

FINAL BILL REPORT

SSB 5986

C 218 L 24
Synopsis as Enacted

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).

Senate Committee on Health & Long Term Care
Senate Committee on Ways & Means
House Committee on Health Care & Wellness
House Committee on Appropriations

Background: 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. 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 to provide crisis response services in its area.

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.

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.

The amended BBPA directed 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.

As part of its work, 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, 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 an 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: Beginning January 1, 2025, a nonparticipating ground ambulance services organization may not balance bill an enrollee of a health plan for covered ground ambulance services. For the purposes of this act, ground ambulance services means:

- the rendering of medical treatment and care at the scene of a medical emergency or while transporting a patient to an appropriate emergency services provider when the services are provided by one or more ground ambulance vehicles designed for this purpose; and
- ground ambulance transport between emergency services providers, emergency services providers and medical facilities, and between medical facilities when the services are medically necessary and are provided by one or more ground ambulance vehicles designed for this purpose.

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

Beginning 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 for these services if a prudent layperson acting reasonably would have believed an emergency medical condition existed. Coverage for these services may be subject to applicable in-network cost sharing.

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. Until December 31, 2027, the allowed amount paid to a nonparticipating ground ambulance services organization for covered ground ambulance services under a health plan 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:

1. 325 percent of the current published rate for ambulance services established by the Centers for Medicare and Medicaid Services for the same service provided in the same geographic area; or
2. the ground ambulance services organization's billed charges.

A 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 OIC. OIC must establish and maintain a publicly accessible database for the rates. The local governmental entity is responsible for providing any updates to the rate submitted to OIC and a carrier may reasonably rely on the published rate.

Payment made in compliance with one of these options is payment in full for the covered services provided, except for any cost-sharing amounts required to be paid by 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 by oral, written, or electronic means, any document that would attempt to avoid, waive, or alter any provision of these payment terms. 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.

OIC 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. OIC 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 1st 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.

Behavioral health emergency services providers and ground ambulance services organizations are added to the providers 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 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 the financial responsibility for those services.

If OIC has cause to believe that any ground ambulance services organization has engaged in a pattern of unresolved violations related to the balance billing provisions of this act, OIC may submit information to DOH or the appropriate disciplining authority for action and DOH or the appropriate disciplining authority may levy a fine up to \$1,000 per violation and take other action as permitted.

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

OIC, in consultation with 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 ambulance services organization is dispatched to the scene of an emergency and the person is treated but is not transported. OIC must submit a report to the Legislature on the outcome of the analysis by October 1, 2025.

The Washington State Institute for Public Policy (WSIPP), in collaboration with DOH, HCA, and OIC, must conduct a study on which other states fund emergency medical services (EMS) exclusively by federal, state, or local governmental entities as a public health service and the current landscape of emergency medical services in Washington. 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, 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 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.

Votes on Final Passage:

Senate	48	0	
House	95	1	(House amended)
Senate	49	0	(Senate concurred)

Effective: June 6, 2024