

WEST VIRGINIA LEGISLATURE

2026 REGULAR SESSION

Introduced

Senate Bill 645

By Senator Deeds

[Introduced January 28, 2026; referred
to the Committee on Health and Human Resources]

1 A BILL to amend the Code of West Virginia, 1931, as amended, by adding five new sections,
2 designated §33-15-24, §33-16-20, §33-24-46, §33-25-23, and §33-25A-37, relating to
3 surprise billing of out-of-network ambulance services; clarifying what is considered full
4 payment to an ambulance service, what the rate of payment is, and the most an
5 ambulance service can be paid; prohibiting the billing of an insured for additional costs
6 except for fees the insurer required the insured to pay; providing procedure for payment;
7 providing exceptions when the insurer does not have to pay within 30 days; and requiring
8 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.

1 For a health insurance policy issued by an insurer on or after January 1, 2027:

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

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

9 (B) The non-participating emergency medical services agency is prohibited from billing the
10 covered individual for any additional amount for the ambulance services provided, except for any
11 copayment, coinsurance, deductible, and other cost-sharing amounts that the insurer requires the
12 covered enrollee to pay.

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

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

19 (B) According to the non-participating emergency medical services agency's billed
20 charges, whichever is less.

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

27 (4) If an insurer receives a clean claim for ground ambulance services provided to a
28 covered individual by a non-participating emergency medical services agency, the insurer shall
29 remit payment for the ambulance services directly to the non-participating emergency medical
30 services agency not more than 30 days after receiving a clean claim and shall not send payment to
31 the covered individual.

32 (5) An insurer shall either pay or deny a clean claim for ground ambulance services
33 provided to a covered individual by a non-participating emergency medical services agency within
34 30 days of receipt of the claim, except in the following circumstances:

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

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

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

38 (D) The claim was submitted fraudulently; or

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

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

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

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

46 (C) States that additional information is needed to determine whether all or part of the claim
47 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 non-participating providers.

1 For a health insurance policy issued by an insurer on or after January 1, 2027:

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

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

9 (B) The non-participating emergency medical services agency is prohibited from billing the
10 covered individual for any additional amount for the ambulance services provided, except for any
11 copayment, coinsurance, deductible, and other cost-sharing amounts that the insurer requires the
12 covered enrollee to pay.

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

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

19 (B) According to the non-participating emergency medical service agency's billed charges,
20 whichever is less.

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

27 (4) If an insurer receives a clean claim for ground ambulance services provided to a
28 covered individual by a non-participating emergency medical services agency, the insurer shall
29 remit payment for the ambulance services directly to the non-participating emergency medical
30 services agency not more than 30 days after receiving a clean claim and shall not send payment to
31 the covered individual.

32 (5) An insurer shall either pay or deny a clean claim for ground ambulance services
33 provided to a covered individual by a non-participating emergency medical services agency within
34 30 days of receipt of the claim, except in the following circumstances:

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

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

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

38 (D) The claim was submitted fraudulently; or

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

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

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

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

46 (C) States that additional information is needed to determine whether all or part of the claim
47 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 non-
participating providers.

1 For a health insurance policy issued by an insurer on or after January 1, 2027:

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

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

9 (B) The non-participating emergency medical services agency is prohibited from billing the
10 covered individual for any additional amount for the ambulance services provided, except for any
11 copayment, coinsurance, deductible, and other cost-sharing amounts that the insurer requires the
12 covered enrollee 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 percent of the current published rate for ambulance services 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 services provided in the same geographic area; or

(B) According to the non-participating 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 non-participating 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 services had been provided to the covered individual by a participating emergency medical services agency.

(4) If an insurer receives a clean claim for ground ambulance services provided to a covered individual by a non-participating emergency medical services agency, the insurer shall remit payment for the ambulance services directly to the non-participating 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 non-participating 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 non-participating 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 non-participating providers.

For a health insurance policy issued by an insurer on or after January 1, 2027:

(1) Payment by an insurer to a non-participating 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 services provided, except for any copayment, coinsurance, deductible, and other cost-sharing amounts that the insurer requires the covered enrollee to pay; and

(B) The non-participating emergency medical services agency is prohibited from billing the covered individual for any additional amount for the ambulance services provided, except for any copayment, coinsurance, deductible, and other cost-sharing amounts that the insurer requires the covered enrollee 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:

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

19 (B) According to the non-participating emergency medical service agency's billed charges,
20 whichever is less.

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

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

32 (5) An insurer shall either pay or deny a clean claim for ground ambulance services
33 provided to a covered individual by a non-participating emergency medical services agency within
34 30 days of receipt of the claim, except in the following circumstances:

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

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

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

38 (D) The claim was submitted fraudulently; or

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

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

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

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

46 (C) States that additional information is needed to determine whether all or part of the claim
47 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 non-participating providers.

1 (a) For a health insurance policy issued by an insurer on or after January 1, 2027:

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

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

9 (B) The non-participating emergency medical services agency is prohibited from billing the
10 covered individual for any additional amount for the ambulance services provided, except for any
11 copayment, coinsurance, deductible, and other cost-sharing amounts that the insurer requires the
12 covered enrollee to pay.

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

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

19 (B) According to the non-participating emergency medical service agency's billed charges;
20 whichever is less.

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

27 (4) If an insurer receives a clean claim for ground ambulance services provided to a
28 covered individual by a non-participating emergency medical services agency, the insurer shall
29 remit payment for the ambulance services directly to the non-participating emergency medical
30 services agency not more than 30 days after receiving a clean claim and shall not send payment to
31 the covered individual.

32 (5) An insurer shall either pay or deny a clean claim for ground ambulance services
33 provided to a covered individual by a non-participating emergency medical services agency within
34 30 days of receipt of the claim, except in the following circumstances:

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

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

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

38 (D) The claim was submitted fraudulently; or

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

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

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

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

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

48 (b) This section shall not apply to insurers that have a contract with the Bureau for Medical
49 Services relating to Medicaid or CHIP.

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.