PacificSource
HEALTH PLANS

August 15, 2025

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Delivered via email: lisa.emerson@dcbs.oregon.gov

Re: Comment on Proposed Ground Ambulance Balance Billing Rules

Dear Lisa:

The PacificSource companies are independent, not-for-profit health insurance providers based in Oregon. We serve over 600,000 commercial, Medicaid, and Medicare Advantage members in three states. PacificSource Community Solutions is the contracted coordinated care organization (CCO) in Central Oregon, the Columbia River Gorge, Marion & Polk Counties, and Lane County. Our mission is to provide better health, better care, and better value to the people and communities we serve.

We write to provide comments on the proposed rules interpreting provisions of 2025 House Bill 3243 (Act), relating to ground ambulance balance billing. Below, we have organized our comments by proposed rule title.

- **OAR 836-053-XXXX, Purpose and Statutory Authority.** In the sense that this provision will help readers locate the new provisions within an already voluminous chapter 836, division 53, this rule makes sense.
- **OAR 836-053-XXXX, Definitions.** Given our understanding that the definitions will appear exactly as described in the underlying Act, we do not have any substantive comments.
- **836-053-XXXX, Balance Billing Prohibition and Consumer Cost Sharing for Ground Ambulance Services.** We question the need for this rule, for the following reasons:
    - The proposed section (1) appears to mirror the Act, so we do not have any comments other than we believe it is unnecessary to copy statute into administrative rule.
    - We do believe that the proposed subsection (a) is unnecessary. As stated later, the allowed amount is already determined by the underlying Act, and the laws governing explanation of benefits still govern how health plans inform members of cost sharing.

- Similarly, we do not believe that subsection (b) is necessary. The underlying Act clearly prohibits ground ambulance service providers from balance billing a member, regardless of their network status. We also remain concerned about how this proposed rule may subject our members to potentially unlawful debt collection practices. At the very least, a consultation with the Department of Justice and a modifier that the ground ambulance service provider remains subject to state and federal law governing debt collection practices is warranted.
- Proposed section (2) infers from the Act that because a member may not be billed if they pay the in-network cost sharing amounts, health plans must also treat the cost sharing amounts as if the provider was in-network. We have deep concerns about this decision as a matter of statutory interpretation and as a policy matter.

  Starting with the text of the Act, there are no provisions specifically requiring health plans to treat ambulance providers as in network. When the Assembly debated this Act earlier this year, no one suggested that this Act created a contractual relationship between health plan and ground ambulance provider. Indeed, PacificSource testified in committee that under the Act there not be "any meaningful incentive to contract with payers."[1]

  This bill instead creates a substitutionary reimbursement methodology in the absence of a network contract. While there are good reasons for health plans to voluntarily not bill members at out of network rates, the department's interpretation goes well beyond what the text and the legislative history support.
- As stated in the advisory committee meeting, we do believe that aligning any refund mechanisms with timelines established for similar purposes on health plans makes sense even if that timeline is longer than 30 days. The larger issue is that given how clear the Assembly was about the reimbursement methodology we do not believe that amounts exceeding in network cost sharing should even be collected at all.

- **836-053-XXXX, Payments to Out-Of-Network Ground Ambulance Service Organizations.** Unfortunately, we believe this rule is problematic for a number of reasons detailed below:
  - We contend that the Act does not give the department discretion to decide on alternative reimbursement. The Act made clear that health plans may only reimburse ground ambulance services in two ways: either through paying an established local rate, or 325% of Medicare. Nothing in the text of the Act allows the department to adjust that rate to keep up with inflation or changes in the rates published by the federal government.

    Established local rates, in turn, are those rates that are developed through a publicly available process and include an analysis of costs to provide the services either by the local government entity itself or by a contracted provider working on behalf of the local government entity. In other words, however the local government delivers ground ambulance services, they must analyze the costs of the service in a manner that apprises the public about the decision.

    The proposed rule purports to set up a tiered reimbursement system where health plans reimburse either at the rate established by the local government, the contracted rate between the local government and the ground ambulance provider, or the "current published" rate established by the Centers for Medicare and Medicaid Services.

[1] https://olis.oregonlegislature.gov/liz/2025R1/Downloads/PublicTestimonyDocument/137862

- Thus, in paragraph (i), we do not believe that allowing reimbursement at a "contracted" rate is not contemplated by the Act. A contracted rate may also not be the established local rate, as it may not have gone through the process of identifying and quantifying the actual cost to deliver the services through a public process. Thus, health plans cannot be subjected to reimbursing a contracted rate.
- In proposed subsection (b), because the Act is so clear about reimbursement being 325% of Medicare in the absence of an established local rate, we read the Act as freezing this rate as it as exists as of the effective date of the Act. In other words, whatever the rate is as of July 31, 2025 is the rate in perpetuity, unless the Assembly acts to change it. Allowing the "current" rate to apply without specificity flies in the face of the state constitution's delegation doctrine. Finally, if the Assembly wished for the department to adjust this amount from time to time to keep pace with CMS, it would have specifically done so. The general grant of authority under section 2(9) of the Act does not give enough specific direction from the Assembly.
- In proposed paragraph (ii), any billed charges would necessarily have to be billed at the established local rate (or the default rate) for health plans to reimburse ground ambulance services under the Act. We believe this proposed paragraph only confuses the issue and should be struck.
- We have no concerns with the proposed section (4), which clarifies that payment of the in-network cost sharing constitutes payment in full for services rendered. It is worth pointing out that the other statute on balance billing prohibitions, ORS 743B.287, does allow a member to voluntarily choose to receive services from an out of network provider, if the provider informs the member of the implications of the choice.
- Finally, we believe the proposed section (5) is unnecessary and should be struck as discussed above.
- Although we did not raise this in the advisory committee, we do believe that the department should consider weighing in on which established local rate controls for purposes of reimbursement. Under the definition of "ground ambulance services," the Act focuses on the scene of a medical emergency, or the transport from one health care facility to another. We believe the established local rate should be the rate set in the jurisdiction where the medical emergency took place or where the originating facility exists for purposes of transport. Adding a provision within this rule clarifying which established local rate applies when would help with implementation.

- **836-053-XXXX, Ground Ambulance Service Organizations Rate Reporting to the Department.**
  - Under section 2(4) of the Act, ground ambulance providers must submit a "catalog" of "established local rates." A catalog, in its plain meaning, is a complete list of items, in an alphabetical or systematic order. An "established local rate" under the Act is a rate "established where the health care services originated for the provision of ground ambulance services through a publicly accessible process *that includes an analysis of the cost to provide the ground ambulance services*[.]" [Emphasis added.] The analysis of cost is either for the local jurisdiction to provide ground ambulance services itself, or for a vendor to provide the services if the local jurisdiction contracts for the provision of ground ambulance services.
  - We believe it follows that an established local rate thus needs (1) documentation of a public process *and* (2) an analysis of the cost to provide the services in order

for it to serve as a valid reimbursement methodology. Any rates submitted to the catalog maintained by the department must also contain this information, if the catalog is to be a complete list of established local rates.

- Admittedly, the legislature gave little guidance on what should be included in the analysis of cost for established local rates. The proponents of the Act testified in committee that rates "are set through a public process and based on cost."[2] Information about the public process may include minutes of a meeting conducted in accordance with the state's Public Meetings Law, and any documents relied upon by decision-makers to arrive at a conclusion.

  We believe the department has some discretion to determine how a local jurisdiction determines cost, but the rules should specify some acceptable methodology for determining cost. In the rulemaking advisory committee meeting, we suggested notations on the presence or absence of an undertaken actuarial analysis. As the default reimbursement rate for ground ambulance services in the absence of an established local rate is a multiple of Medicare, perhaps the cost analysis should mirror the provisions of Medicare's fee schedule.[3]

- Finally, we believe that any database should be abundantly clear if any established local rate reflects whether the rate was developed for an in-house ground ambulance service or a contracted service. Given that some health care literature[4] draws a substantial cost distinction between public sector and private sector ownership, clearly demarking the rates could serve as a useful data point for policymakers.

Thank you for fully considering our comments. We look forward to more discussions in this interim about these rules.

Sincerely,

/s

Richard Blackwell
Director, Oregon Government Relations

[2] https://olis.oregonlegislature.gov/liz/2025R1/Downloads/PublicTestimonyDocument/135851
[3] https://www.cms.gov/medicare/payment/fee-schedules/ambulance/ambulance-fee-schedule-public-use-files
[4] https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.00738