SB51

3P5JQZZ-2

By Senators Singleton, Coleman, Coleman-Madison, Stewart

RFD: Banking and Insurance

First Read: 04-Feb-25

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 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. The transmission of data for purposes of payment of covered health care expenses that is submitted to a health care insurer which contains substantially all of the required data elements necessary for accurate adjudication, without obtaining additional

information from the provider of the service or from a third party, in an electronic data format specified by the health care insurer.

(3) CLEAN WRITTEN CLAIM. A claim for payment of covered health care expenses that is submitted to a health care insurer, on the claim form of the health care insurer which contains substantially all of the required data elements necessary for accurate adjudication, without obtaining additional information from the provider of the service or from a third party.

(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 and medical services provided by the ground ambulance of an emergency medical service provider which are covered by an enrollee's health care benefit plan.

(7) 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.

(8) ENROLLEE. An individual who is covered by a health care benefit plan.

(9) 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 plans, accident-only plans, specified disease plans, long-term care plans, supplemental hospital or fixed indemnity plans, dental and vision plans, or Medicaid.

(10) 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.

(11) 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.

(12) 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.

Section 2. (a) A health care insurer shall contract with any willing emergency medical service provider to provide services if the provider is willing to accept the payments and terms offered comparable providers that are in-network. An

in-network provider shall meet licensing requirements provided by law.

(b) The minimum reimbursement from a health insurer to an emergency medical service provider that is in-network for covered services shall be the greater of: (i) the amount contracted between the health insurer and the emergency medical service provider; or (ii) 200 percent of the Medicare rate that is in effect on January 1, 2025, for the geographic area in which the covered service is provided as published by the Centers for Medicare and Medicaid Services.

(c) 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 the lesser of: (i) the emergency medical service provider's billed charge or (ii) 180 percent of the Medicare rate that is in effect on January 1, 2025, for the geographic area in which the covered service is provided, as published by the Centers for Medicare and Medicaid Services.

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 which is in excess of the minimum reimbursement amount as provided in Section 2, 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) Within 30 days after receipt of a clean electronic claim, or within 45 days of 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, within 30 days 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 and the specific reason for the denial.

b. Additional information is necessary to determine if the claim is payable and 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.

Section 4. (a) An emergency medical service provider

shall annually submit to the Alabama Department of Public Health a report that includes, but is not limited to, the following information for the preceding 12-month reporting period:

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

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

(3) The total of ground ambulance transports rendered.

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

(5) The gross income received 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 year of implementation of this act, the amount of receipts collected by the emergency medical services 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 year of implementation of this act, the amount paid or reimbursed to an emergency medical service provider by health care insurers, presented on a monthly or quarterly basis.

(b) The Alabama Department of Public Health shall adopt rules to implement this section, may prescribe reporting

periods, deadlines, and formatting of information to be reported, and may require an emergency medical service provider to submit operational and financial data or information in addition to the information required under subsection (a).

(c) The financial information required under subdivisions (a)(5) through (8) shall be confidential and may not be made public by the Alabama Department of Public Health or any contractor of the department.

Section 5. (a) The Alabama Department of Public Health shall contract with an consultant with expertise in health care delivery and health care financing to study the impact of this act 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 of Alabama, and which also offer individual health care benefit plans on the Health Insurance Marketplace.

(c) In addition to findings on the impact of this act 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 effects.

(2) Recommend measures that would balance the goals of ensuring adequate access to emergency medical services with the cost burden of such measures on the State of Alabama, 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 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 2 and 3 of this act.

(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 2 and 3 of this act."

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 2 and 3 of this act.~~

(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 2 and 3 of this act.~~"

Section 8. Sections 1 through 6 shall be repealed on June 1, 2029.

Section 9. This act shall become effective on January 1, 2026, except Section 7 shall become effective on June 1, 2029.

Senate

Read for the first time and referred 04-Feb-25
to the Senate committee on Banking
and Insurance

Read for the second time and placed 09-Apr-25
on the calendar:
0 amendments

Read for the third time and passed 24-Apr-25
as amended
Yeas 29
Nays 0
Abstains 0

Patrick Harris,
Secretary.