SB269

MSKB2WW-1

By Senator Singleton

RFD: Banking and Insurance

First Read: 05-Feb-26

SYNOPSIS:

This bill would regulate the provision of emergency ground ambulance services in the state by imposing requirements on reimbursement by health insurers for ambulance services.

This bill would prohibit surprise billing of insurance enrollees by providing that the reimbursement requirements be accepted as payment in full. A ground ambulance provider could directly charge an individual for no more than the in-network cost-sharing amount under an insurance contract.

This bill would require that both ground ambulance services and health care insurers submit reports on their operations, with financial information, to the Alabama Department of Public Health.

This bill would also require the Alabama Department of Public Health to retain an outside expert to study and report on the effects of this act on access to ground ambulance services in the state, with recommended measures to improve access.

This bill would be repealed on June 1, 2029.

A BILL

TO BE ENTITLED

AN ACT

Relating to health insurance; to set requirements on reimbursement rates by health care insurers for ground ambulance services; to provide that the established reimbursement rate is payment in full for ground ambulance services; to impose reporting requirements by emergency medical service providers that provide ground ambulance services and health care insurers to the Alabama Department of Public Health; to require the Alabama Department of Public Health to contract with a consultant to report on the effects of this act, with recommendations for improving access to emergency medical transport; and to provide for repeal of this act.

BE IT ENACTED BY THE LEGISLATURE OF ALABAMA:

Section 1. For the purposes of this act, the following words have the following meanings:

(1) CLEAN CLAIM. A clean electronic claim or a clean written claim.

(2) CLEAN ELECTRONIC CLAIM. As defined in Section 27-1-17, Code of Alabama 1975.

(3) CLEAN WRITTEN CLAIM. As defined in Section 27-1-17, Code of Alabama 1975.

(4) COLLECTION. Any written or oral communication made to an enrollee for the purpose of obtaining payment for the services rendered by an emergency medical service provider, including invoicing and legal debt collection efforts.

(5) COST-SHARING AMOUNT. The enrollee's deductible, coinsurance, copayment, or other amount due under a health care benefit plan for covered services.

(6) COVERED SERVICES or COVERED SERVICE. Transport or medical services provided by the ground ambulance of an emergency medical service provider which are covered by an enrollee's health care benefit plan, including emergency ground transport and treat in place.

(7) EMERGENCY GROUND TRANSPORT. a. When an enrollee is transported by an emergency medical service provider to a hospital or definitive care facility as defined in Section 22-18-1, Code of Alabama 1975, and which may include basic life support or advanced life support, in response to a medical condition described in paragraph b.

b. An event as defined by the Centers for Medicare and Medicaid Services (CMS) that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the patient's health in serious jeopardy;

2. Serious impairment to bodily functions; or

3. Serious dysfunction of any bodily organ or part.

(8) EMERGENCY MEDICAL SERVICE PROVIDER or PROVIDER. Any public or private organization that is licensed to provide emergency medical services as defined in Section 22-18-1, Code of Alabama 1975.

(9) ENROLLEE. An individual who is covered by a health

care benefit plan.

(10) HEALTH CARE BENEFIT PLAN. Any individual or group plan, policy, or contract issued, delivered, or renewed in this state by a health care insurer to provide, deliver, arrange for, pay for, or reimburse health care services, including those provided by an emergency medical service provider, except for payments for health care made under automobile or homeowners' insurance plan, accident-only plan, specified disease plan, long-term care plan, supplemental hospital or fixed indemnity plan, dental or vision plan, or Medicaid.

(11) HEALTH CARE INSURER. Any entity that issues or administers a health care benefit plan, including a health care insurer, a health care services plan incorporated under Chapter 20 of Title 10A, Code of Alabama 1975, a health maintenance organization established under Chapter 21A of Title 27, Code of Alabama 1975, or a nonprofit agricultural organization that offers health benefits to its membership pursuant to Chapter 33 of Title 2, Code of Alabama 1975.

(12) IN-NETWORK. When an emergency medical service provider is in a contract with a health care insurer to provide covered services in the health care insurer's provider network.

(13) OUT-OF-NETWORK. When an emergency medical service provider does not have a contract with a health care insurer to provide covered services in the health care insurer's provider network.

(14) TREAT IN PLACE. An emergency response event in

which an emergency medical service provider assesses an enrollee or Medicaid recipient and renders basic life support at his or her location without emergency ground transport.

Section 2. (a)(1) A health care insurer shall contract with any willing emergency medical service provider to provide covered services in the health care insurer's provider network under terms extended to comparable providers that are in-network.

(2) An in-network provider shall meet licensing requirements provided by law.

(b)(1) Beginning October 1, 2026, the minimum reimbursement from a health insurer to an emergency medical service provider that is in-network for emergency ground transport shall be 200 percent of the Medicare Ambulance Fee Schedule rate as published by the Centers for Medicare & Medicaid Services (CMS).

(2)a. Beginning October 1, 2026, the minimum reimbursement from a health insurer to an emergency medical service provider that is in-network for treat in place shall be 200 percent of the Medicare Ambulance Fee Schedule rate for basic life support as published by CMS which is in effect on January 1, 2027.

b. Submission of a claim for reimbursement for treat in place is prohibited if the emergency medical service provider has submitted a claim for emergency ground transport for the same event or occurrence.

(c) Beginning January 1, 2027, the minimum reimbursement amount from a health care insurer to an

emergency medical service provider that is out-of-network for covered services shall be 180 percent of the Medicare Ambulance Fee Schedule rate as published by CMS.

(d)(1) For purposes of this section, the Medicare Ambulance Fee Schedule rate shall be the rate applicable to zip code 35462, including the applicable Medicare base rate and mileage components.

(2) The reimbursement rate established under this section shall be applied uniformly on a statewide basis, without regard to the geographic locality, population density, or zip code in which the ground ambulance service is furnished.

Section 3. (a)(1) Payment in accordance with Section 2 shall be payment in full for covered services.

(2) An emergency medical service provider, whether in-network or out-of-network, including the provider's agent, contractor, or assignee, may not bill or seek collection of any amount from an enrollee except for the enrollee's in-network cost-sharing amount.

(3) The health care insurer shall certify an enrollee's in-network cost-sharing amount to an out-of-network provider upon request.

(b)(1) Not later than 30 days after receipt of a clean electronic claim, or not later than 45 days after receipt of a clean written claim, a health care insurer shall remit payment to an out-of-network emergency medical service provider and shall not send payment to an enrollee.

(2) If a claim for reimbursement submitted by an

emergency medical service provider to a health care insurer is not a clean claim, not later than 30 days after receiving the claim, the health care insurer shall send the provider a written receipt acknowledging the claim, accompanied with one of the following applicable statements:

a. The insurer is declining to pay all or a part of the claim, with the specific reason for the denial.

b. Additional information is necessary to determine if the claim is payable, with the specific additional information that is required.

(3) In no event shall a health care insurer require the provider to submit either of the following as a condition to the acceptance and processing of an initial claim as a clean claim:

a. Data elements in excess of those required on the standard electronic health insurance claim format designated by Section 27-1-16, Code of Alabama 1975.

b. Information or data elements in excess of those required on the standard health insurance claim form designated by Section 27-1-16, Code of Alabama 1975.

(4) Any dispute between a health care insurer and an emergency medical service provider over the amount to be paid, or over full or partial denial of a claim, may be settled by one of the following means:

a. Affording the provider access to the insurer's internal forum for resolving provider disputes concerning coverage and reimbursement amounts.

b. Selecting an independent dispute resolution

contractor mutually agreeable to the insurer and the provider.

Section 4. (a) Beginning in the year 2028, and in each year thereafter, an emergency medical service provider shall submit to the Alabama Department of Public Health a report that includes, but is not limited to, the following information for the preceding calendar year:

(1) The number and type of emergency medical service vehicles that are in service.

(2) The number of employees, both full-time and part-time, classified by position or emergency medical service provider license classification.

(3) The total number of ground ambulance transports rendered.

(4) The average response time for collecting and transporting a patient to a definitive care facility.

(5) The gross income received by the emergency medical service provider in the State of Alabama and the net profit.

(6) If the emergency medical service provider distributes ownership shares to the public, the number and amount of dividends issued.

(7) For the calendar year 2027, the amount of receipts collected by the emergency medical service provider that are remitted to a parent entity, both before and after implementation of any change in payment or reimbursement by a health care insurer.

(8) For the calendar year 2027, the amount paid or reimbursed to an emergency medical service provider by health care insurers, presented on a monthly or quarterly basis.

(b)(1) Beginning in the year 2027, a health care insurer shall submit to the Alabama Department of Public Health a report on claims for reimbursement submitted by emergency medical service providers which presents, for each of the three calendar years preceding January 1, 2027:

a. The number of denied claims;

b. The aggregate dollar value of denied claims;

c. The percentage of denied claims to approved claims;

d. The applicable out-of-pocket charge under each health care benefit plan issued by the health care insurer on an approved claim for covered services; and

e. The total amount paid on claims for covered services, including in comparison to the total amount paid out on all claims for health care services.

(2) Beginning in the year 2028, and in each year thereafter, a health care insurer shall submit to the Alabama Department of Public Health a report that includes, but may not be limited to, each item of information required under subdivision (1) for the preceding calendar year.

(c) The financial information required for submission under subsections (a) and (b) shall be confidential and may not be made public by the Alabama Department of Public Health or any contractor of the department.

(d) The Alabama Department of Public Health shall adopt rules to implement this section, and may prescribe reporting periods, deadlines, or formatting of information to be reported, and may require an emergency medical service provider or health care insurer to submit operational and

financial data or information in addition to the information required under subsections (a) and (b).

Section 5. (a) The Alabama Department of Public Health shall contract with a consultant with expertise in health care delivery and health care financing to study the impact of Sections 1 through 4 on the provision of emergency medical services.

(b) The consultant shall produce a report on the findings, which shall not exceed fifty thousand dollars ($50,000) in cost, the cost to be borne by the three largest health care insurers as measured by the number of enrollees in the state, and which also offer individual health care benefit plans on the Health Insurance Marketplace.

(c) In addition to findings on the impact of Sections 1 through 4 on the provision of emergency medical services, the report shall include, but not be limited to, the following:

(1) Measures taken by other states on the provision of emergency medical services and the effectiveness of those measures.

(2) Recommendations of measures that would balance the goals of ensuring adequate access to emergency medical services with the cost burden of such measures on the state, its employers, and residents.

(d) The report shall be submitted to the President Pro Tempore of the Senate and the Speaker of the House of Representatives no later than December 1, 2028.

Section 6. Sections 1 through 5 are repealed on June 1, 2029.

Section 7. Sections 10A-20-6.16 and 27-21A-23, Code of Alabama 1975, are amended to read as follows:

"§10A-20-6.16

(a) No statute of this state applying to insurance companies shall be applicable to any corporation organized under this article and amendments thereto or to any contract made by the corporation; except the corporation shall be subject to the following:

(1) The provisions regarding annual premium tax to be paid by insurers on insurance premiums.

(2) Chapter 55 of Title 27.

(3) Article 2 and Article 3 of Chapter 19 of Title 27.

(4) Section 27-1-17.

(5) Chapter 56 of Title 27.

(6) Rules adopted by the Commissioner of Insurance pursuant to Sections 27-7-43 and 27-7-44.

(7) Chapter 54 of Title 27.

(8) Chapter 57 of Title 27.

(9) Chapter 58 of Title 27.

(10) Chapter 59 of Title 27.

(11) Chapter 54A of Title 27.

(12) Chapter 12A of Title 27.

(13) Chapter 2B of Title 27.

(14) Chapter 29 of Title 27.

(15) Chapter 62 of Title 27.

(16) Chapter 63 of Title 27.

(17) Chapter 45A of Title 27.

(18) Sections 1 through 5.

(b) The provisions in subsection (a) that require specific types of coverage to be offered or provided shall not apply when the corporation is administering a self-funded benefit plan or similar plan, fund, or program that it does not insure."

"§27-21A-23

(a) Except as otherwise provided in this chapter, provisions of the insurance law and provisions of health care service plan laws shall not be applicable to any health maintenance organization granted a certificate of authority under this chapter. This provision shall not apply to an insurer or health care service plan licensed and regulated pursuant to the insurance law or the health care service plan laws of this state except with respect to its health maintenance organization activities authorized and regulated pursuant to this chapter.

(b) Solicitation of enrollees by a health maintenance organization granted a certificate of authority shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals.

(c) Any health maintenance organization authorized under this chapter shall not be deemed to be practicing medicine and shall be exempt from the provisions of Section 34-24-310, et seq., relating to the practice of medicine.

(d) No person participating in the arrangements of a health maintenance organization other than the actual provider of health care services or supplies directly to enrollees and their families shall be liable for negligence, misfeasance,

nonfeasance, or malpractice in connection with the furnishing of such services and supplies.

(e) Nothing in this chapter shall be construed in any way to repeal or conflict with any provision of the certificate of need law.

(f) Notwithstanding the provisions of subsection (a), a health maintenance organization shall be subject to all of the following:

(1) Section 27-1-17.

(2) Chapter 56.

(3) Chapter 54.

(4) Chapter 57.

(5) Chapter 58.

(6) Chapter 59.

(7) Rules adopted by the Commissioner of Insurance pursuant to Sections 27-7-43 and 27-7-44.

(8) Chapter 12A.

(9) Chapter 54A.

(10) Chapter 2B.

(11) Chapter 29.

(12) Chapter 62.

(13) Chapter 63.

(14) Chapter 45A

(15) Sections 1 through 5."

Section 8. This act shall become effective on October 1, 2026.