WEST VIRGINIA LEGISLATURE

2025 REGULAR SESSION

Introduced

House Bill 3470

By Delegate Jennings

[Introduced March 17, 2025; referred to the

Committee on Finance]

A BILL to amend the Code of West Virginia, 1931, as amended, by adding five new sections, designated §33-15-24, §33-16-20, §33-24-46, §33-25-23, and §33-25A-37, relating to surprise billing of out-of-network ambulance services; clarifying what is considered full payment to an ambulance service, what the rate of payment is, and the most an ambulance service can be paid; prohibiting billing and insured for additional costs except for fees the insurer required the insured to pay; providing procedure for payment; providing exceptions when the insurer does not have to pay within 30 days; and requiring written notices for denied claims.

Be it enacted by the Legislature of West Virginia:

ARTICLE 15. ACCIDENT AND SICKNESS INSURANCE.

§33-15-24. Prohibiting surprise billing of ground emergency medical services by nonparticipating providers.

(a) For a health insurance policy issued by an insurer on or after January 1, 2026:

(1) Payment by an insurer to a nonparticipating emergency medical services agency for covered ambulance services provided under the provisions of §16-4C-1 *et seq*. of this code, excluding air ambulance services as defined in §16-4C-3(a) of this code, to a covered enrollee in accordance with subsection (2) of this section:

(A) Shall be considered payment in full for the ambulance service provided, except for any copayment, coinsurance, deductible, and other cost sharing amounts that the insurer requires the covered enrollee to pay; and

(B) The nonparticipating emergency medical services agency is prohibited from billing the covered individual for any additional amount for the ambulance service provided, except for any copayment, coinsurance, deductible, and other cost sharing amounts that the insurer requires the covered enrolled to pay.

(2) The insurer shall provide direct payment to a non-participating emergency medical services agency for covered ground ambulance services provided to a covered individual:

(A) At the rate of 400% of the current published rate for ambulance service as established by the Centers for Medicare and Medicaid Services under Title XVIII of the federal Social Security Act (42 U.S.C. 1395 *et seq*.) for the same ambulance service provided in the same geographic area; or

(B) According to the nonparticipating emergency medical service agency's billed charges; whichever is less.

(3) The copayment, coinsurance, deductible, and other cost sharing amounts that an insurer requires a covered individual to pay in connection with ground ambulance services provided to the covered individual by a nonparticipating emergency medical services agency shall not exceed the copayment, coinsurance, deductible, and other cost sharing amounts that the covered individual would be required to pay if the ambulance service had been provided to the covered individual by a participating emergency medical services agency.

(4) If an insurer that receives a clean claim for ground ambulance services provided to a covered individual by a nonparticipating emergency medical services agency the insurer shall remit payment for the ambulance services directly to the nonparticipating emergency medical services agency not more than 30 days after receiving a clean claim and shall not send payment to the covered individual.

(5) An insurer shall either pay or deny a clean claim for ground ambulance services provided to a covered individual by a nonparticipating emergency medical services agency within 30 days of receipt of the claim, except in the following circumstances:

(A) Another payor or party is responsible for the claim;

(B) The insurer is coordinating benefits with another payor;

(C) The provider has already been paid for the claim;

(D) The claim was submitted fraudulently; or

(E) There was a material misrepresentation in the claim.

(6) If an insurer denies a claim for ground ambulance services provided to a covered

individual by a nonparticipating emergency medical services agency, the insurer shall provide written notice that:

(A) Acknowledges the date of the receipt of the claim; and

(B) States that the insurer is declining to pay all or part of the claim and sets forth the specific reason or reasons for declining to pay the claim in full; or

(C) States that additional information is needed to determine whether all or part of the claim is payable and specifically describes the additional information that is needed.

ARTICLE 16. GROUP ACCIDENT AND SICKNESS INSURANCE.

§33-16-20. Prohibiting surprise billing of ground emergency medical services by nonparticipating providers.

(a) For a health insurance policy issued by an insurer on or after January 1, 2026:

(1) Payment by an insurer to a nonparticipating emergency medical services agency for covered ambulance services provided under the provisions of §16-4C-1 *et seq*. of this code, excluding air ambulance services as defined in §16-4C-3(a) of this code, to a covered enrollee in accordance with subsection (2) of this section:

(A) Shall be considered payment in full for the ambulance service provided, except for any copayment, coinsurance, deductible, and other cost sharing amounts that the insurer requires the covered enrollee to pay; and

(B) The nonparticipating emergency medical services agency is prohibited from billing the covered individual for any additional amount for the ambulance service provided, except for any copayment, coinsurance, deductible, and other cost sharing amounts that the insurer requires the covered enrolled to pay.

(2) The insurer shall provide direct payment to a non-participating emergency medical services agency for covered ground ambulance services provided to a covered individual:

(A) At the rate of 400% of the current published rate for ambulance service as established by the Centers for Medicare and Medicaid Services under Title XVIII of the federal Social Security

Act (42 U.S.C. 1395 *et seq*.) for the same ambulance service provided in the same geographic area; or

(B) According to the nonparticipating emergency medical service agency's billed charges; whichever is less.

(3) The copayment, coinsurance, deductible, and other cost sharing amounts that an insurer requires a covered individual to pay in connection with ground ambulance services provided to the covered individual by a nonparticipating emergency medical services agency shall not exceed the copayment, coinsurance, deductible, and other cost sharing amounts that the covered individual would be required to pay if the ambulance service had been provided to the covered individual by a participating emergency medical services agency.

(4) If an insurer that receives a clean claim for ground ambulance services provided to a covered individual by a nonparticipating emergency medical services agency the insurer shall remit payment for the ambulance services directly to the nonparticipating emergency medical services agency not more than 30 days after receiving a clean claim and shall not send payment to the covered individual.

(5) An insurer shall either pay or deny a clean claim for ground ambulance services provided to a covered individual by a nonparticipating emergency medical services agency within 30 days of receipt of the claim, except in the following circumstances:

(A) Another payor or party is responsible for the claim;

(B) The insurer is coordinating benefits with another payor;

(C) The provider has already been paid for the claim;

(D) The claim was submitted fraudulently; or

(E) There was a material misrepresentation in the claim.

(6) If an insurer denies a claim for ground ambulance services provided to a covered individual by a nonparticipating emergency medical services agency, the insurer shall provide written notice that:

(A) Acknowledges the date of the receipt of the claim; and

(B) States that the insurer is declining to pay all or part of the claim and sets forth the specific reason or reasons for declining to pay the claim in full; or

(C) States that additional information is needed to determine whether all or part of the claim is payable and specifically describes the additional information that is needed.

ARTICLE 24. HOSPITAL SERVICE CORPORATIONS, MEDICAL SERVICE CORPORATIONS, DENTAL SERVICE CORPORATIONS AND HEALTH SERVICE CORPORATIONS.

§33-24-46. Prohibiting surprise billing of ground emergency medical services by nonparticipating providers.

(a) For a health insurance policy issued by an insurer on or after January 1, 2026:

(1) Payment by an insurer to a nonparticipating emergency medical services agency for covered ambulance services provided under the provisions of §16-4C-1 *et seq*. of this code, excluding air ambulance services as defined in §16-4C-3(a) of this code, to a covered enrollee in accordance with subsection (2) of this section:

(A) Shall be considered payment in full for the ambulance service provided, except for any copayment, coinsurance, deductible, and other cost sharing amounts that the insurer requires the covered enrollee to pay; and

(B) The nonparticipating emergency medical services agency is prohibited from billing the covered individual for any additional amount for the ambulance service provided, except for any copayment, coinsurance, deductible, and other cost sharing amounts that the insurer requires the covered enrolled to pay.

(2) The insurer shall provide direct payment to a non-participating emergency medical services agency for covered ground ambulance services provided to a covered individual:

(A) At the rate of 400% of the current published rate for ambulance service as established

by the Centers for Medicare and Medicaid Services under Title XVIII of the federal Social Security Act (42 U.S.C. 1395 *et seq*.) for the same ambulance service provided in the same geographic area; or

(B) According to the nonparticipating emergency medical service agency's billed charges; whichever is less.

(3) The copayment, coinsurance, deductible, and other cost sharing amounts that an insurer requires a covered individual to pay in connection with ground ambulance services provided to the covered individual by a nonparticipating emergency medical services agency shall not exceed the copayment, coinsurance, deductible, and other cost sharing amounts that the covered individual would be required to pay if the ambulance service had been provided to the covered individual by a participating emergency medical services agency.

(4) If an insurer that receives a clean claim for ground ambulance services provided to a covered individual by a nonparticipating emergency medical services agency the insurer shall remit payment for the ambulance services directly to the nonparticipating emergency medical services agency not more than 30 days after receiving a clean claim and shall not send payment to the covered individual.

(5) An insurer shall either pay or deny a clean claim for ground ambulance services provided to a covered individual by a nonparticipating emergency medical services agency within 30 days of receipt of the claim, except in the following circumstances:

(A) Another payor or party is responsible for the claim;

(B) The insurer is coordinating benefits with another payor;

(C) The provider has already been paid for the claim;

(D) The claim was submitted fraudulently; or

(E) There was a material misrepresentation in the claim.

(6) If an insurer denies a claim for ground ambulance services provided to a covered individual by a nonparticipating emergency medical services agency, the insurer shall provide

written notice that:

(A) Acknowledges the date of the receipt of the claim; and

(B) States that the insurer is declining to pay all or part of the claim and sets forth the specific reason or reasons for declining to pay the claim in full; or

(C) States that additional information is needed to determine whether all or part of the claim is payable and specifically describes the additional information that is needed.

ARTICLE 25. HEALTH CARE CORPORATIONS.

§33-25-23. Prohibiting surprise billing of ground emergency medical services by nonparticipating providers.

For a health insurance policy issued by an insurer on or after January 1, 2026:

(1) Payment by an insurer to a nonparticipating emergency medical services agency for covered ambulance services provided under the provisions of §16-4C-1 *et seq*. of this code, excluding air ambulance services as defined in §16-4C-3(a) of this code, to a covered enrollee in accordance with subsection (2) of this section:

(A) Shall be considered payment in full for the ambulance service provided, except for any copayment, coinsurance, deductible, and other cost sharing amounts that the insurer requires the covered enrollee to pay; and

(B) The nonparticipating emergency medical services agency is prohibited from billing the covered individual for any additional amount for the ambulance service provided, except for any copayment, coinsurance, deductible, and other cost sharing amounts that the insurer requires the covered enrolled to pay.

(2) The insurer shall provide direct payment to a non-participating emergency medical services agency for covered ground ambulance services provided to a covered individual:

(A) At the rate of 400% of the current published rate for ambulance service as established by the Centers for Medicare and Medicaid Services under Title XVIII of the federal Social Security Act (42 U.S.C. 1395 *et seq*.) for the same ambulance service provided in the same geographic

area; or

(B) According to the nonparticipating emergency medical service agency's billed charges; whichever is less.

(3) The copayment, coinsurance, deductible, and other cost sharing amounts that an insurer requires a covered individual to pay in connection with ground ambulance services provided to the covered individual by a nonparticipating emergency medical services agency shall not exceed the copayment, coinsurance, deductible, and other cost sharing amounts that the covered individual would be required to pay if the ambulance service had been provided to the covered individual by a participating emergency medical services agency.

(4) If an insurer that receives a clean claim for ground ambulance services provided to a covered individual by a nonparticipating emergency medical services agency the insurer shall remit payment for the ambulance services directly to the nonparticipating emergency medical services agency not more than 30 days after receiving a clean claim and shall not send payment to the covered individual.

(5) An insurer shall either pay or deny a clean claim for ground ambulance services provided to a covered individual by a nonparticipating emergency medical services agency within 30 days of receipt of the claim, except in the following circumstances:

(A) Another payor or party is responsible for the claim;

(B) The insurer is coordinating benefits with another payor;

(C) The provider has already been paid for the claim;

(D) The claim was submitted fraudulently; or

(E) There was a material misrepresentation in the claim.

(6) If an insurer denies a claim for ground ambulance services provided to a covered individual by a nonparticipating emergency medical services agency, the insurer shall provide written notice that:

(A) Acknowledges the date of the receipt of the claim; and

(B) States that the insurer is declining to pay all or part of the claim and sets forth the specific reason or reasons for declining to pay the claim in full; or

(C) States that additional information is needed to determine whether all or part of the claim is payable and specifically describes the additional information that is needed.

ARTICLE 25A. HEALTH MAINTENANCE ORGANIZATION ACT.

§33-25A-37. Prohibiting surprise billing of ground emergency medical services by nonparticipating providers.

For a health insurance policy issued by an insurer on or after January 1, 2026:

(1) Payment by an insurer to a nonparticipating emergency medical services agency for covered ambulance services provided under the provisions of §16-4C-1 *et seq*. of this code, excluding air ambulance services as defined in §16-4C-3(a) of this code, to a covered enrollee in accordance with subsection (2) of this section:

(A) Shall be considered payment in full for the ambulance service provided, except for any copayment, coinsurance, deductible, and other cost sharing amounts that the insurer requires the covered enrollee to pay; and

(B) The nonparticipating emergency medical services agency is prohibited from billing the covered individual for any additional amount for the ambulance service provided, except for any copayment, coinsurance, deductible, and other cost sharing amounts that the insurer requires the covered enrolled to pay.

(2) The insurer shall provide direct payment to a non-participating emergency medical services agency for covered ground ambulance services provided to a covered individual:

(A) At the rate of 400% of the current published rate for ambulance service as established by the Centers for Medicare and Medicaid Services under Title XVIII of the federal Social Security Act (42 U.S.C. 1395 *et seq*.) for the same ambulance service provided in the same geographic area; or

(B) According to the nonparticipating emergency medical service agency's billed charges;

whichever is less.

(3) The copayment, coinsurance, deductible, and other cost sharing amounts that an insurer requires a covered individual to pay in connection with ground ambulance services provided to the covered individual by a nonparticipating emergency medical services agency shall not exceed the copayment, coinsurance, deductible, and other cost sharing amounts that the covered individual would be required to pay if the ambulance service had been provided to the covered individual by a participating emergency medical services agency.

(4) If an insurer that receives a clean claim for ground ambulance services provided to a covered individual by a nonparticipating emergency medical services agency the insurer shall remit payment for the ambulance services directly to the nonparticipating emergency medical services agency not more than 30 days after receiving a clean claim and shall not send payment to the covered individual.

(5) An insurer shall either pay or deny a clean claim for ground ambulance services provided to a covered individual by a nonparticipating emergency medical services agency within 30 days of receipt of the claim, except in the following circumstances:

(A) Another payor or party is responsible for the claim;

(B) The insurer is coordinating benefits with another payor;

(C) The provider has already been paid for the claim;

(D) The claim was submitted fraudulently; or

(E) There was a material misrepresentation in the claim.

(6) If an insurer denies a claim for ground ambulance services provided to a covered individual by a nonparticipating emergency medical services agency, the insurer shall provide written notice that:

(A) Acknowledges the date of the receipt of the claim; and

(B) States that the insurer is declining to pay all or part of the claim and sets forth the specific reason or reasons for declining to pay the claim in full; or

(C) States that additional information is needed to determine whether all or part of the claim is payable and specifically describes the additional information that is needed.

NOTE: The purpose of this bill is to prohibit out-of-network emergency medical services agencies from balance billing a covered enrollee in a health insurance plan for ground ambulance services. The bill establishes the minimum payment to be made by an insurer to an out-of-network emergency medical services agency for ambulance services. The bill requires payment by the insurer directly to the out-of-network emergency medical services agency and the prompt payment of clean claims.

Strike-throughs indicate language that would be stricken from a heading or the present law and underscoring indicates new language that would be added.