H-2499.1

HOUSE BILL 2285

State of Washington 68th Legislature 2024 Regular Session

By Representatives Riccelli, Schmick, and Bronoske

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; amending RCW 48.43.005, 48.49.003, 48.49.060, 48.49.070, 48.49.090, 48.49.100, and 48.49.130; adding new sections to chapter 48.49 RCW; adding new sections to chapter 18.73 RCW; adding a new section to chapter 48.43 RCW; creating a new section; and repealing RCW 48.49.190.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

Sec. 1. RCW 48.43.005 and 2023 c 433 s 20 are each amended to read as follows:

Unless otherwise specifically provided, the definitions in this section apply throughout this chapter.

(1) "Adjusted community rate" means the rating method used to establish the premium for health plans adjusted to reflect actuarially demonstrated differences in utilization or cost attributable to geographic region, age, family size, and use of wellness activities.

(2) "Adverse benefit determination" means a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit, including a denial, reduction, termination,

or failure to provide or make payment that is based on a determination of an enrollee's or applicant's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

(3) "Air ambulance service" has the same meaning as defined in section 2799A-2 of the public health service act (42 U.S.C. Sec. 300gg-112) and implementing federal regulations in effect on March 31, 2022.

(4) "Allowed amount" means the maximum portion of a billed charge a health carrier will pay, including any applicable enrollee cost-sharing responsibility, for a covered health care service or item rendered by a participating provider or facility or by a nonparticipating provider or facility.

(5) "Applicant" means a person who applies for enrollment in an individual health plan as the subscriber or an enrollee, or the dependent or spouse of a subscriber or enrollee.

(6) "Balance bill" means a bill sent to an enrollee by a nonparticipating provider or facility for health care services provided to the enrollee after the provider or facility's billed amount is not fully reimbursed by the carrier, exclusive of permitted cost-sharing.

(7) "Basic health plan" means the plan described under chapter 70.47 RCW, as revised from time to time.

(8) "Basic health plan model plan" means a health plan as required in RCW 70.47.060(2)(e).

(9) "Basic health plan services" means that schedule of covered health services, including the description of how those benefits are to be administered, that are required to be delivered to an enrollee under the basic health plan, as revised from time to time.

(10) "Behavioral health emergency services provider" means emergency services provided in the following settings:

(a) A crisis stabilization unit as defined in RCW 71.05.020;

(b) A 23-hour crisis relief center as defined in RCW 71.24.025;

(c) An evaluation and treatment facility that can provide directly, or by direct arrangement with other public or private

agencies, emergency evaluation and treatment, outpatient care, and timely and appropriate inpatient care to persons suffering from a mental disorder, and which is licensed or certified as such by the department of health;

(d) An agency certified by the department of health under chapter 71.24 RCW to provide outpatient crisis services;

(e) An agency certified by the department of health under chapter 71.24 RCW to provide medically managed or medically monitored withdrawal management services; or

(f) A mobile rapid response crisis team as defined in RCW 71.24.025 that is contracted with a behavioral health administrative services organization operating under RCW 71.24.045 to provide crisis response services in the behavioral health administrative services organization's service area.

(11) "Board" means the governing board of the Washington health benefit exchange established in chapter 43.71 RCW.

(12)(a) For grandfathered health benefit plans issued before January 1, 2014, and renewed thereafter, "catastrophic health plan" means:

(i) In the case of a contract, agreement, or policy covering a single enrollee, a health benefit plan requiring a calendar year deductible of, at a minimum, ((~~one thousand seven hundred fifty dollars~~)) $1,750 and an annual out-of-pocket expense required to be paid under the plan (other than for premiums) for covered benefits of at least ((~~three thousand five hundred dollars~~)) $3,500, both amounts to be adjusted annually by the insurance commissioner; and

(ii) In the case of a contract, agreement, or policy covering more than one enrollee, a health benefit plan requiring a calendar year deductible of, at a minimum, ((~~three thousand five hundred dollars~~)) $3,500 and an annual out-of-pocket expense required to be paid under the plan (other than for premiums) for covered benefits of at least ((~~six thousand dollars~~)) $6,000, both amounts to be adjusted annually by the insurance commissioner.

(b) In July 2008, and in each July thereafter, the insurance commissioner shall adjust the minimum deductible and out-of-pocket expense required for a plan to qualify as a catastrophic plan to reflect the percentage change in the consumer price index for medical care for a preceding ((~~twelve~~)) 12 months, as determined by the United States department of labor. For a plan year beginning in 2014, the out-of-pocket limits must be adjusted as specified in section

1302(c)(1) of P.L. 111-148 of 2010, as amended. The adjusted amount shall apply on the following January 1st.

(c) For health benefit plans issued on or after January 1, 2014, "catastrophic health plan" means:

(i) A health benefit plan that meets the definition of catastrophic plan set forth in section 1302(e) of P.L. 111-148 of 2010, as amended; or

(ii) A health benefit plan offered outside the exchange marketplace that requires a calendar year deductible or out-of-pocket expenses under the plan, other than for premiums, for covered benefits, that meets or exceeds the commissioner's annual adjustment under (b) of this subsection.

(13) "Certification" means a determination by a review organization that an admission, extension of stay, or other health care service or procedure has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness under the auspices of the applicable health benefit plan.

(14) "Concurrent review" means utilization review conducted during a patient's hospital stay or course of treatment.

(15) "Covered person" or "enrollee" means a person covered by a health plan including an enrollee, subscriber, policyholder, beneficiary of a group plan, or individual covered by any other health plan.

(16) "Dependent" means, at a minimum, the enrollee's legal spouse and dependent children who qualify for coverage under the enrollee's health benefit plan.

(17) "Emergency medical condition" means a medical, mental health, or substance use disorder condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain or emotional distress, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical, mental health, or substance use disorder treatment attention to result in a condition (a) placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part.

(18) "Emergency services" means:

(a)(i) A medical screening examination, as required under section 1867 of the social security act (42 U.S.C. Sec. 1395dd), that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate that emergency medical condition;

(ii) Medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the social security act (42 U.S.C. Sec. 1395dd) to stabilize the patient. Stabilize, with respect to an emergency medical condition, has the meaning given in section 1867(e)(3) of the social security act (42 U.S.C. Sec. 1395dd(e)(3)); and

(iii) Covered services provided by staff or facilities of a hospital after the enrollee is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit during which screening and stabilization services have been furnished. Poststabilization services relate to medical, mental health, or substance use disorder treatment necessary in the short term to avoid placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part; or

(b)(i) A screening examination that is within the capability of a behavioral health emergency services provider including ancillary services routinely available to the behavioral health emergency services provider to evaluate that emergency medical condition;

(ii) Examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the behavioral health emergency services provider, as are required under section 1867 of the social security act (42 U.S.C. Sec. 1395dd) or as would be required under such section if such section applied to behavioral health emergency services providers, to stabilize the patient. Stabilize, with respect to an emergency medical condition, has the meaning given in section 1867(e)(3) of the social security act (42 U.S.C. Sec. 1395dd(e)(3)); and

(iii) Covered behavioral health services provided by staff or facilities of a behavioral health emergency services provider after the enrollee is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit during which screening and stabilization services have been furnished.

Poststabilization services relate to mental health or substance use disorder treatment necessary in the short term to avoid placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

(19) "Employee" has the same meaning given to the term, as of January 1, 2008, under section 3(6) of the federal employee retirement income security act of 1974.

(20) "Enrollee point-of-service cost-sharing" or "cost-sharing" means amounts paid to health carriers directly providing services, health care providers, or health care facilities by enrollees and may include copayments, coinsurance, or deductibles.

(21) "Essential health benefit categories" means:

(a) Ambulatory patient services;

(b) Emergency services;

(c) Hospitalization;

(d) Maternity and newborn care;

(e) Mental health and substance use disorder services, including behavioral health treatment;

(f) Prescription drugs;

(g) Rehabilitative and habilitative services and devices;

(h) Laboratory services;

(i) Preventive and wellness services and chronic disease management; and

(j) Pediatric services, including oral and vision care.

(22) "Exchange" means the Washington health benefit exchange established under chapter 43.71 RCW.

(23) "Final external review decision" means a determination by an independent review organization at the conclusion of an external review.

(24) "Final internal adverse benefit determination" means an adverse benefit determination that has been upheld by a health plan or carrier at the completion of the internal appeals process, or an adverse benefit determination with respect to which the internal appeals process has been exhausted under the exhaustion rules described in RCW 48.43.530 and 48.43.535.

(25) "Grandfathered health plan" means a group health plan or an individual health plan that under section 1251 of the patient protection and affordable care act, P.L. 111-148 (2010) and as

amended by the health care and education reconciliation act, P.L. 111-152 (2010) is not subject to subtitles A or C of the act as amended.

(26) "Grievance" means a written complaint submitted by or on behalf of a covered person regarding service delivery issues other than denial of payment for medical services or nonprovision of medical services, including dissatisfaction with medical care, waiting time for medical services, provider or staff attitude or demeanor, or dissatisfaction with service provided by the health carrier.

(27) "Ground ambulance services" means:

(a) 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

(b) 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.

(28) "Ground ambulance services organization" means a public or private organization licensed by the department of health under chapter 18.73 RCW to provide ground ambulance services. For purposes of this chapter, ground ambulance services organizations are not considered providers.

(29) "Health care facility" or "facility" means hospices licensed under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW, rural health care facilities as defined in RCW 70.175.020, psychiatric hospitals licensed under chapter 71.12 RCW, nursing homes licensed under chapter 18.51 RCW, community mental health centers licensed under chapter 71.05 or 71.24 RCW, kidney disease treatment centers licensed under chapter 70.41 RCW, ambulatory diagnostic, treatment, or surgical facilities licensed under chapter 70.41 or 70.230 RCW, drug and alcohol treatment facilities licensed under chapter 70.96A RCW, and home health agencies licensed under chapter 70.127 RCW, and includes such facilities if owned and operated by a political subdivision or instrumentality of the state and such other facilities as required by federal law and implementing regulations.

((~~(28)~~)) (30) "Health care provider" or "provider" means:

(a) A person regulated under Title 18 or chapter 70.127 RCW, to practice health or health-related services or otherwise practicing health care services in this state consistent with state law; or

(b) An employee or agent of a person described in (a) of this subsection, acting in the course and scope of his or her employment.

((~~(29)~~)) (31) "Health care service" means that service offered or provided by health care facilities and health care providers relating to the prevention, cure, or treatment of illness, injury, or disease.

((~~(30)~~)) (32) "Health carrier" or "carrier" means a disability insurer regulated under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, or a health maintenance organization as defined in RCW 48.46.020, and includes "issuers" as that term is used in the patient protection and affordable care act (P.L. 111-148).

((~~(31)~~)) (33) "Health plan" or "health benefit plan" means any policy, contract, or agreement offered by a health carrier to provide, arrange, reimburse, or pay for health care services except the following:

(a) Long-term care insurance governed by chapter 48.84 or 48.83 RCW;

(b) Medicare supplemental health insurance governed by chapter 48.66 RCW;

(c) Coverage supplemental to the coverage provided under chapter 55, Title 10, United States Code;

(d) Limited health care services offered by limited health care service contractors in accordance with RCW 48.44.035;

(e) Disability income;

(f) Coverage incidental to a property/casualty liability insurance policy such as automobile personal injury protection coverage and homeowner guest medical;

(g) Workers' compensation coverage;

(h) Accident only coverage;

(i) Specified disease or illness-triggered fixed payment insurance, hospital confinement fixed payment insurance, or other fixed payment insurance offered as an independent, noncoordinated benefit;

(j) Employer-sponsored self-funded health plans;

(k) Dental only and vision only coverage;

(l) Plans deemed by the insurance commissioner to have a short-term limited purpose or duration, or to be a student-only plan that

is guaranteed renewable while the covered person is enrolled as a regular full-time undergraduate or graduate student at an accredited higher education institution, after a written request for such classification by the carrier and subsequent written approval by the insurance commissioner;

(m) Civilian health and medical program for the veterans affairs administration (CHAMPVA); and

(n) Stand-alone prescription drug coverage that exclusively supplements medicare part D coverage provided through an employer group waiver plan under federal social security act regulation 42 C.F.R. Sec. 423.458(c).

((~~(32)~~)) (34) "Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

((~~(33)~~)) (35) "In-network" or "participating" means a provider or facility that has contracted with a carrier or a carrier's contractor or subcontractor to provide health care services to enrollees and be reimbursed by the carrier at a contracted rate as payment in full for the health care services, including applicable cost-sharing obligations.

((~~(34)~~)) (36) "Material modification" means a change in the actuarial value of the health plan as modified of more than five percent but less than fifteen percent.

((~~(35)~~)) (37) "Nonemergency health care services performed by nonparticipating providers at certain participating facilities" means covered items or services other than emergency services with respect to a visit at a participating health care facility, as provided in section 2799A-1(b) of the public health service act (42 U.S.C. Sec. 300gg-111(b)), 45 C.F.R. Sec. 149.30, and 45 C.F.R. Sec. 149.120 as in effect on March 31, 2022.

((~~(36)~~)) (38) "Open enrollment" means a period of time as defined in rule to be held at the same time each year, during which applicants may enroll in a carrier's individual health benefit plan without being subject to health screening or otherwise required to provide evidence of insurability as a condition for enrollment.

((~~(37)~~)) (39) "Out-of-network" or "nonparticipating" means a provider or facility that has not contracted with a carrier or a carrier's contractor or subcontractor to provide health care services to enrollees.

((~~(38)~~)) (40) "Out-of-pocket maximum" or "maximum out-of-pocket" means the maximum amount an enrollee is required to pay in the form of cost-sharing for covered benefits in a plan year, after which the carrier covers the entirety of the allowed amount of covered benefits under the contract of coverage.

((~~(39)~~)) (41) "Preexisting condition" means any medical condition, illness, or injury that existed any time prior to the effective date of coverage.

((~~(40)~~)) (42) "Premium" means all sums charged, received, or deposited by a health carrier as consideration for a health plan or the continuance of a health plan. Any assessment or any "membership," "policy," "contract," "service," or similar fee or charge made by a health carrier in consideration for a health plan is deemed part of the premium. "Premium" shall not include amounts paid as enrollee point-of-service cost-sharing.

((~~(41)~~)) (43)(a) "Protected individual" means:

(i) An adult covered as a dependent on the enrollee's health benefit plan, including an individual enrolled on the health benefit plan of the individual's registered domestic partner; or

(ii) A minor who may obtain health care without the consent of a parent or legal guardian, pursuant to state or federal law.

(b) "Protected individual" does not include an individual deemed not competent to provide informed consent for care under RCW 11.88.010(1)(e).

((~~(42)~~)) (44) "Review organization" means a disability insurer regulated under chapter 48.20 or 48.21 RCW, health care service contractor as defined in RCW 48.44.010, or health maintenance organization as defined in RCW 48.46.020, and entities affiliated with, under contract with, or acting on behalf of a health carrier to perform a utilization review.

((~~(43)~~)) (45) "Sensitive health care services" means health services related to reproductive health, sexually transmitted diseases, substance use disorder, gender dysphoria, gender-affirming care, domestic violence, and mental health.

((~~(44)~~)) (46) "Small employer" or "small group" means any person, firm, corporation, partnership, association, political subdivision, sole proprietor, or self-employed individual that is actively engaged in business that employed an average of at least one but no more than ((~~fifty~~)) 50 employees, during the previous calendar year and employed at least one employee on the first day of the plan year, is

not formed primarily for purposes of buying health insurance, and in which a bona fide employer-employee relationship exists. In determining the number of employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this state, shall be considered an employer. Subsequent to the issuance of a health plan to a small employer and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, a small employer shall continue to be considered a small employer until the plan anniversary following the date the small employer no longer meets the requirements of this definition. A self-employed individual or sole proprietor who is covered as a group of one must also: (a) Have been employed by the same small employer or small group for at least twelve months prior to application for small group coverage, and (b) verify that he or she derived at least ((~~seventy-five~~)) 75 percent of his or her income from a trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, schedule C or F, for the previous taxable year, except a self-employed individual or sole proprietor in an agricultural trade or business, must have derived at least ((~~fifty-one~~)) 51 percent of his or her income from the trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, for the previous taxable year.

((~~(45)~~)) (47) "Special enrollment" means a defined period of time of not less than thirty-one days, triggered by a specific qualifying event experienced by the applicant, during which applicants may enroll in the carrier's individual health benefit plan without being subject to health screening or otherwise required to provide evidence of insurability as a condition for enrollment.

((~~(46)~~)) (48) "Standard health questionnaire" means the standard health questionnaire designated under chapter 48.41 RCW.

((~~(47)~~)) (49) "Utilization review" means the prospective, concurrent, or retrospective assessment of the necessity and appropriateness of the allocation of health care resources and services of a provider or facility, given or proposed to be given to an enrollee or group of enrollees.

((~~(48)~~)) (50) "Wellness activity" means an explicit program of an activity consistent with department of health guidelines, such as, smoking cessation, injury and accident prevention, reduction of alcohol misuse, appropriate weight reduction, exercise, automobile and motorcycle safety, blood cholesterol reduction, and nutrition education for the purpose of improving enrollee health status and reducing health service costs.

Sec. 2. RCW 48.49.003 and 2022 c 263 s 6 are each amended to read as follows:

(1) The legislature finds that:

(a) Consumers receive surprise bills or balance bills for services provided at nonparticipating facilities ((~~or~~)), by nonparticipating health care providers at in-network facilities, and by ground ambulance services organizations;

(b) Consumers must not be placed in the middle of contractual disputes between ((~~providers~~)) entities referenced in this section and health insurance carriers; and

(c) Facilities, providers, and health insurance carriers all share responsibility to ensure consumers have transparent information on network providers and benefit coverage, and the insurance commissioner is responsible for ensuring that provider networks include sufficient numbers and types of contracted providers to reasonably ensure consumers have in-network access for covered benefits.

(2) It is the intent of the legislature to:

(a) Ban balance billing of consumers enrolled in fully insured, regulated ((~~insurance~~)) health plans and plans offered to public and school employees under chapter 41.05 RCW for the services described in RCW 48.49.020((~~,~~)) and section 8 of this act and to provide self-funded group health plans with an option to elect to be subject to the provisions of this chapter;

(b) Remove consumers from balance billing disputes and require that nonparticipating providers and carriers negotiate nonparticipating provider payments in good faith under the terms of this chapter;

(c) Align Washington state law with the federal balance billing prohibitions and transparency protections in sections 2799A-1 et seq. of the public health service act (P.L. 116-260) and implementing federal regulations in effect on March 31, 2022, while maintaining

provisions of this chapter that provide greater protection for consumers; and

(d) Provide an environment that encourages self-funded groups to negotiate payments in good faith with nonparticipating providers and facilities in return for balance billing protections.

Sec. 3. RCW 48.49.060 and 2022 c 263 s 13 are each amended to read as follows:

(1) The commissioner, in consultation with health carriers, health care providers, health care facilities, behavioral health emergency services providers, ground ambulance services organizations, and consumers, must develop standard template language for a notice of consumer rights notifying consumers of their rights under this chapter, and sections 2799A-1 and 2799A-2 of the public health service act (42 U.S.C. Secs. 300gg-111 and 300gg-112) and implementing federal regulations in effect on March 31, 2022.

(2) The standard template language must include contact information for the office of the insurance commissioner so that consumers may contact the office of the insurance commissioner if they believe they have received a balance bill in violation of this chapter.

(3) The office of the insurance commissioner shall determine by rule when and in what format health carriers, health care providers, ((~~and~~)) health care facilities, behavioral health emergency services providers, and ground ambulance services organizations must provide consumers with the notice developed under this section.

Sec. 4. RCW 48.49.070 and 2022 c 263 s 14 are each amended to read as follows:

(1)(a) A hospital, ambulatory surgical facility, ((~~or~~)) behavioral health emergency services provider, or ground ambulance services organization must post the following information on its website, if one is available:

(i) The listing of the carrier health plan provider networks with which the hospital, ambulatory surgical facility, ((~~or~~)) behavioral health emergency services provider, or ground ambulance services organization is an in-network provider, based upon the information provided by the carrier pursuant to RCW 48.43.730(7); and

(ii) The notice of consumer rights developed under RCW 48.49.060.

(b) If the hospital, ambulatory surgical facility, ((~~or~~)) behavioral health emergency services provider, or ground ambulance services organization does not maintain a website, this information must be provided to consumers upon an oral or written request.

(2) Posting or otherwise providing the information required in this section does not relieve a hospital, ambulatory surgical facility, ((~~or~~)) behavioral health emergency services provider, or ground ambulance services organization of its obligation to comply with the provisions of this chapter.

(3) Not less than ((~~thirty~~)) 30 days prior to executing a contract with a carrier, a hospital or ambulatory surgical facility must provide the carrier with a list of the nonemployed providers or provider groups contracted to provide emergency medicine, anesthesiology, pathology, radiology, neonatology, surgery, hospitalist, intensivist((~~,~~)), and diagnostic services, including radiology and laboratory services at the hospital or ambulatory surgical facility. The hospital or ambulatory surgical facility must notify the carrier within thirty days of a removal from or addition to the nonemployed provider list. A hospital or ambulatory surgical facility also must provide an updated list of these providers within ((~~fourteen~~)) 14 calendar days of a request for an updated list by a carrier.

Sec. 5. RCW 48.49.090 and 2022 c 263 s 15 are each amended to read as follows:

(1) A carrier must update its website and provider directory no later than thirty days after the addition or termination of a facility or provider.

(2) A carrier must provide an enrollee with:

(a) A clear description of the health plan's out-of-network health benefits;

(b) The notice of consumer rights developed under RCW 48.49.060;

(c) Notification that if the enrollee receives services from an out-of-network provider, facility, ((~~or~~)) behavioral health emergency services provider, or ground ambulance services organization, under circumstances other than those described in RCW 48.49.020 and section 8 of this act, the enrollee will have the financial responsibility applicable to services provided outside the health plan's network in excess of applicable cost-sharing amounts and that the enrollee may

be responsible for any costs in excess of those allowed by the health plan;

(d) Information on how to use the carrier's member transparency tools under RCW 48.43.007;

(e) Upon request, information regarding whether a health care provider is in-network or out-of-network, and whether there are in-network providers available to provide emergency medicine, anesthesiology, pathology, radiology, neonatology, surgery, hospitalist, intensivist((~~,~~)), and diagnostic services, including radiology and laboratory services at specified in-network hospitals or ambulatory surgical facilities; and

(f) Upon request, an estimated range of the out-of-pocket costs for an out-of-network benefit.

Sec. 6. RCW 48.49.100 and 2022 c 263 s 16 are each amended to read as follows:

(1) If the commissioner has cause to believe that any health care provider, hospital, ambulatory surgical facility, or behavioral health emergency services provider, has engaged in a pattern of unresolved violations of RCW 48.49.020 or 48.49.030, the commissioner may submit information to the department of health or the appropriate disciplining authority for action. Prior to submitting information to the department of health or the appropriate disciplining authority, the commissioner may provide the health care provider, hospital, ambulatory surgical facility, or behavioral health emergency services provider, with an opportunity to cure the alleged violations or explain why the actions in question did not violate RCW 48.49.020 or 48.49.030.

(2) If any health care provider, hospital, ambulatory surgical facility, or behavioral health emergency services provider, has engaged in a pattern of unresolved violations of RCW 48.49.020 or 48.49.030, the department of health or the appropriate disciplining authority may levy a fine or cost recovery upon the health care provider, hospital, ambulatory surgical facility, or behavioral health emergency services provider in an amount not to exceed the applicable statutory amount per violation and take other action as permitted under the authority of the department or disciplining authority. Upon completion of its review of any potential violation submitted by the commissioner or initiated directly by an enrollee, the department of health or the disciplining authority shall notify

the commissioner of the results of the review, including whether the violation was substantiated and any enforcement action taken as a result of a finding of a substantiated violation.

(3) If the commissioner has cause to believe that any ground ambulance services organization has engaged in a pattern of unresolved violations of section 8 of this act, the authority and process provided in subsections (1) and (2) of this section apply.

(4) If a carrier has engaged in a pattern of unresolved violations of any provision of this chapter, the commissioner may levy a fine or apply remedies authorized under this chapter, chapter 48.02 RCW, RCW 48.44.166, 48.46.135, or 48.05.185.

((~~(4)~~)) (5) For purposes of this section, "disciplining authority" means the agency, board, or commission having the authority to take disciplinary action against a holder of, or applicant for, a professional or business license upon a finding of a violation of chapter 18.130 RCW or a chapter specified under RCW 18.130.040.

Sec. 7. RCW 48.49.130 and 2022 c 263 s 17 are each amended to read as follows:

As authorized in 45 C.F.R. Sec. 149.30 as in effect on March 31, 2022, the provisions of this chapter apply to a self-funded group health plan whether governed by or exempt from the provisions of the federal employee retirement income security act of 1974 (29 U.S.C. Sec. 1001 et seq.) only if the self-funded group health plan elects to participate in the provisions of RCW 48.49.020 ((~~and~~)), 48.49.030, 48.49.040, 48.49.160, and ((~~48.49.040~~)) section 8 of this act. To elect to participate in these provisions, the self-funded group health plan shall provide notice, on ((~~an annual~~)) a periodic basis, to the commissioner in a manner and by a date prescribed by the commissioner, attesting to the plan's participation and agreeing to be bound by RCW 48.49.020 ((~~and~~)), 48.49.030, 48.49.040, 48.49.160, and ((~~48.49.040~~)) section 8 of this act. An entity administering a self-funded health benefits plan that elects to participate under this section, shall comply with the provisions of RCW 48.49.020 ((~~and~~)), 48.49.030, 48.49.040, 48.49.160, and ((~~48.49.040~~)) section 8 of this act.

NEW SECTION. **Sec. 8.** A new section is added to chapter 48.49 RCW to read as follows:

(1) 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.

(2) If an enrollee receives covered ground ambulance services:

(a) 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 enrollee's obligation must be calculated using the allowed amount determined under subsection (3) of this section. The carrier shall provide an explanation of benefits to the enrollee and the nonparticipating ground ambulance services organization that reflects the cost-sharing amount determined under this subsection;

(b) The carrier, nonparticipating ground ambulance services organization, and any agent, trustee, or assignee of the carrier or nonparticipating ground ambulance services organization shall ensure that the enrollee incurs no greater cost than the amount determined under (a) of this subsection;

(c) The nonparticipating ground ambulance services organization and any agent, trustee, or assignee of the nonparticipating ground ambulance services organization may not balance bill or otherwise attempt to collect from the enrollee any amount greater than the amount determined under (a) of this subsection. This does not impact the ground ambulance services organization's ability to collect a past due balance for that cost-sharing amount with interest;

(d) The carrier shall treat any cost-sharing amounts determined under (a) of this subsection paid by the enrollee for a nonparticipating ground ambulance services organization's services in the same manner as cost sharing for health care services provided by an in-network ground ambulance services organization and must apply any cost sharing amounts paid by the enrollee for such services toward the enrollee's maximum out-of-pocket payment obligation; and

(e) A ground ambulance services organization shall refund any amount in excess of the in-network cost-sharing amount to an enrollee within 30 business days of receipt if the enrollee has paid the nonparticipating ground ambulance services organization an amount that exceeds the in-network cost-sharing amount determined under (a) of this subsection. Interest must be paid to the enrollee for any unrefunded payments at a rate of 12 percent beginning on the first calendar day after the 30 business days.

(3) The allowed amount paid to a nonparticipating ground ambulance services organization for covered ground ambulance services under a health plan issued by a carrier must be one of the following amounts:

(a) If a local governmental entity has submitted a rate to the office of the insurance commissioner under section 9 of this act, the rate set by the local governmental entity in the jurisdiction in which the covered health care services originated; or

(b) If the local governmental entity has not submitted a rate to the office of the insurance commissioner under section 9 of this act, the lesser of:

(i) 325 percent of the current published rate for ambulance services as established by the federal centers for medicare and medicaid services under Title XVIII of the social security act for the same service provided in the same geographic area; or

(ii) The ground ambulance services organization's billed charges.

(4) Payment made in compliance with this section is payment in full for the covered services provided, except for any in-network copayment, coinsurance, deductible, and other cost-sharing amounts required to be paid by the enrollee.

(5) The carrier shall make payments for ground ambulance services provided by nonparticipating ground ambulance services organizations directly to the organization, rather than the enrollee.

(6) 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 this section.

(7) Carriers shall make available through electronic and other methods of communication generally used by a ground ambulance services organization to verify enrollee eligibility and benefits information regarding whether an enrollee's health plan is subject to the requirements of this section.

(8) For purposes of this chapter, ground ambulance services organizations are not considered providers. RCW 48.49.020, 48.49.030, 48.49.040, and 48.49.160 do not apply to ground ambulance services or ground ambulance services organizations.

NEW SECTION. **Sec. 9.** A new section is added to chapter 48.49 RCW to read as follows:

A local governmental entity may submit to the office of the insurance commissioner, in the form and manner prescribed by the commissioner, the rate set by the local governmental entity as authorized in RCW 35.27.370, 35.23.456, or 52.12.135, or chapter 35.21 RCW, for purposes of section 8 of this act. The commissioner shall establish and maintain, directly or through the lead organization for administrative simplification designated under RCW 48.165.030, 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 or the lead organization for administrative simplification, as directed by the commissioner.

NEW SECTION. **Sec. 10.** A new section is added to chapter 48.49 RCW to read as follows:

(1) The commissioner must undertake a process to review the reasonableness of the percentage of the medicare rate established in section 8 of this act and any trends in changes to ground ambulance services rates set by local governmental entities. In conducting the review, the commissioner should consider the relationship of the rates 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 for these services by carriers.

(2) The results of the review must be submitted to the legislature by the earlier of:

(a) October 1, 2027; or

(b) October 1st following any update in medicare ground ambulance services payment rates by the federal centers for medicare and medicaid services.

NEW SECTION. **Sec. 11.** A new section is added to chapter 18.73 RCW to read as follows:

If the insurance commissioner reports to the department that they have cause to believe that a ground ambulance services organization has engaged in a pattern of violations of section 8 of this act, and the report is substantiated after investigation, the department may levy a fine upon the ground ambulance services organization in an amount not to exceed $1,000 per violation and take other formal or

informal disciplinary action as permitted under the authority of the department.

NEW SECTION. **Sec. 12.** A new section is added to chapter 48.43 RCW to read as follows:

(1) For health plans issued or renewed on or after January 1, 2025, a health carrier shall provide coverage for ground ambulance transports to behavioral health emergency services providers for enrollees who are experiencing an emergency medical condition as defined in RCW 48.43.005. 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.

(2) Coverage of ground ambulance transports to behavioral health emergency services providers may be subject to applicable in-network copayments, coinsurance, and deductibles, as provided in chapter 48.49 RCW.

NEW SECTION. **Sec. 13.** (1) The office of the insurance commissioner, in consultation with the health care authority, shall 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 to a hospital or behavioral health emergency services provider. The analysis must calculate net costs or savings separately for the individual, small group, and large group health plan markets and for public and school employee programs administered under chapter 41.05 RCW. The analysis should consider, at a minimum:

(a) The proportion of ground ambulance dispatches that do not result in patient transport to a hospital or behavioral health emergency services provider;

(b) Appropriate payment rates for these services;

(c) Any potential impact of coverage of these services on the number or type of transports to hospitals or behavioral health emergency services providers and associated costs or cost savings; and

(d) Other considerations identified by the commissioner.

(2) The report must include the findings of the actuarial analysis described in this section and recommendations related to whether the services described in this section should be treated as covered services under health plans issued or renewed in Washington state and health benefit programs for public and school employees administered under chapter 41.05 RCW. The office of the insurance commissioner shall submit the report to the legislature by October 1, 2025.

NEW SECTION. **Sec. 14.** A new section is added to chapter 18.73 RCW to read as follows:

(1) The Washington state institute for public policy, in collaboration with the department, the health care authority, and the office of the insurance commissioner, shall 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.

(2) The institute shall consider the following elements in conducting the study:

(a) Trends in the number and types of emergency medical services available and the volume of 911 responses and interfacility transports provided by emergency medical services organizations over time and by county in Washington state;

(b) Projections of the need for emergency medical services in Washington state counties over the next 10 years;

(c) Identification of geographic areas in Washington state without access to emergency medical services within an average 30-minute response time;

(d) Estimates for the cost to address gaps in emergency medical services so all parts of the state are assured a timely response; and

(e) Models for funding emergency medical services that are used by other states.

(3) In conducting the study, the institute shall consult with emergency medical services organizations, local governmental entities, hospitals, labor organizations representing emergency medical services personnel, and other interested entities as determined by the institute in consultation with the department, the health care authority, and the office of the insurance commissioner.

(4) The report and recommendations must be submitted to relevant policy and fiscal committees of the legislature on or before October 1, 2026.

NEW SECTION. **Sec. 15.** RCW 48.49.190 (Reports to legislature) and 2022 c 263 s 21 are each repealed.

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