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**SUBSTITUTE SENATE BILL 5986**

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AS AMENDED BY THE HOUSE

Passed Legislature - 2024 Regular Session

**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 from the scene to  
14 an appropriate health care facility or behavioral health emergency  
15 services provider when the services are provided by one or more  
16 ground ambulance vehicles designed for this purpose; and

17 (b) Ground ambulance transport between hospitals or behavioral  
18 health emergency services providers, hospitals or behavioral health  
19 emergency services providers and other health care facilities or  
20 locations, and between health care facilities when the services are  
21 medically necessary and are provided by one or more ground ambulance  
22 vehicles designed for this purpose.

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

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

1           ~~((28))~~ (30) "Health care provider" or "provider" means:  
2           (a) A person regulated under Title 18 or chapter 70.127 RCW, to  
3 practice health or health-related services or otherwise practicing  
4 health care services in this state consistent with state law; or  
5           (b) An employee or agent of a person described in (a) of this  
6 subsection, acting in the course and scope of his or her employment.  
7           ~~((29))~~ (31) "Health care service" means that service offered or  
8 provided by health care facilities and health care providers relating  
9 to the prevention, cure, or treatment of illness, injury, or disease.  
10           ~~((30))~~ (32) "Health carrier" or "carrier" means a disability  
11 insurer regulated under chapter 48.20 or 48.21 RCW, a health care  
12 service contractor as defined in RCW 48.44.010, or a health  
13 maintenance organization as defined in RCW 48.46.020, and includes  
14 "issuers" as that term is used in the patient protection and  
15 affordable care act (P.L. 111-148).  
16           ~~((31))~~ (33) "Health plan" or "health benefit plan" means any  
17 policy, contract, or agreement offered by a health carrier to  
18 provide, arrange, reimburse, or pay for health care services except  
19 the following:  
20           (a) Long-term care insurance governed by chapter 48.84 or 48.83  
21 RCW;  
22           (b) Medicare supplemental health insurance governed by chapter  
23 48.66 RCW;  
24           (c) Coverage supplemental to the coverage provided under chapter  
25 55, Title 10, United States Code;  
26           (d) Limited health care services offered by limited health care  
27 service contractors in accordance with RCW 48.44.035;  
28           (e) Disability income;  
29           (f) Coverage incidental to a property/casualty liability  
30 insurance policy such as automobile personal injury protection  
31 coverage and homeowner guest medical;  
32           (g) Workers' compensation coverage;  
33           (h) Accident only coverage;  
34           (i) Specified disease or illness-triggered fixed payment  
35 insurance, hospital confinement fixed payment insurance, or other  
36 fixed payment insurance offered as an independent, noncoordinated  
37 benefit;  
38           (j) Employer-sponsored self-funded health plans;  
39           (k) Dental only and vision only coverage;



1 (l) Plans deemed by the insurance commissioner to have a short-  
2 term limited purpose or duration, or to be a student-only plan that  
3 is guaranteed renewable while the covered person is enrolled as a  
4 regular full-time undergraduate or graduate student at an accredited  
5 higher education institution, after a written request for such  
6 classification by the carrier and subsequent written approval by the  
7 insurance commissioner;

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

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

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

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

23 (~~(34)~~) (36) "Local governmental entity" means any entity that  
24 is authorized to establish or provide ground ambulance services or  
25 set rates for ground ambulance services, including those as  
26 authorized in RCW 35.27.370, 35.23.456, 52.12.135, chapter 35.21 RCW,  
27 or as authorized under any state law.

28 (37) "Material modification" means a change in the actuarial  
29 value of the health plan as modified of more than five percent but  
30 less than fifteen percent.

31 (~~(35)~~) (38) "Nonemergency health care services performed by  
32 nonparticipating providers at certain participating facilities" means  
33 covered items or services other than emergency services with respect  
34 to a visit at a participating health care facility, as provided in  
35 section 2799A-1(b) of the public health service act (42 U.S.C. Sec.  
36 300gg-111(b)), 45 C.F.R. Sec. 149.30, and 45 C.F.R. Sec. 149.120 as  
37 in effect on March 31, 2022.

38 (~~(36)~~) (39) "Open enrollment" means a period of time as defined  
39 in rule to be held at the same time each year, during which  
40 applicants may enroll in a carrier's individual health benefit plan

1 without being subject to health screening or otherwise required to  
2 provide evidence of insurability as a condition for enrollment.

3 ~~((37))~~ (40) "Out-of-network" or "nonparticipating" means a  
4 provider or facility that has not contracted with a carrier or a  
5 carrier's contractor or subcontractor to provide health care services  
6 to enrollees.

7 ~~((38))~~ (41) "Out-of-pocket maximum" or "maximum out-of-pocket"  
8 means the maximum amount an enrollee is required to pay in the form  
9 of cost-sharing for covered benefits in a plan year, after which the  
10 carrier covers the entirety of the allowed amount of covered benefits  
11 under the contract of coverage.

12 ~~((39))~~ (42) "Preexisting condition" means any medical  
13 condition, illness, or injury that existed any time prior to the  
14 effective date of coverage.

15 ~~((40))~~ (43) "Premium" means all sums charged, received, or  
16 deposited by a health carrier as consideration for a health plan or  
17 the continuance of a health plan. Any assessment or any "membership,"  
18 "policy," "contract," "service," or similar fee or charge made by a  
19 health carrier in consideration for a health plan is deemed part of  
20 the premium. "Premium" shall not include amounts paid as enrollee  
21 point-of-service cost-sharing.

22 ~~((41))~~ (44)(a) "Protected individual" means:

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

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

28 (b) "Protected individual" does not include an individual deemed  
29 not competent to provide informed consent for care under RCW  
30 11.88.010(1)(e).

31 ~~((42))~~ (45) "Review organization" means a disability insurer  
32 regulated under chapter 48.20 or 48.21 RCW, health care service  
33 contractor as defined in RCW 48.44.010, or health maintenance  
34 organization as defined in RCW 48.46.020, and entities affiliated  
35 with, under contract with, or acting on behalf of a health carrier to  
36 perform a utilization review.

37 ~~((43))~~ (46) "Sensitive health care services" means health  
38 services related to reproductive health, sexually transmitted  
39 diseases, substance use disorder, gender dysphoria, gender-affirming  
40 care, domestic violence, and mental health.

1       (~~(44)~~) (47) "Small employer" or "small group" means any person,  
2 firm, corporation, partnership, association, political subdivision,  
3 sole proprietor, or self-employed individual that is actively engaged  
4 in business that employed an average of at least one but no more than  
5 (~~(fifty)~~) 50 employees, during the previous calendar year and  
6 employed at least one employee on the first day of the plan year, is  
7 not formed primarily for purposes of buying health insurance, and in  
8 which a bona fide employer-employee relationship exists. In  
9 determining the number of employees, companies that are affiliated  
10 companies, or that are eligible to file a combined tax return for  
11 purposes of taxation by this state, shall be considered an employer.  
12 Subsequent to the issuance of a health plan to a small employer and  
13 for the purpose of determining eligibility, the size of a small  
14 employer shall be determined annually. Except as otherwise  
15 specifically provided, a small employer shall continue to be  
16 considered a small employer until the plan anniversary following the  
17 date the small employer no longer meets the requirements of this  
18 definition. A self-employed individual or sole proprietor who is  
19 covered as a group of one must also: (a) Have been employed by the  
20 same small employer or small group for at least twelve months prior  
21 to application for small group coverage, and (b) verify that he or  
22 she derived at least (~~(seventy-five)~~) 75 percent of his or her income  
23 from a trade or business through which the individual or sole  
24 proprietor has attempted to earn taxable income and for which he or  
25 she has filed the appropriate internal revenue service form 1040,  
26 schedule C or F, for the previous taxable year, except a self-  
27 employed individual or sole proprietor in an agricultural trade or  
28 business, must have derived at least (~~(fifty-one)~~) 51 percent of his  
29 or her income from the trade or business through which the individual  
30 or sole proprietor has attempted to earn taxable income and for which  
31 he or she has filed the appropriate internal revenue service form  
32 1040, for the previous taxable year.

33       (~~(45)~~) (48) "Special enrollment" means a defined period of time  
34 of not less than thirty-one days, triggered by a specific qualifying  
35 event experienced by the applicant, during which applicants may  
36 enroll in the carrier's individual health benefit plan without being  
37 subject to health screening or otherwise required to provide evidence  
38 of insurability as a condition for enrollment.

39       (~~(46)~~) (49) "Standard health questionnaire" means the standard  
40 health questionnaire designated under chapter 48.41 RCW.

1       (~~(47)~~) (50) "Utilization review" means the prospective,  
2 concurrent, or retrospective assessment of the necessity and  
3 appropriateness of the allocation of health care resources and  
4 services of a provider or facility, given or proposed to be given to  
5 an enrollee or group of enrollees.

6       (~~(48)~~) (51) "Wellness activity" means an explicit program of an  
7 activity consistent with department of health guidelines, such as,  
8 smoking cessation, injury and accident prevention, reduction of  
9 alcohol misuse, appropriate weight reduction, exercise, automobile  
10 and motorcycle safety, blood cholesterol reduction, and nutrition  
11 education for the purpose of improving enrollee health status and  
12 reducing health service costs.

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

15       (1) The legislature finds that:

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

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

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

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

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

37       (b) Remove consumers from balance billing disputes and require  
38 that nonparticipating providers and carriers negotiate

1 nonparticipating provider payments in good faith under the terms of  
2 this chapter;

3 (c) Align Washington state law with the federal balance billing  
4 prohibitions and transparency protections in sections 2799A-1 et seq.  
5 of the public health service act (P.L. 116-260) and implementing  
6 federal regulations in effect on March 31, 2022, while maintaining  
7 provisions of this chapter that provide greater protection for  
8 consumers; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

38 (c) Notification that if the enrollee receives services from an  
39 out-of-network provider, facility, ~~((~~or~~))~~ behavioral health emergency

1 services provider, or ground ambulance services organization, under  
2 circumstances other than those described in RCW 48.49.020 and section  
3 8 of this act, the enrollee will have the financial responsibility  
4 applicable to services provided outside the health plan's network in  
5 excess of applicable cost-sharing amounts and that the enrollee may  
6 be responsible for any costs in excess of those allowed by the health  
7 plan;

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

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

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

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

21 (1) If the commissioner has cause to believe that any health care  
22 provider, hospital, ambulatory surgical facility, or behavioral  
23 health emergency services provider, has engaged in a pattern of  
24 unresolved violations of RCW 48.49.020 or 48.49.030, the commissioner  
25 may submit information to the department of health or the appropriate  
26 disciplining authority for action. Prior to submitting information to  
27 the department of health or the appropriate disciplining authority,  
28 the commissioner may provide the health care provider, hospital,  
29 ambulatory surgical facility, or behavioral health emergency services  
30 provider, with an opportunity to cure the alleged violations or  
31 explain why the actions in question did not violate RCW 48.49.020 or  
32 48.49.030.

33 (2) If any health care provider, hospital, ambulatory surgical  
34 facility, or behavioral health emergency services provider, has  
35 engaged in a pattern of unresolved violations of RCW 48.49.020 or  
36 48.49.030, the department of health or the appropriate disciplining  
37 authority may levy a fine or cost recovery upon the health care  
38 provider, hospital, ambulatory surgical facility, or behavioral  
39 health emergency services provider in an amount not to exceed the

1 applicable statutory amount per violation and take other action as  
2 permitted under the authority of the department or disciplining  
3 authority. Upon completion of its review of any potential violation  
4 submitted by the commissioner or initiated directly by an enrollee,  
5 the department of health or the disciplining authority shall notify  
6 the commissioner of the results of the review, including whether the  
7 violation was substantiated and any enforcement action taken as a  
8 result of a finding of a substantiated violation.

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

13 (4) If a carrier has engaged in a pattern of unresolved  
14 violations of any provision of this chapter, the commissioner may  
15 levy a fine or apply remedies authorized under this chapter, chapter  
16 48.02 RCW, RCW 48.44.166, 48.46.135, or 48.05.185.

17 ((4)) (5) For purposes of this section, "disciplining  
18 authority" means the agency, board, or commission having the  
19 authority to take disciplinary action against a holder of, or  
20 applicant for, a professional or business license upon a finding of a  
21 violation of chapter 18.130 RCW or a chapter specified under RCW  
22 18.130.040.

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

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



1 ((and)), 48.49.030, 48.49.040, 48.49.160, and ((48.49.040)) section 8  
2 of this act.

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

5 (1) For health plans issued or renewed on or after January 1,  
6 2025, a nonparticipating ground ambulance services organization may  
7 not balance bill an enrollee for covered ground ambulance services.

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

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

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

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

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

36 (e) A ground ambulance services organization shall refund any  
37 amount in excess of the in-network cost-sharing amount to an enrollee  
38 within 30 business days of receipt if the enrollee has paid the  
39 nonparticipating ground ambulance services organization an amount

1 that exceeds the in-network cost-sharing amount determined under (a)  
2 of this subsection. Interest must be paid to the enrollee for any  
3 unrefunded payments at a rate of 12 percent beginning on the first  
4 calendar day after the 30 business days.

5 (3) Until December 31, 2027, the allowed amount paid to a  
6 nonparticipating ground ambulance services organization for covered  
7 ground ambulance services under a health plan issued by a carrier  
8 must be one of the following amounts:

9 (a)(i) The rate established by the local governmental entity  
10 where the covered health care services originated for the provision  
11 of ground ambulance services by ground ambulance services  
12 organizations owned or operated by the local governmental entity and  
13 submitted to the office of the insurance commissioner under section 9  
14 of this act; or

15 (ii) Where the ground ambulance services were provided by a  
16 private ground ambulance services organization under contract with  
17 the local governmental entity where the covered health care services  
18 originated, the amount set by the contract submitted to the office of  
19 the insurance commissioner under section 9 of this act; or

20 (b) If a rate has not been established under (a) of this  
21 subsection, the lesser of:

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

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

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

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

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

39 (7) Carriers shall make available through electronic and other  
40 methods of communication generally used by a ground ambulance

1 services organization to verify enrollee eligibility and benefits  
2 information regarding whether an enrollee's health plan is subject to  
3 the requirements of this section.

4 (8) For purposes of this chapter, ground ambulance services  
5 organizations are not considered providers. RCW 48.49.020, 48.49.030,  
6 48.49.040, and 48.49.160 do not apply to ground ambulance services or  
7 ground ambulance services organizations.

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

10 (1) Each local governmental entity that has established or  
11 contracted for rates for ground ambulance services provided in their  
12 geographic service area must submit the rates to the office of the  
13 insurance commissioner, in the form and manner prescribed by the  
14 commissioner for purposes of section 8 of this act. Rates established  
15 for ground ambulance transports include rates for services provided  
16 directly by the local governmental entity and rates for ground  
17 ambulance services provided by private ground ambulance services  
18 organizations under contract with the local governmental entity.

19 (2) The commissioner shall establish and maintain, directly or  
20 through the lead organization for administrative simplification  
21 designated under RCW 48.165.030, a publicly accessible database for  
22 the rates. A carrier may rely in good faith on the rates shown on the  
23 website. Local governmental entities are solely responsible for  
24 submitting any updates to their rates to the commissioner or the lead  
25 organization for administrative simplification, as directed by the  
26 commissioner.

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

29 (1) The commissioner must undertake a process to review the  
30 reasonableness of the percentage of the medicare rate established in  
31 section 8 of this act and any trends in changes to ground ambulance  
32 services rates set by local governmental entities and ground  
33 ambulance services organizations' billed charges. In conducting the  
34 review, the commissioner should consider the relationship of the  
35 rates to the cost of providing ground ambulance services and any  
36 impacts on health plan enrollees that may result from health plans  
37 increasing in-network consumer cost-sharing for ground ambulance  
38 services due to increased rates paid for these services by carriers.

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

3 (a) October 1, 2026; or

4 (b) October 1st following any:

5 (i) Significant trend of increasing rates for ground ambulance  
6 services established or contracted for by local governmental  
7 entities, increasing billed charges by ground ambulance services  
8 organizations, or increasing consumer cost-sharing for ground  
9 ambulance services;

10 (ii) Significant reduction in access to ground ambulance services  
11 in Washington state, including in rural or frontier communities; or

12 (iii) Update in medicare ground ambulance services payment rates  
13 by the federal centers for medicare and medicaid services.

14 (3) The report submitted to the legislature under subsection  
15 (2)(a) of this section must include:

16 (a) Health carrier spending on ground ambulance transports for  
17 fully insured health plans and for public and school employee  
18 programs administered under chapter 41.05 RCW during plan years 2024  
19 and 2025;

20 (b) Individual and small group health plan premium trends and  
21 cost-sharing trends for ground ambulance services for plan years 2024  
22 and 2025;

23 (c) Trends in coverage of ground ambulance services for fully  
24 insured health plans and for public and school employee programs  
25 administered under chapter 41.05 RCW for plan years 2024 and 2025;

26 (d) A description of current emergency medical services training,  
27 equipment, and personnel standards for emergency medical services  
28 licensure; and

29 (e) A description of emergency medical services interfacility  
30 transport capabilities in Washington state.

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

33 If the insurance commissioner reports to the department that they  
34 have cause to believe that a ground ambulance services organization  
35 has engaged in a pattern of violations of section 8 of this act, and  
36 the report is substantiated after investigation, the department may  
37 levy a fine upon the ground ambulance services organization in an  
38 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) 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 (2) The institute shall consider the following elements in  
19 conducting the study:

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

26 (c) Examination of geographic disparities in emergency medical  
27 services access and average response times, including identification  
28 of geographic areas in Washington state without access to emergency  
29 medical services within an average 25-minute response time;

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

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

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

36 (3) In conducting the study, the institute shall consult with  
37 emergency medical services organizations, local governmental  
38 entities, hospitals, labor organizations representing emergency  
39 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 (4) 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 NEW SECTION. **Sec. 15.** RCW 48.49.190 (Reports to legislature)  
7 and 2022 c 263 s 21 are each repealed.

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