
SUBSTITUTE SENATE BILL 5986

State of Washington

68th Legislature

2024 Regular Session

By Senate Ways & Means (originally sponsored by Senators Cleveland, Muzzall, Hasegawa, Kuderer, Mullet, Nobles, Randall, Salomon, Valdez, and Wellman)

READ FIRST TIME 02/05/24.

1 AN ACT Relating to protecting consumers from charges for out-of-
2 network health care services by prohibiting balance billing for
3 ground ambulance services and addressing coverage of transports to
4 treatment for emergency medical conditions; amending RCW 48.43.005,
5 48.49.003, 48.49.060, 48.49.070, 48.49.090, 48.49.100, and 48.49.130;
6 adding new sections to chapter 48.49 RCW; adding new sections to
7 chapter 18.73 RCW; adding a new section to chapter 48.43 RCW;
8 creating a new section; and repealing RCW 48.49.190.

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

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

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

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

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

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

10 (3) "Air ambulance service" has the same meaning as defined in
11 section 2799A-2 of the public health service act (42 U.S.C. Sec.
12 300gg-112) and implementing federal regulations in effect on March
13 31, 2022.

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

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

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

27 (7) "Basic health plan" means the plan described under chapter
28 70.47 RCW, as revised from time to time.

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

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

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

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

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

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

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

5 (d) An agency certified by the department of health under chapter
6 71.24 RCW to provide outpatient crisis services;

7 (e) An agency certified by the department of health under chapter
8 71.24 RCW to provide medically managed or medically monitored
9 withdrawal management services; or

10 (f) A mobile rapid response crisis team as defined in RCW
11 71.24.025 that is contracted with a behavioral health administrative
12 services organization operating under RCW 71.24.045 to provide crisis
13 response services in the behavioral health administrative services
14 organization's service area.

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

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

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

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

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

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

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

5 (i) A health benefit plan that meets the definition of
6 catastrophic plan set forth in section 1302(e) of P.L. 111-148 of
7 2010, as amended; or

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

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

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

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

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

28 (17) "Emergency medical condition" means a medical, mental
29 health, or substance use disorder condition manifesting itself by
30 acute symptoms of sufficient severity including, but not limited to,
31 severe pain or emotional distress, such that a prudent layperson, who
32 possesses an average knowledge of health and medicine, could
33 reasonably expect the absence of immediate medical, mental health, or
34 substance use disorder treatment attention to result in a condition

35 (a) placing the health of the individual, or with respect to a
36 pregnant woman, the health of the woman or her unborn child, in
37 serious jeopardy, (b) serious impairment to bodily functions, or (c)
38 serious dysfunction of any bodily organ or part.

39 (18) "Emergency services" means:

1 (a) (i) A medical screening examination, as required under section
2 1867 of the social security act (42 U.S.C. Sec. 1395dd), that is
3 within the capability of the emergency department of a hospital,
4 including ancillary services routinely available to the emergency
5 department to evaluate that emergency medical condition;

6 (ii) Medical examination and treatment, to the extent they are
7 within the capabilities of the staff and facilities available at the
8 hospital, as are required under section 1867 of the social security
9 act (42 U.S.C. Sec. 1395dd) to stabilize the patient. Stabilize, with
10 respect to an emergency medical condition, has the meaning given in
11 section 1867(e) (3) of the social security act (42 U.S.C. Sec.
12 1395dd(e) (3)); and

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

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

27 (ii) Examination and treatment, to the extent they are within the
28 capabilities of the staff and facilities available at the behavioral
29 health emergency services provider, as are required under section
30 1867 of the social security act (42 U.S.C. Sec. 1395dd) or as would
31 be required under such section if such section applied to behavioral
32 health emergency services providers, to stabilize the patient.
33 Stabilize, with respect to an emergency medical condition, has the
34 meaning given in section 1867(e) (3) of the social security act (42
35 U.S.C. Sec. 1395dd(e) (3)); and

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

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

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

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

14 (21) "Essential health benefit categories" means:

15 (a) Ambulatory patient services;

16 (b) Emergency services;

17 (c) Hospitalization;

18 (d) Maternity and newborn care;

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

21 (f) Prescription drugs;

22 (g) Rehabilitative and habilitative services and devices;

23 (h) Laboratory services;

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

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

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

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

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

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

1 amended by the health care and education reconciliation act, P.L.
2 111-152 (2010) is not subject to subtitles A or C of the act as
3 amended.

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

11 (27) "Ground ambulance services" means:

12 (a) The rendering of medical treatment and care at the scene of a
13 medical emergency or while transporting a patient to an appropriate
14 emergency services provider when the services are provided by one or
15 more ground ambulance vehicles designed for this purpose; and

16 (b) Ground ambulance transport between emergency services
17 providers, emergency services providers and medical facilities, and
18 between medical facilities when the services are medically necessary
19 and are provided by one or more ground ambulance vehicles designed
20 for this purpose.

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

26 (29) "Health care facility" or "facility" means hospices licensed
27 under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW,
28 rural health care facilities as defined in RCW 70.175.020,
29 psychiatric hospitals licensed under chapter 71.12 RCW, nursing homes
30 licensed under chapter 18.51 RCW, community mental health centers
31 licensed under chapter 71.05 or 71.24 RCW, kidney disease treatment
32 centers licensed under chapter 70.41 RCW, ambulatory diagnostic,
33 treatment, or surgical facilities licensed under chapter 70.41 or
34 70.230 RCW, drug and alcohol treatment facilities licensed under
35 chapter 70.96A RCW, and home health agencies licensed under chapter
36 70.127 RCW, and includes such facilities if owned and operated by a
37 political subdivision or instrumentality of the state and such other
38 facilities as required by federal law and implementing regulations.

39 ~~((28))~~ (30) "Health care provider" or "provider" means:

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

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

6 ~~((29))~~ (31) "Health care service" means that service offered or
7 provided by health care facilities and health care providers relating
8 to the prevention, cure, or treatment of illness, injury, or disease.

9 ~~((30))~~ (32) "Health carrier" or "carrier" means a disability
10 insurer regulated under chapter 48.20 or 48.21 RCW, a health care
11 service contractor as defined in RCW 48.44.010, or a health
12 maintenance organization as defined in RCW 48.46.020, and includes
13 "issuers" as that term is used in the patient protection and
14 affordable care act (P.L. 111-148).

15 ~~((31))~~ (33) "Health plan" or "health benefit plan" means any
16 policy, contract, or agreement offered by a health carrier to
17 provide, arrange, reimburse, or pay for health care services except
18 the following:

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

21 (b) Medicare supplemental health insurance governed by chapter
22 48.66 RCW;

23 (c) Coverage supplemental to the coverage provided under chapter
24 55, Title 10, United States Code;

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

27 (e) Disability income;

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

31 (g) Workers' compensation coverage;

32 (h) Accident only coverage;

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

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

38 (k) Dental only and vision only coverage;

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

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

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

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

12 (~~(32)~~) (34) "Individual market" means the market for health
13 insurance coverage offered to individuals other than in connection
14 with a group health plan.

15 (~~(33)~~) (35) "In-network" or "participating" means a provider or
16 facility that has contracted with a carrier or a carrier's contractor
17 or subcontractor to provide health care services to enrollees and be
18 reimbursed by the carrier at a contracted rate as payment in full for
19 the health care services, including applicable cost-sharing
20 obligations.

21 (~~(34)~~) (36) "Material modification" means a change in the
22 actuarial value of the health plan as modified of more than five
23 percent but less than fifteen percent.

24 (~~(35)~~) (37) "Nonemergency health care services performed by
25 nonparticipating providers at certain participating facilities" means
26 covered items or services other than emergency services with respect
27 to a visit at a participating health care facility, as provided in
28 section 2799A-1(b) of the public health service act (42 U.S.C. Sec.
29 300gg-111(b)), 45 C.F.R. Sec. 149.30, and 45 C.F.R. Sec. 149.120 as
30 in effect on March 31, 2022.

31 (~~(36)~~) (38) "Open enrollment" means a period of time as defined
32 in rule to be held at the same time each year, during which
33 applicants may enroll in a carrier's individual health benefit plan
34 without being subject to health screening or otherwise required to
35 provide evidence of insurability as a condition for enrollment.

36 (~~(37)~~) (39) "Out-of-network" or "nonparticipating" means a
37 provider or facility that has not contracted with a carrier or a
38 carrier's contractor or subcontractor to provide health care services
39 to enrollees.

1 (~~(38)~~) (40) "Out-of-pocket maximum" or "maximum out-of-pocket"
2 means the maximum amount an enrollee is required to pay in the form
3 of cost-sharing for covered benefits in a plan year, after which the
4 carrier covers the entirety of the allowed amount of covered benefits
5 under the contract of coverage.

6 (~~(39)~~) (41) "Preexisting condition" means any medical
7 condition, illness, or injury that existed any time prior to the
8 effective date of coverage.

9 (~~(40)~~) (42) "Premium" means all sums charged, received, or
10 deposited by a health carrier as consideration for a health plan or
11 the continuance of a health plan. Any assessment or any "membership,"
12 "policy," "contract," "service," or similar fee or charge made by a
13 health carrier in consideration for a health plan is deemed part of
14 the premium. "Premium" shall not include amounts paid as enrollee
15 point-of-service cost-sharing.

16 (~~(41)~~) (43)(a) "Protected individual" means:

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

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

22 (b) "Protected individual" does not include an individual deemed
23 not competent to provide informed consent for care under RCW
24 11.88.010(1)(e).

25 (~~(42)~~) (44) "Review organization" means a disability insurer
26 regulated under chapter 48.20 or 48.21 RCW, health care service
27 contractor as defined in RCW 48.44.010, or health maintenance
28 organization as defined in RCW 48.46.020, and entities affiliated
29 with, under contract with, or acting on behalf of a health carrier to
30 perform a utilization review.

31 (~~(43)~~) (45) "Sensitive health care services" means health
32 services related to reproductive health, sexually transmitted
33 diseases, substance use disorder, gender dysphoria, gender-affirming
34 care, domestic violence, and mental health.

35 (~~(44)~~) (46) "Small employer" or "small group" means any person,
36 firm, corporation, partnership, association, political subdivision,
37 sole proprietor, or self-employed individual that is actively engaged
38 in business that employed an average of at least one but no more than
39 (~~fifty~~) 50 employees, during the previous calendar year and
40 employed at least one employee on the first day of the plan year, is

1 not formed primarily for purposes of buying health insurance, and in
2 which a bona fide employer-employee relationship exists. In
3 determining the number of employees, companies that are affiliated
4 companies, or that are eligible to file a combined tax return for
5 purposes of taxation by this state, shall be considered an employer.
6 Subsequent to the issuance of a health plan to a small employer and
7 for the purpose of determining eligibility, the size of a small
8 employer shall be determined annually. Except as otherwise
9 specifically provided, a small employer shall continue to be
10 considered a small employer until the plan anniversary following the
11 date the small employer no longer meets the requirements of this
12 definition. A self-employed individual or sole proprietor who is
13 covered as a group of one must also: (a) Have been employed by the
14 same small employer or small group for at least twelve months prior
15 to application for small group coverage, and (b) verify that he or
16 she derived at least (~~(seventy-five)~~) 75 percent of his or her income
17 from a trade or business through which the individual or sole
18 proprietor has attempted to earn taxable income and for which he or
19 she has filed the appropriate internal revenue service form 1040,
20 schedule C or F, for the previous taxable year, except a self-
21 employed individual or sole proprietor in an agricultural trade or
22 business, must have derived at least (~~(fifty-one)~~) 51 percent of his
23 or her income from the trade or business through which the individual
24 or sole proprietor has attempted to earn taxable income and for which
25 he or she has filed the appropriate internal revenue service form
26 1040, for the previous taxable year.

27 (~~((45))~~) (47) "Special enrollment" means a defined period of time
28 of not less than thirty-one days, triggered by a specific qualifying
29 event experienced by the applicant, during which applicants may
30 enroll in the carrier's individual health benefit plan without being
31 subject to health screening or otherwise required to provide evidence
32 of insurability as a condition for enrollment.

33 (~~((46))~~) (48) "Standard health questionnaire" means the standard
34 health questionnaire designated under chapter 48.41 RCW.

35 (~~((47))~~) (49) "Utilization review" means the prospective,
36 concurrent, or retrospective assessment of the necessity and
37 appropriateness of the allocation of health care resources and
38 services of a provider or facility, given or proposed to be given to
39 an enrollee or group of enrollees.

1 (~~(48)~~) (50) "Wellness activity" means an explicit program of an
2 activity consistent with department of health guidelines, such as,
3 smoking cessation, injury and accident prevention, reduction of
4 alcohol misuse, appropriate weight reduction, exercise, automobile
5 and motorcycle safety, blood cholesterol reduction, and nutrition
6 education for the purpose of improving enrollee health status and
7 reducing health service costs.

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

10 (1) The legislature finds that:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

28 (2) A carrier must provide an enrollee with:

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

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

32 (c) Notification that if the enrollee receives services from an
33 out-of-network provider, facility, (~~or~~) behavioral health emergency
34 services provider, or ground ambulance services organization, under
35 circumstances other than those described in RCW 48.49.020 and section
36 8 of this act, the enrollee will have the financial responsibility
37 applicable to services provided outside the health plan's network in
38 excess of applicable cost-sharing amounts and that the enrollee may

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

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

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

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

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

16 (1) If the commissioner has cause to believe that any health care
17 provider, hospital, ambulatory surgical facility, or behavioral
18 health emergency services provider, has engaged in a pattern of
19 unresolved violations of RCW 48.49.020 or 48.49.030, the commissioner
20 may submit information to the department of health or the appropriate
21 disciplining authority for action. Prior to submitting information to
22 the department of health or the appropriate disciplining authority,
23 the commissioner may provide the health care provider, hospital,
24 ambulatory surgical facility, or behavioral health emergency services
25 provider, with an opportunity to cure the alleged violations or
26 explain why the actions in question did not violate RCW 48.49.020 or
27 48.49.030.

28 (2) If any health care provider, hospital, ambulatory surgical
29 facility, or behavioral health emergency services provider, has
30 engaged in a pattern of unresolved violations of RCW 48.49.020 or
31 48.49.030, the department of health or the appropriate disciplining
32 authority may levy a fine or cost recovery upon the health care
33 provider, hospital, ambulatory surgical facility, or behavioral
34 health emergency services provider in an amount not to exceed the
35 applicable statutory amount per violation and take other action as
36 permitted under the authority of the department or disciplining
37 authority. Upon completion of its review of any potential violation
38 submitted by the commissioner or initiated directly by an enrollee,
39 the department of health or the disciplining authority shall notify

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

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

8 (4) If a carrier has engaged in a pattern of unresolved
9 violations of any provision of this chapter, the commissioner may
10 levy a fine or apply remedies authorized under this chapter, chapter
11 48.02 RCW, RCW 48.44.166, 48.46.135, or 48.05.185.

12 ((4)) (5) For purposes of this section, "disciplining
13 authority" means the agency, board, or commission having the
14 authority to take disciplinary action against a holder of, or
15 applicant for, a professional or business license upon a finding of a
16 violation of chapter 18.130 RCW or a chapter specified under RCW
17 18.130.040.

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

20 As authorized in 45 C.F.R. Sec. 149.30 as in effect on March 31,
21 2022, the provisions of this chapter apply to a self-funded group
22 health plan whether governed by or exempt from the provisions of the
23 federal employee retirement income security act of 1974 (29 U.S.C.
24 Sec. 1001 et seq.) only if the self-funded group health plan elects
25 to participate in the provisions of RCW 48.49.020 ((and)), 48.49.030,
26 48.49.040, 48.49.160, and ((48.49.040)) section 8 of this act. To
27 elect to participate in these provisions, the self-funded group
28 health plan shall provide notice, on ((an annual)) a periodic basis,
29 to the commissioner in a manner and by a date prescribed by the
30 commissioner, attesting to the plan's participation and agreeing to
31 be bound by RCW 48.49.020 ((and)), 48.49.030, 48.49.040, 48.49.160,
32 and ((48.49.040)) section 8 of this act. An entity administering a
33 self-funded health benefits plan that elects to participate under
34 this section, shall comply with the provisions of RCW 48.49.020
35 ((and)), 48.49.030, 48.49.040, 48.49.160, and ((48.49.040)) section 8
36 of this act.

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

1 (1) For health plans issued or renewed on or after January 1,
2 2025, a nonparticipating ground ambulance services organization may
3 not balance bill an enrollee for covered ground ambulance services.

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

5 (a) The enrollee satisfies their obligation to pay for the ground
6 ambulance services if they pay the in-network cost-sharing amount
7 specified in the enrollee's or applicable group's health plan
8 contract. The enrollee's obligation must be calculated using the
9 allowed amount determined under subsection (3) of this section. The
10 carrier shall provide an explanation of benefits to the enrollee and
11 the nonparticipating ground ambulance services organization that
12 reflects the cost-sharing amount determined under this subsection;

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

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

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

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

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

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

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

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

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

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

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

24 (6) A ground ambulance services organization may not request or
25 require a patient at any time, for any procedure, service, or supply,
26 to sign or otherwise execute by oral, written, or electronic means,
27 any document that would attempt to avoid, waive, or alter any
28 provision of this section.

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

34 (8) For purposes of this chapter, ground ambulance services
35 organizations are not considered providers. RCW 48.49.020, 48.49.030,
36 48.49.040, and 48.49.160 do not apply to ground ambulance services or
37 ground ambulance services organizations.

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

1 A local governmental entity may submit to the office of the
2 insurance commissioner, in the form and manner prescribed by the
3 commissioner, the rate set by the local governmental entity as
4 authorized in RCW 35.27.370, 35.23.456, or 52.12.135, or chapter
5 35.21 RCW, for purposes of section 8 of this act. The commissioner
6 shall establish and maintain, directly or through the lead
7 organization for administrative simplification designated under RCW
8 48.165.030, a publicly accessible database for the rates. A carrier
9 may rely in good faith on the rates shown on the website. Local
10 governmental entities are solely responsible for submitting any
11 updates to their rates to the commissioner or the lead organization
12 for administrative simplification, as directed by the commissioner.

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

15 (1) The commissioner must undertake a process to review the
16 reasonableness of the percentage of the medicare rate established in
17 section 8 of this act and any trends in changes to ground ambulance
18 services rates set by local governmental entities. In conducting the
19 review, the commissioner should consider the relationship of the
20 rates to the cost of providing ground ambulance services and any
21 impacts on health plan enrollees that may result from health plans
22 increasing in-network consumer cost-sharing for ground ambulance
23 services due to increased rates paid for these services by carriers.

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

26 (a) October 1, 2027; or

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

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

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

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

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

5 (1) For health plans issued or renewed on or after January 1,
6 2025, a health carrier shall provide coverage for ground ambulance
7 transports to behavioral health emergency services providers for
8 enrollees who are experiencing an emergency medical condition as
9 defined in RCW 48.43.005. A health carrier may not require prior
10 authorization of ground ambulance services if a prudent layperson
11 acting reasonably would have believed that an emergency medical
12 condition existed.

13 (2) Coverage of ground ambulance transports to behavioral health
14 emergency services providers may be subject to applicable in-network
15 copayments, coinsurance, and deductibles, as provided in chapter
16 48.49 RCW.

17 NEW SECTION. **Sec. 13.** (1) The office of the insurance
18 commissioner, in consultation with the health care authority, shall
19 contract for an actuarial analysis of the cost, potential cost
20 savings, and total net costs or savings of covering services provided
21 by ground ambulance services organizations when a ground ambulance
22 services organization is dispatched to the scene of an emergency and
23 the person is treated but is not transported to a hospital or
24 behavioral health emergency services provider. The analysis must
25 calculate net costs or savings separately for the individual, small
26 group, and large group health plan markets and for public and school
27 employee programs administered under chapter 41.05 RCW. The analysis
28 should consider, at a minimum:

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

32 (b) Appropriate payment rates for these services;

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

37 (d) Other considerations identified by the commissioner.

1 (2) The report must include the findings of the actuarial
2 analysis described in this section and recommendations related to
3 whether the services described in this section should be treated as
4 covered services under health plans issued or renewed in Washington
5 state and health benefit programs for public and school employees
6 administered under chapter 41.05 RCW. The office of the insurance
7 commissioner shall submit the report to the legislature by October 1,
8 2025.

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

11 (1)(a) The Washington state institute for public policy, in
12 collaboration with the department, the health care authority, and the
13 office of the insurance commissioner, shall conduct a study on the
14 extent to which other states fund or have considered funding
15 emergency medical services substantially or entirely through federal,
16 state, or local governmental funding and the current landscape of
17 emergency medical services in Washington.

18 (b) The institute shall consider the following elements in
19 conducting the study:

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

24 (ii) Projections of the need for emergency medical services in
25 Washington state counties over the next two years;

26 (iii) Identification of geographic areas in Washington state
27 without access to emergency medical services within an average 25-
28 minute response time;

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

31 (v) Models for funding emergency medical services that are used
32 by other states; and

33 (vi) Existing research and literature related to funding models
34 for emergency medical services.

35 (c) In conducting the study, the institute shall consult with
36 emergency medical services organizations, local governmental
37 entities, hospitals, labor organizations representing emergency
38 medical services personnel, and other interested entities as

1 determined by the institute in consultation with the department, the
2 health care authority, and the office of the insurance commissioner.

3 (d) A report detailing the results of the study must be submitted
4 to the department and the relevant policy and fiscal committees of
5 the legislature on or before June 1, 2026.

6 (2) The department, in consultation with the health care
7 authority, the office of the insurance commissioner, and the entities
8 referenced in subsection (1)(c) of this section, shall develop
9 recommendations, based on the report completed pursuant to subsection
10 (1) of this section, on whether emergency medical services should be
11 treated as an essential health service provided by state and local
12 governmental entities and funded exclusively by federal, state, or
13 local governmental entities as a public health service. The report
14 must be submitted to the relevant policy and fiscal committees of the
15 legislature on or before December 1, 2026.

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

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