SENATE BILL REPORT
SB 5986

As of January 29, 2024

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: Senators Cleveland, Muzzall, Hasegawa, Kuderer, Mullet, Nobles, Randall, Salomon, Valdez and Wellman.

Brief History:
Committee Activity: Health & Long Term Care: 1/12/24, 1/16/24 [DP-WM]. Ways & Means: 1/29/24.

Brief Summary of Bill

- Establishes balance billing protections for certain 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.

SENATE COMMITTEE ON HEALTH & LONG TERM CARE

Majority Report: Do pass and be referred to Committee on Ways & Means.

Signed by Senators Cleveland, Chair; Robinson, Vice Chair; Rivers, Ranking Member; Muzzall, Assistant Ranking Member; Conway, Dhingra, Holy, Padden, Randall and Van De Wege.

Staff: Greg Attanasio (786-7410)

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.

SENATE COMMITTEE ON WAYS & MEANS

Staff: Sandy Stith (786-7710)

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 (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 Commissioner (OIC) must develop a template to notify consumers of their rights under the Balancing Billing Protection Act, and the NSA and its implementing federal regulations. Hospitals, ambulatory surgical facilities, and behavioral health emergency service providers must posts 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 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 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 Bill: 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. 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:

- if a local governmental entity has submitted a rate to OIC in the form and manner prescribed by OIC, the rate set by the local governmental entity in the jurisdiction in which the covered health care services originated will be used; or
- if a local governmental entity has not submitted a rate, the rate will be the lesser of:
    1. 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
    2. the ground ambulance services organization's billed charges.

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.

OIC must review the reasonableness of the 325 percent of Medicare rate for ground ambulance services considering the relationship of the rate to the cost of providing ground ambulance services and any impacts on health plan enrollees that may result from health plans increasing in-network consumer cost-sharing for ground ambulance services due to increased rates paid. By October 1, 2027 or October 1st following an update in the Medicare ground ambulance payment rate, whichever is sooner, OIC must submit its report on the review to the Legislature.

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, in collaboration with DOH, HCA, and OIC, must conduct a study and develop recommendations on whether emergency medical services should be treated as an essential health service provided by state and local governmental entities and funded exclusively by federal, state, or local governmental entities as a public health service.

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

Appropriation: None.

Fiscal Note: Available.

Creates Committee/Commission/Task Force that includes Legislative members: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony (Health & Long Term Care): PRO: Fifteen other states have already acted on this issue. Many patients face surprise bills even when they

have coverage because they have no choice in what service provider transport them. Patients pay their premiums and should not be exposed to additional expenses of balance billing. The Medicare percentage rate should remain at 325 percent. The 325 percent rate would cover most of the cost for a typical transport. The cost study is an essential part of the bill to monitor the impact of the 325 percent of Medicare rate.

OTHER: Health plans support resolving this issue. It is important to have a default rate but carriers are concerned with the 325 percent rate because it could still cause large bills for consumers.

Persons Testifying (Health & Long Term Care): PRO: Senator Annette Cleveland, Prime Sponsor; Jane Beyer, Office of the Insurance Commissioner; Sydney Rogalla, Office of the Insurance Commissioner; Shaun Ford, Washington Fire Chief's Association; Mike Battis, Washington Ambulance Association; Paul Priest, American Medical Response; Shawn Baird, Olympic Ambulance; Christy Shum; David Feng; Alex Hamasaki, American Heart Association & Patient Coalition of Washington; Maribeth Guarino, WASHPIRG; Cathy MacCaul, AARP Washington; Emily Brice, Northwest Health Law Advocates.

OTHER: Jennifer Ziegler, Association of Washington Health Care Plans; Chris Bandoli, America's Health Insurance Plans.

Persons Signed In To Testify But Not Testifying (Health & Long Term Care): No one.

Staff Summary of Public Testimony (Ways & Means): PRO: This is the last piece of the puzzle to necessary to protect consumers from balance billing. This applies to both emergency and nonemergency transportation. We did not want to ask tiny districts to go into arbitration, which is why we developed the rate formula. We did a review of the All Payer Claims Database and there is significant variance in rates. The CMS default rate is the community rate and the OIC will do a lookback in a couple years. The current EMS system is unstable and multiple agencies have been forced to close. This bill will help provide stability. The 325 percent rate was not arbitrary. It mirrors our findings from across the country and upcoming federal limits. This rate doesn't impact the insurance industry, but a low rate will. Rates set properly will also protect the patient. Maine set a rate too low and had to be bailed out. This was a collaborative process. People can't call an ambulance based on their health plan. This isn't how emergencies work. This allows predictability. This is how insurance should work. We're still working on the rate. Running an ambulance service is not a money making venture. Any less than 325 percent is a detriment to small fire districts and other fire districts. Washingtonians have a fair expectation that services are timely and available.

OTHER: We are signed in as other because disagree on the 325 percent rate. We think 200 percent is better and will balance the needs of carriers and consumers. Two carriers already cover the balance with no balance billing. This would cost these carriers about $12 million. We have concerns that this will drive up costs. at about $2 to $3 per member per month. We

already pay billed charges at 100 percent, so this will make that go up. We support the extension of consumer protections, but not the rate. This is more than 100 points higher than our current payments and will increase patient out of pocket.

Persons Testifying (Ways & Means): PRO: Shaun Ford, Washington Fire Chief's Association; Mike Battis, Ballard Ambulance; Shawn Baird, Cascade Ambulance; Jane Beyer, Office of the Insurance Commissioner; Chris Cato, EMS Division Chief; Jim Freeburg, Patient Coalition of Washington; Dwight Worden, EMT - Teamsters Union Local 231.

OTHER: Jennifer Ziegler, Association of Washington Health Care Plans; Marissa Ingalls, Coordinated Care; Jane Douthit, Regence Blue Shield; Samuel Wilcoxson, Premera.

Persons Signed In To Testify But Not Testifying (Ways & Means): No one.