for this idea, and many agree that it is time to eliminate balance billing for ambulance services. However, there is still a lot of concern about the 325 percent of Medicare amount. For example, currently a carrier pays for one type of transport at 200 percent of Medicare, which is about $800. The carrier pays full billed charges so that the patient is not balance billed. If the carrier had to pay 325 percent of Medicare, that would be close to $1,300, which is $500 more, and the consumer would have to pay this if their insurance did not cover the full amount. This bill is the only place where there is a specific rate identified in statute for balance billing, and there are concerns about the long-term impact of this.

Several plans currently provide generous reimbursement for ground ambulance services and pay the full amount so that members do not have balance bills. The average for these reimbursements now is 275 percent of Medicare. A rate of 325 percent of Medicare is excessive and should be reduced or the rate should be eliminated and handled under the BBPA.

Persons Testifying: (In support) Jane Beyer, Office of the Insurance Commissioner; Mike Battis, Ballard Ambulance and Washington Ambulance Association; Shawn Baird, Metro West Ambulance; Jeff Faucett; and Emily Brice, Northwest Health Law Advocates.

(Other) Jennifer Ziegler, Association of Washington Health Care Plans; and Gary Strannigan, Premera Blue Cross.

Persons Signed In To Testify But Not Testifying: None.