

California Health Benefits Review Program

Analysis of California Assembly Bill 651

Air Ambulance Services

A Report to the 2019–2020 California State Legislature

April 15, 2019



Key Findings:

Analysis of California Assembly Bill 651 Air Ambulance Services

Summary to the 2019–2020 California State Legislature, April 15, 2019



AT A GLANCE

For coverage of air ambulance services, the version of California Assembly Bill 651 analyzed by CHBRP would address cost sharing and balance billing for commercial and CalPERS enrollees. It would also establish a transport rate for all Medi-Cal beneficiaries, including those enrolled in plans regulated by the California Department of Managed Health Care (DMHC). In 2020, of the 25 million Californians enrolled in state-regulated health insurance, 100% will have insurance subject to some aspect of AB 651.

1. **Benefit coverage.** 100% of commercial/CalPERS enrollees would have in-network cost sharing and no balance billing. All Medi-Cal beneficiaries would have a single transport rate.
2. **Utilization.** No measurable change would be expected, because patients are unlikely to alter use of emergency services due to changes in costs.
3. **Expenditures.** Expenditures would increase by \$8,036,4000 (0.005%) for enrollees in DMHC-regulated plans and CDI-regulated policies.
 - For commercial/CalPERS enrollees, this is due to an \$18,500 increase in total premiums and a \$15,000 decrease in enrollee expenses for covered benefits, as well as a potential (based on a likely upper threshold of balance bills) a \$2,174,700 decrease in enrollee expenses for noncovered benefits.
 - For the 7.6 million Medi-Cal beneficiaries enrolled in DMHC-regulated plans, this is due to a \$10,211,000 increase in expenditures related to the new Medi-Cal transport rate.

Additional impacts from the new rate would also be expected for Medi-Cal beneficiaries enrolled in Country Operated Health System (COHS) managed care or in the Medi-Cal fee-for-service (FFS) program.

CONTEXT¹

In California, there are 33 air ambulance service providers operating 134 aircrafts across 95 bases. About 48% are independent contractors, about 48% are government entities, and the remaining are hospital-based. Prior to the 2002 increase in the Medicare rate, most air ambulance services were hospital-based.

Reimbursement for air ambulance service generally consists of both a transport rate (applicable to all trips) and a mileage rate (varying by distance traveled). For air ambulance services provided to Medi-Cal beneficiaries in the fee-for-service (FFS) program, California's Emergency Medical Air Transport Act (EMATA) currently adds a supplemental payment.

"Balance billing" refers to any provider billing enrollees for the difference between the billed charge and the amount paid by the health plan or insurer plus any amount paid by the enrollee as cost sharing. Balance billing is typically not allowed for in-network providers.

An existing Federal Law, the Airline Deregulation Act of 1978, prohibits much state regulation related to air transport. In addition, changes to Medi-Cal rates may require federal agreement. For this analysis, CHBRP has assumed that federal agreement would be obtained and federal law would not preempt AB 651's prohibition on balance billing.

BILL SUMMARY

AB 651 addresses coverage of air ambulance services.

For commercial and California Public Employees' Retirement System (CalPERS) enrollees in plans and policies regulated by California Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI), AB 651 would require enrollee cost sharing be the same for in-network and out-of-network (OON) air ambulance service providers, and would require

¹ Refer to CHBRP's full report for full citations and references.

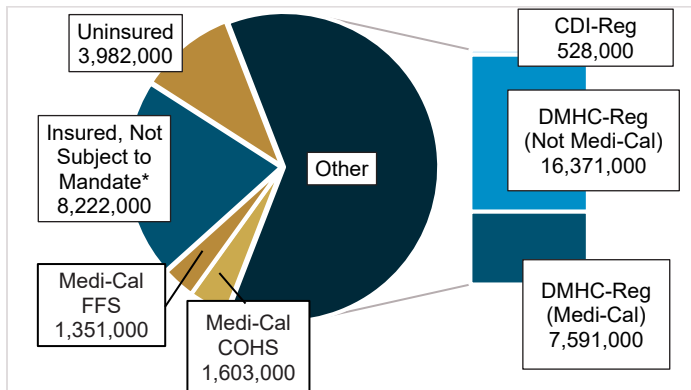
that such cost-sharing count towards deductible and annual out-of-pocket limits.

AB 651 would also prohibit air ambulance service providers from balance billing enrollees in DMHC-regulated plans and CDI-regulated policies.

In addition, AB 651 would place requirements on the Medi-Cal program which would be applicable to the benefit coverage of Medi-Cal beneficiaries enrolled in DMHC-regulated plans, enrolled in County Operated Health System (COHS) managed care, or in the Medi-Cal FFS program. The bill would require Medi-Cal to set and maintain a transport rate for air ambulance services and would require that contracted and noncontracted air ambulance service providers accept that rate. AB 651 would require a rate similar to the rural Medicare transport rate for those services. AB 651 would not alter the Medi-Cal mileage rate.

Figure A notes how many Californians have health insurance that would be subject to AB 651.

Figure A. Health Insurance in CA and AB 651



Source: California Health Benefits Review Program, 2019.
Notes: *Medicare beneficiaries, enrollees in self-insured products, etc.

IMPACTS

Benefit Coverage, Utilization, and Cost

Benefit Coverage

At baseline, all enrollees in DMHC-regulated plans and CDI-regulated policies (as well as all Medi-Cal

beneficiaries) have coverage for air ambulance services. However, none have AB 651-compliant benefit coverage.

Postmandate, all commercial and CalPERS enrollees would have air ambulance service coverage that includes only in-network cost sharing and that prohibits balance billing.

Post mandate, all Medi-Cal beneficiaries, including those enrolled in DMHC-regulated plans, would have benefit coverage that includes a particular transport rate for air ambulance service.

Utilization

CHBRP does not anticipate changes in utilization due to AB 651 because a patient in a life-threatening emergency is unlikely to refuse air ambulance services regardless of possible costs.

Balance Billing

Balance billing is generally associated with out-of-network (OON) providers. Balance billing of Medi-Cal beneficiaries is already prohibited.²

CHBRP estimates that 15% of air ambulance services for commercial and CalPERS enrollees will be delivered by OON providers. However, not every OON provider balance bills, and not every balance-billed enrollee pays balance bills. For this analysis, CHBRP has estimated — as an upper threshold — that 20% of OON air ambulance services to commercial and CalPERS enrollees would generate a balance bill that would be paid by the enrollee. Post mandate, CHBRP has assumed that no balance billing of enrollees in DMHC-regulated plans and CDI-regulated policies would occur.

As noted in Figure B, for an upper threshold in the expected number of balance bills, this would mean a \$2,174,700 decrease in enrollee expenses for noncovered benefits (balance billing). The decrease represents an average \$24,200 decrease for an enrollee who would have received a balance bill.

Unit Cost

CHBRP estimates that there will be a shift in the average unit cost for using air ambulance services resulting from

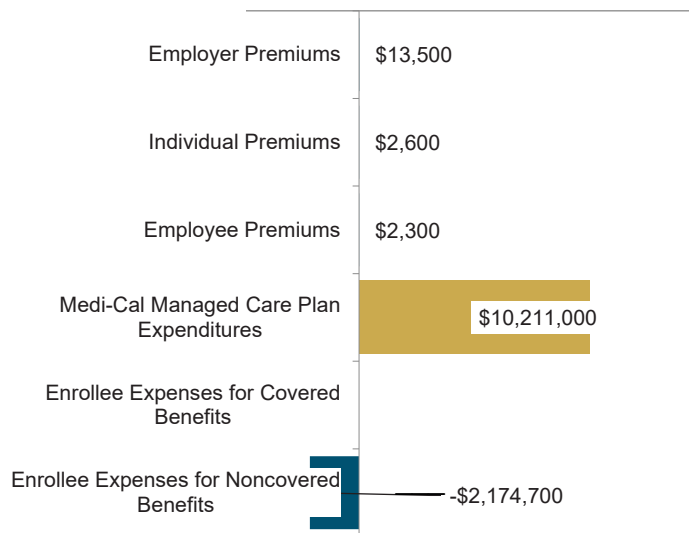
² Welfare and Institutions Code 14019.4

the prohibition of balance billing for commercial/CalPERS enrollees. For commercial/CalPERS enrollees, the in-network and OON air ambulance average unit cost will be unchanged (\$32,288 and \$27,727, respectively). However, the postmandate prohibition on balance billing will decrease the total paid for OON air ambulance service, as enrollees would no longer pay balance bills..

Expenditures

As noted in Figure B, AB 651 would decrease total net annual expenditures by \$8,039,400 (0.005%) for enrollees in DMHC-regulated plans and CDI-regulated policies.

Figure B. Expenditure Impacts of AB 651



Source: California Health Benefits Review Program, 2019.

For commercial/ CalPERS enrollees, this is due to

- An \$18,500 increase in total commercial/CalPERS health insurance premiums paid by employers and enrollees;
- A \$15,000 decrease in enrollee expenses for covered benefits (as OON cost sharing will be reduced to the same as in-network cost sharing); and

- A \$2,174,700 decrease in enrollee expenses for noncovered benefits (balance billing).

For Medi-Cal beneficiaries enrolled in DMHC-regulated plans, this is due to a \$10,211,000 increase in expenditures related to the new Medi-Cal transport rate.

Medi-Cal

As previously noted, for the 7.6 million Medi-Cal beneficiaries in DMHC-regulated plans, CHBRP would expect a \$10,211,000 increase in expenditures as a result of the new Medi-Cal transport rate. Considering other Medi-Cal beneficiaries, CHBRP would expect a similar per capita impact for the 1.6 million Medi-Cal beneficiaries enrolled in COHS managed care, resulting in an additional \$2,200,000 increase in expenditures. CHBRP would also expect that the new rates required by AB 651 would require, for the 1.4 million Medi-Cal beneficiaries in the FFS program, to result in a further \$1,800,000 expenditure because Medi-Cal must pay, for these beneficiaries, the amount that had been supplied by EMATA supplements.

CalPERS

CalPERS total premiums for enrollees in DMHC-regulated plans would increase by approximately \$500.

Number of Uninsured in California

No measureable impact on the number of uninsured Californians is projected.

Essential Health Benefits and the Affordable Care Act

As the bill would not require coverage for a new benefit, the bill does not appear to exceed essential health benefits (EHBs).

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California Health Benefits Review Program
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ABOUT CHBRP

The California Health Benefits Review Program (CHBRP) was established in 2002. As per its authorizing statute, CHBRP provides the California Legislature with independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit-related legislation. The state funds CHBRP through an annual assessment on health plans and insurers in California.

An analytic staff based at the University of California, Berkeley, supports a task force of faculty and research staff from multiple University of California campuses to complete each CHBRP analysis. A strict conflict-of-interest policy ensures that the analyses are undertaken without bias. A certified, independent actuary helps to estimate the financial impact. Content experts with comprehensive subject-matter expertise are consulted to provide essential background and input on the analytic approach for each report.

More detailed information on CHBRP's analysis methodology, authorizing statute, as well as all CHBRP reports and other publications are available at www.chbrp.org.

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Table 1. AB 651 Impacts on Benefit Coverage, Utilization, and Cost, 2020

	Baseline	Postmandate	Increase/ Decrease	Percentage Change
Benefit coverage				
Total enrollees with health insurance subject to state benefit mandates (a)	24,490,000	24,490,000	0	0%
Total enrollees with health insurance subject to AB 651	24,490,000	24,490,000	0	0%
Percent Commercial/CalPERS enrollees	69.0%	69.0%	0%	0%
Percent of Commercial/CalPERS enrollees who have AB 651 compliant coverage	0%	100.0%	100%	0%
Percent Medi-Cal enrollees	31.0%	31.0%	0%	0%
Percent of Medi-Cal enrollees with AB 651 compliant coverage	0%	100.0%	100%	0%
Utilization and unit cost				
<u>Commercial/CalPERS</u>				
Commercial/CalPERS enrollees using air ambulance services	2,910	2,910	0	0%
Commercial/CalPERS enrollees using air ambulance services who pay in-network cost sharing and no balance billing	2,460	2,910	450	18%
Commercial/CalPERS enrollees using air ambulance services who pay OON cost sharing	450	0	-450	-100%
Commercial/CalPERS enrollees using air ambulance services who pay balance billing (subset of enrollees who pay OON cost sharing)	90	0	-90	-100%
Average cost per Commercial/CalPERS enrollee for in-network air ambulance services	\$38,288	\$38,288	0	0%
Average cost per Commercial/CalPERS enrollee for out-of-network air ambulance services	\$27,727	\$22,884	-\$4,843	-17%
<u>Medi-Cal</u>				
Medi-Cal enrollees using air ambulance services	2,080	2,080	0	0%

Average cost per Medi-Cal enrollee	\$2,684	\$7,011	\$4,327	161%
Expenditures				
<u>Premiums by payer</u>				
Private employers for group insurance	\$86,438,374,600	\$86,438,387,600	\$13,000	0.0000%
CalPERS HMO employer expenditures (c)	\$3,098,551,200	\$3,098,551,700	\$500	0.0000%
Medi-Cal Managed Care Plan expenditures (d)	\$28,492,272,700	\$28,502,483,700	\$10,211,000	0.0358%
Enrollees with individually purchased insurance	\$12,045,323,500	\$12,045,326,100	\$2,600	0.0000%
Individually purchased – outside Exchange	\$2,486,221,600	\$2,486,222,000	\$400	0.0000%
Individually purchased – Covered California	\$9,559,101,900	\$9,559,104,100	\$2,200	0.0000%
Enrollees with group insurance, CalPERS HMOs, Covered California, and Medi-Cal Managed Care (a) (b)	\$14,476,394,000	\$14,476,396,300	\$2,300	0.0000%
<u>Enrollee expenses</u>				
For covered benefits (deductibles, copayments, etc.)	\$14,750,879,700	\$14,750,864,400	-\$15,300	-0.0001%
For noncovered benefits (balance billing) (e)	\$2,174,700	\$0	-\$2,174,700	-100.00%
Total expenditures	\$159,303,970,400	\$159,312,009,800	\$8,039,400	0.0050%

Source: California Health Benefits Review Program, 2019.

Notes: (a) This population includes persons with privately funded and publicly funded (e.g., CalPERS HMOs, Medi-Cal Managed Care Plans) health insurance products regulated by DMHC or CDI. Population includes enrollees aged 0 to 64 years and enrollees 65 years or older covered by employment sponsored insurance.

(b) Premium expenditures by enrollees include employee contributions to employer-sponsored health insurance and enrollee contributions for publicly purchased insurance.

(c) Of the increase in CalPERS employer expenditures, about 56.4% or \$300 would be state expenditures for CalPERS members who are state employees or their dependents. It should be noted, however, that should CalPERS choose to make similar adjustments for consistency to the benefit coverage of enrollees associated with CalPERS' self-insured products, the fiscal impact on CalPERS could be greater.

(d) In addition to the possible increase of \$10.2 million increase in expenditures CHBRP is estimating for the 7.6 million Medi-Cal beneficiaries enrolled in DMHC-regulated plans, it seems likely that there would also be a proportional increase of \$2.2 million for the 1.6 million beneficiaries enrolled in COHS managed care. In addition, as the EMATA supplements phase out, CHBRP would expect Medi-Cal to expend an additional \$1.8 million of its own funds to meet the rate AB 651 would establish (without the EMATA supplements).

(e) Includes only those expenses that are paid directly by enrollees to providers for services related to the mandated benefit that are not currently covered by insurance. In addition this only includes those expenses that will be newly covered, postmandate. Other components of expenditures in this table include all health care services covered by insurance.

(f) Includes both fixed wing and rotary air ambulance providers. Also includes transport cost and mileage cost. Medi-Cal fee change only impacts the transport cost.

Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; COHS = County Operated Health system; DMHC = Department of Managed Health Care; EMATA = Emergency Air Transport Act; HMO = Health Maintenance Organization; OON = out-of-network.

POLICY CONTENT

The California Assembly Committee on Health has requested that the California Health Benefits Review Program (CHBRP)³ conduct an evidence-based assessment of the impacts of AB 651 Air Ambulance Services.

Bill-Specific Analysis

AB 651 addresses coverage of air ambulance services.

AB 651 would place requirements on the benefit coverage of enrollees in health plans and policies regulated by California Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI). The bill would require that an enrollee's cost sharing be the same for in-network and out-of-network (OON) air ambulance service providers, regardless of whether the provider is "in-network," and would require that such cost sharing count towards any deductible and annual out-of-pocket limits. The bill is silent regarding the transport rates to be paid on behalf of commercial and California Public Employees' Retirement System (CalPERS) enrollees (but please see further discussion regarding Medi-Cal beneficiaries).

AB 651 would also place a prohibition on air ambulance service providers. The bill would prohibit balance billing a commercial or CalPERS enrollee for more than the set in-network cost-sharing amount.

- How the bill would interact with an existing California law (HSC 1367.11 and INC 10352), which explicitly allows balance billing for medical transportation, is unclear. For this analysis, CHBRP has assumed that the California law would not prevent AB 651 from applying to air ambulance service providers.
- How the bill would interact with an existing federal law (Airline Deregulation Act of 1978), which prohibits much state regulation related to air transport, is unclear. For this analysis, CHBRP has assumed that the federal law would not prevent AB 651 from applying to air ambulance service providers.

In addition, AB 651 would place requirements on the Medi-Cal program, requirements that would then be applicable to the benefit coverage of Medi-Cal beneficiaries enrolled in DMHC-regulated plans, enrolled in County Operated Health System (COHS) managed care, or associated with the fee-for-service (FFS) program. The bill would require Medi-Cal to set and maintain a transport rate for air ambulance services and would require that in-network and out-of-network (OON) air ambulance service providers accept that transport rate. The bill would relate the new transport rate to the rural Medicare transport rate.

- The bill notes that its requirement that Medi-Cal establish and implement an air ambulance service fee schedule "shall be implemented only to the extent federal financial participation is available and only if necessary federal approvals have been obtained." For this analysis, CHBRP has assumed that federal participation and approval will be obtained.
- How the bill would interact with an existing federal law (Airline Deregulation Act of 1978), which prohibits much state regulation related to air transport, is unclear. For this analysis, CHBRP has assumed that the Federal law would not prevent AB 651 from requiring an established transport rate to be paid to air ambulance service providers on behalf of Medi-Cal beneficiaries by Medi-

³ CHBRP's authorizing statute is available at <http://chbrp.org/faqs.php>.

Cal, by DMHC-regulated plans and by COHS managed care programs, as well as by Medi-Cal for beneficiaries in the fee-for-service (FFS) program.

AB 651 would interact with an existing California law (Welfare and Institutions Code 14019.4), which prohibits air ambulance service providers from balance billing Medi-Cal beneficiaries.

- How the existing law interacts with an existing federal law (Airline Deregulation Act of 1978) is unclear. For this analysis, CHBRP has assumed that the federal law does not prevent California law from prohibiting balance billing to Medi-Cal beneficiaries by air ambulance service providers.

The full text of AB 651 can be found in Appendix A.

Relevant Populations

If enacted, AB 651 would affect the health insurance of approximately 24.5 million enrollees (63% of all Californians). This represents 100% of Californians who will have health insurance regulated by the state that may be subject to any state health benefit mandate law — health insurance regulated by the DMHC or the CDI. This figure includes the 7.6 million Medi-Cal beneficiaries enrolled in DMHC-regulated plans. For this group, the bill would prohibit air ambulance service providers from balance billing enrollees.

In addition, AB 651 would affect the health insurance of all Medi-Cal beneficiaries — the 1.6 million Medi-Cal beneficiaries enrolled in COHS managed care programs and the 1.4 million Medi-Cal beneficiaries in Medi-Cal's FFS program, and the 7.6 million enrolled in DMHC-regulated plans. For all Medi-Cal beneficiaries, AB 651 would also establish a transport rate for air ambulance services. As previously noted, balance billing of Medi-Cal beneficiaries is already prohibited.

Analytic Approach and Key Assumptions

As noted above, though there are a number of state and federal laws that may conflict, for the purposes of this analysis, CHBRP has assumed that AB 651 will be applicable to the benefit coverage of enrollees in CDI-regulated policies, enrollees in DMHC-regulated plans, and all Medi-Cal beneficiaries.

In addition to impacts on benefit coverage, cost, utilization, and public health, CHBRP generally addresses the medical effectiveness of relevant services. This typically involves a systematic literature review on the benefit or treatment referenced in the legislation on health outcomes related to relevant conditions and/or diseases. In this case, that would be a review of the effectiveness of air ambulance services for a very wide range of conditions and diseases. It was not feasible to complete such a task, given the timeframe for this analysis. Without an analysis on the medical effectiveness of the service, no impacts on public health can be predicted.

Interaction With Existing Requirements

Health benefit mandates may interact and align with the following state and federal mandates or provisions.

California Policy Landscape

California law and regulations

As noted previously noted,

- Current law (HSC 1367.11 and INC 10352) explicitly allows balance billing of commercial/ California Public Employees' Retirement System (CalPERS) enrollees for medical transportation. For this analysis, CHBRP has assumed that the California law would not prevent AB 651 from applying to air ambulance service providers.
- Current law (Welfare and Institutions Code 14019.4) prohibits air ambulance service providers from balance billing Medi-Cal beneficiaries. For this analysis, CHBRP has assumed the law functions, despite the presence of an existing Federal Law (Airline Deregulation Act of 1978) which prohibits much state regulation related to air transport.

Current California law also established the Emergency Medical Air Transportation Act (EMATA) (Government Code 76000.10), which supplements Medi-Cal FFS payments to air ambulance service providers. The Medi-Cal rate that would be established by AB 651 would replace the EMATA supplements for air ambulance services provided to Medi-Cal beneficiaries.

Similar Requirements in Other States

Other states and the federal government have taken an interest in air ambulance service (AHIP, 2016; Nichols and Norton, 2018). Some recent examples of proposed legislation (which did not pass) from other states, which would have addressed rates for some portion of that state's enrollees, are below.

- Florida: In 2015, two bills (H.B. 681 and S.B. 516) were introduced but failed to pass, which would have limited reimbursements to nonparticipating providers to the greater of: 1) the amount negotiated with a participating or nonparticipating provider; 2) the usual, customary and reasonable amount calculated using the methodology generally used to determine nonparticipating provider reimbursements; or 3) the Medicare rate.
- New Mexico: In 2015, a bill (H.B. 402) was introduced but failed to pass, which would have capped reimbursement of air ambulance services paid by health insurance at 250% of the Medicare fee guideline and would have prohibited balance billing.
- South Carolina: In 2015, the "Air Ambulance Affordability Act" (H. 3448) was introduced but failed to pass, which would have set reimbursement for covered air ambulance services at the Medicare rate plus 15%, which would apply retroactively 5 years from the law's effective date.
- West Virginia: In 2016, the Legislature passed a bill (H.B. 4315) that prohibits, for some consumers, balance billing by air ambulance service providers. In 2017, a bill (S.B. 276) was introduced but failed to pass, which would have prohibited air ambulance service providers from collecting more than the Medicare rate.
- Montana: In 2018 the Legislature passed a bill (S.B. 44) that prohibits balance billing for air ambulance services.

The interaction of these bills and laws with existing federal law (Airline Deregulation Act of 1978), which prohibits much state regulation related to air transport, is unclear.

Federal Policy Landscape

As previously noted,

- An existing federal law (Airline Deregulation Act of 1978) prohibits much state regulation related to air transport. Although Medicare, as a federal entity, is not bound by the Americans With Disabilities Act (ADA), and Medi-Cal (as a joint state and federal entity), is likely not bound by the

ADA, the ADA has often been interpreted as preventing states from setting commercial health insurance rates for air ambulance service (AHIP, 2016; Nichols and Norton, 2018). For this analysis, CHBRP has assumed that the federal law would not prevent AB 651 from applying to air ambulance service providers.

- Current federal law requires federal approval for Medi-Cal to set pay rates for air ambulances. For this analysis, CHBRP has assumed that federal participation and approval will be obtained.

In addition, current federal law (Public Health Service Act section 2719A) provides, among other things, that if a group health plan or health insurance coverage provides any benefits for emergency services in an emergency department of a hospital, the plan or issuer must cover emergency services without regard to whether a particular health care provider is an in-network provider with respect to the services, and generally cannot impose any copayment or coinsurance that is greater than what would be imposed if services were provided in-network. It also establishes minimum payment standards for emergency services. However, the statute does not require plans or issuers to cover amounts that out-of-network providers may balance bill and does not prohibit balance billing of the enrollee.

Affordable Care Act and essential health benefits

A number of Affordable Care Act (ACA) provisions have the potential to or do interact with state benefit mandates. Below is an analysis of how AB 651 may interact with requirements of the ACA as presently exists in federal law, including the requirement for certain health insurance to cover essential health benefits (EHBs).⁴

Any changes at the federal level may impact the analysis or implementation of this bill, were it to pass into law. However, CHBRP analyzes bills in the current environment given current law and regulations.

State health insurance marketplaces, such as Covered California, are responsible for certifying and selling qualified health plans (QHPs) in the small-group and individual markets. QHPs are required to meet a minimum standard of benefits as defined by the ACA as EHBs. In California, EHBs are related to the benefit coverage available in the Kaiser Foundation Health Plan Small Group Health Maintenance Organization (HMO) 30 plan, the state's benchmark plan for federal EHBs.^{5,6}

States may require QHPs to offer benefits that exceed EHBs.⁷ However, a state that chooses to do so must make payments to defray the cost of those additionally mandated benefits, either by paying the purchaser directly or by paying the QHP.^{8,9} State rules related to provider types, cost sharing, or

⁴ The ACA requires nongrandfathered small-group and individual market health insurance — including, but not limited to, QHPs sold in Covered California — to cover 10 specified categories of EHBs. Resources on EHBs and other ACA impacts are available on the CHBRP website: http://www.chbrp.org/other_publications/index.php.

⁵ The U.S. Department of Health and Human Services (HHS) has allowed each state to define its own EHBs for 2014 and 2015 by selecting one of a set of specified benchmark plan options. CCIO, Information on Essential Health Benefits Benchmark Plans. Available at: <https://www.cms.gov/ccio/resources/data-resources/ehb.html>.

⁶ H&SC Section 1367.005; IC Section 10112.27.

⁷ ACA Section 1311(d)(3).

⁸ State benefit mandates enacted on or before December 31, 2011, may be included in a state's EHBs, according to the U.S. Department of Health and Human Services (HHS). Patient Protection and Affordable Care Act: Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation. Final Rule. Federal Register, Vol. 78, No. 37. February 25, 2013. Available at: www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf2013-04084.pdf.

⁹ However, as laid out in the Final Rule on EHBs that HHS released in February 2013, state benefit mandates enacted on or before December 31, 2011, would be included in the state's EHBs, and there would be no requirement that the state defray the costs of those state-mandated benefits. For state benefit mandates enacted after December 31, 2011, that are identified as exceeding EHBs, the state would be required to defray the cost.

reimbursement methods would *not meet* the definition of state benefit mandates that could exceed EHBs.¹⁰

AB 651 would not require coverage for a new state benefit mandate that appears not to exceed the definition of EHBs in California.

¹⁰ Essential Health Benefits. Final Rule. A state's health insurance marketplace would be responsible for determining when a state benefit mandate exceeds EHBs, and QHP issuers would be responsible for calculating the cost that must be defrayed.

BACKGROUND ON AIR AMBULANCE SERVICES

Air ambulance service occurs either when a patient requires transport from the scene of an accident to a hospital or between hospitals where a patient may require treatment at another facility, and may include both urban and rural locales (Vaughn Sarrazin et al., 2019). Air ambulances are generally staffed with medical professionals, and are equipped with medical equipment and operate similarly to ground transport ambulances.

Air ambulances are employed for the purposes of reducing barriers to access. Because they can bypass obstacles on the road, air ambulances are able to respond sooner than ground transport during the “golden hour,” a critical period for trauma patient survival (Fleming et al., 2016; Galvagno et al., 2013). Air ambulances operating in traffic and congested roads in urban settings or inaccessible terrain in some rural locations result in faster transport times (Fleming et al., 2016).

Air ambulances are operated either through a hospital-based system, an independent contractor, or a government entity. Prior to 2002, most air ambulances were owned and operated by hospitals. However, Medicare increased reimbursement for air ambulance in its fee schedule in 2002. These higher rates have encouraged more independent operators to enter into the market (Campbell, 2017; Consumers Union, 2017). In California, both independent contractors and government entities each comprised approximately 48% of air ambulance services in the state, and only one air ambulance service operated through a hospital (ADAMS, 2018). More specifically, there were 33 air ambulance service providers operating 134 aircrafts across 95 bases throughout the state, which was an increase of 15 rotor wing aircrafts and 13 bases since 2017 (ADAMS, 2018).

Disparities¹¹ and Social Determinants of Health¹² in Accessing Air Ambulance Services.

Per statute, CHBRP includes discussion of disparities and social determinants of health (SDoH) as it relates to air ambulance services. Disparities are differences between groups that are modifiable. CHBRP found literature identifying disparities by race/ethnicity and age.

Race or Ethnicity Differences

Air ambulance utilization differs by race/ethnicity. Studies on emergency transport for spinal cord injury and stroke found that the majority of patients being transported were white (71%), followed by Hispanic (7%), black (5%), and Asian and Native American (1%) (Fleming et al., 2016; Hutton et al. 2015). Racial disparities in accessing air ambulance suggest that whites are more likely to receive air ambulance transport. One study found that Hispanics were less likely to receive air ambulance services and instead received basic life support ground ambulance (Vaughn Sarrazin et al., 2019). Hispanics who lived in rural environments also experienced decreased access to trauma care (Carr et al., 2017). In another study, Black Americans were more likely to experience air transport barriers to receiving stroke care (Hutton et al., 2015).

¹¹ Several competing definitions of “health disparities” exist. CHBRP relies on the following definition: Health disparity is defined as the differences, whether unjust or not, in health status or outcomes within a population. Wyatt et al., 2016.

¹² CHBRP defines social determinants of health as conditions in which people are born, grow, live, work, learn, and age. These social determinants of health (economic factors, social factors, education, physical environment) are shaped by the distribution of money, power, and resources, and impacted by policy. See CHBRP’s SDoH white paper for further information: http://chbrp.com/analysis_methodology/public_health_impact_analysis.php.

Age Differences

A difference in access and use is seen among people of varying ages. Those who are younger, namely below 19 years of age exhibited greater challenges accessing air ambulance services for specific conditions such as stroke, (Hutton et al., 2015). Access for adults was higher, with older adults above 55 years of age benefitting from air ambulance services the most (Brown et al., 2016).

BENEFIT COVERAGE, UTILIZATION, AND COST IMPACTS

As discussed in the *Policy Context* section, AB 651 would impact cost sharing and would prohibit balance billing for air ambulance services for commercial and CalPERS enrollees in DMHC-regulated health plans and CDI-regulated policies. AB 651 would also require Medi-Cal to set and maintain a transport rate for air ambulance services, a transport rate that would be applicable for Medi-Cal beneficiaries enrolled in DMHC-regulated plans as well as Medi-Cal beneficiaries in County Operated Health System (COHS) managed care or in Medi-Cal's fee-for-service (FFS) program.

This section reports the estimated impacts of AB 651 on air ambulance benefit coverage, utilization, and cost, defining cost as premiums and enrollee expenses. For the purposes of describing AB 651's impact, CHBRP has used the following terms and definitions:

- **Billed Charge** — The amount billed for services by providers. Health plans and insurers have contracts with in-network providers to pay an agreed upon “allowed charge,” which is usually lower than the billed charge. Plans and insurers generally only pay out-of-network providers a portion of their billed charges. Billed charges are typically higher than in-network rates, out-of-network effective rates, or local Medicare rates.
- **In-Network Rate** — The total amount paid for a service by a plan/insurer and an enrollee (cost sharing) to in-network providers. The amount is based on contracts between the provider and the health plan/insurer, and dictates the plan/policy requirements regarding enrollee cost-sharing.
- **Out-of-Network (OON) Effective Rate** — The total amount the plan/insurer defines to be appropriate for the OON service. The amount is then shared between the plan's payment and the enrollee cost sharing. There is no contract with these providers. The plan pays a specified amount. The enrollee is responsible for the OON cost sharing and any amounts balance billed by the provider.
- **Balance Bill** — This term refers to the practice of providers billing enrollees for the difference between the billed charge and the amount paid by the plan or insurer and the amount paid as cost sharing. This is the amount a provider may send as a bill directly to an enrollee. Balance billing is typically not allowed for in-network providers.
- **Medi-Cal Rate** — The total amount paid for a service by fee-for-service (FFS) Medi-Cal. AB 651 requires the Medi-Cal air ambulance transportation rate to be a percentage of the rural Medicare rate for these services. AB 651 would require the same rate be used for all Medi-Cal beneficiaries, including those enrolled in DMHC-regulated plans. Note that this rate would be the full amount paid because Medi-Cal beneficiaries have no cost sharing, and there is an existing prohibition on balance billing Medi-Cal beneficiaries.
- **Medicare Rate** — The total amount paid for a service according to the Medicare Fee Schedule, which is set by the federal government. Local Medicare rates can vary by region due to geographic and overhead factors.

Rates for air ambulance service generally consist of both a transport rate (applicable to all trips) and a mileage rate (varying by distance traveled). For air ambulance services provided to Medi-Cal beneficiaries in the fee-for-service (FFS) program, California's Emergency Medical Air Transport Act (EMATA) currently adds a supplemental payment.¹³ AB 651 would not alter either rate for commercial or CalPERS enrollees but would establish a new transport rate for all Medi-Cal beneficiaries. For this

¹³ See Appendix A. AB 651 would also alter EMATA.

analysis, CHBRP has assumed an end of the EMATA supplements, as the EMATA enabling legislation includes a sunset date.

For further details on the underlying data sources and methods, please see Appendix C.

Baseline and Postmandate Benefit Coverage

Enrollees in DMHC-regulated plans¹⁴ and enrollees in CDI-regulated policies¹⁵ have coverage for air ambulance services, as do all Medi-Cal beneficiaries.¹⁶ As noted in Table 1, CHBRP has estimated that 100% of commercial/CalPERS enrollees in DMHC-regulated plans (including Medi-Cal beneficiaries) and enrollees in CDI-regulated policies have health insurance that would be subject to AB 651 and have coverage for air ambulance services. However, approximately 0% of these enrollees have coverage of air ambulance services that is compliant with AB 651. Postmandate, 100% of the commercial/CalPERS enrollees in DMHC-regulated plans and CDI-regulated policies would have air ambulance coverage that has only in-network cost sharing and that prohibits balance billing. In addition, 100% of Medi-Cal beneficiaries enrolled in DMHC-regulated plans (as well as other Medi-Cal beneficiaries) would have benefit coverage that complies with the transport rates AB 651 would establish.

Baseline and Postmandate Utilization

CHBRP has assumed that utilization of types of air ambulances used will remain unchanged in 2020 — 17% fixed wing and 83% rotary wing for commercial/CalPERS enrollees and 12% fixed wing and 88% rotary wing for Medi-Cal enrollees. Utilization and cost related to the aggregate of both types of air ambulance service are presented in Table 1.

In 2020, CHBRP estimates that 2,910 commercial/CalPERS enrollees 2,080 Medi-Cal beneficiaries enrolled in DMHC-regulated plans will use air ambulance services (see Table 1). CHBRP's estimates of per capita utilization of air ambulance service is higher for Medi-Cal enrollees than for commercial/CalPERS enrollees. Milliman's proprietary Consolidated Health Cost Guidelines Sources Database (CHSD) shows a Medi-Cal utilization rate of 0.2736 per thousand compared to a commercial utilization rate of 0.1722 per thousand enrollees. These figures are in line with reported national figures (Clark, 2016; AHIP, 2016).

CHBRP does not anticipate changes in utilization due to AB 651. CHBRP assumes that the demand of this service, as is generally the case for emergency services (Ellis et al., 2017), is inelastic from the perspective of the patient, and possibly limited by supply from the perspective of the providers. It is unlikely that a patient in a life-threatening emergency would refuse air ambulance services because of the potential for high out-of-pocket costs. However, a provider may choose to not provide care if they consider the reimbursement rates to be too low, and they are not bound by law to respond. AB 651 results in a decrease in reimbursement for services provided to commercial/CalPERS enrollees (due to lower cost sharing and the balance billing prohibition) but will also result in an increase in reimbursement for services provided to Medi-Cal beneficiaries (due to the new rate, which will increase for Medi-Cal beneficiaries in managed care).

¹⁴ Health and Safety Code Sections 1345(b)(2), 1345(b)(6), and 1371.8.

¹⁵ Insurance Code 10126.6(a)

¹⁶ 42 C.F.R. § 431.53

Baseline and Postmandate Per-Unit Cost

Because AB 651 places one set of requirements on the benefit coverage of commercial/CalPERS enrollees and different requirements on the benefit coverage of Medi-Cal beneficiaries, the impacts on unit cost vary.

Commercial and CalPERS Enrollees

Balance billing of enrollees for air ambulance services with health insurance that would be subject to AB 651 occurs for commercial/CalPERS enrollees in DMHC-regulated plans and CDI-regulated policies. Using Milliman's 2016 CHSD data, CHBRP estimates that 15% of these air ambulance services in 2020 will be provided by OON providers, and could result in balance billing. However, not every OON provider will balance bill, and if they do, they may not bill the full amount. Similarly, not every enrollee who receives a balance bill will pay or pay the full amount. For this analysis, CHBRP assumes that — as an upper threshold — 20% of OON providers will balance bill and will receive the average amount. The estimated 2020 total for balance bills sent to and paid by commercial and CalPERS enrollees, and the impact of AB 651 are presented in Table 1 as “enrollee expenses for noncovered benefits (balance billing).” Because balance billing is generally prohibited when Medi-Cal beneficiaries are involved, no balance billing is expected for Medi-Cal beneficiaries enrolled in DMHC-regulated plans.

CHBRP observed lower OON effective rates than in-network rates for air ambulance services in Milliman's CHSD data. Commercial/CalPERS OON providers can make additional revenue by balance billing patients up to their billed charge. When balance billing is prohibited, OON providers will be paid less unless they become in-network providers. It is not clear that health plans and insurers will have a financial incentive to contract with these OON providers to become in-network providers, so CHBRP assumes that OON providers will continue to be paid by health plans using the same OON effective rates postmandate.

For commercial/CalPERS enrollees, CHBRP estimates that there will be a shift in the average unit cost resulting from the prohibition of balance billing for OON air ambulance services for commercial/CalPERS enrollees. As shown in Table 1, the in-network air ambulance average cost per commercial/CalPERS enrollee for 2020 is \$38,288 and will remain so postmandate. The OON air ambulance average cost per commercial/CalPERS enrollee is \$27,727 (\$22,884 of this is the OON effective rate, and the remainder is balance billing) and will decrease to \$22,884 postmandate. This estimate uses the upper threshold figure of 20% of OON air ambulance providers balance billing. This estimate expects an average of \$24,200 to be the balance bill an enrollee would receive (which is about half of the difference between the billed charge and the OON effective rate). Postmandate, CHBRP assumes that there would be no balance billing of enrollees in DMHC-regulated plans and CDI-regulated policies..

Medi-Cal Beneficiaries

As previously noted, Table 1 presents the aggregate information on air ambulance service, combining fixed wing and rotary wing providers into the aggregate air ambulance services.

Reimbursement for both types, fixed wing and rotary wing, generally consist of both a transport rate (applicable to all trips) and a mileage rate (varying by distance traveled).. For air ambulance services provided to Medi-Cal beneficiaries in the fee-for-service (FFS) program, California's Emergency Medical Air Transport Act (EMATA) also adds a supplemental payment. AB 651 would not alter either rate for commercial or CalPERS enrollees but would establish a new transport rate for all Medi-Cal beneficiaries and anticipates the end of the EMATA supplements.

AB 651 requires no change in plan/insurer rates for air ambulance services delivered to commercial/CalPERS enrollees, but will alter the transport rate for Medi-Cal enrollees.

Currently, for Medi-Cal beneficiaries in the FFS program, air ambulance providers are currently reimbursed a base rate for transport, plus a mileage rate, plus a supplemental payment from a California state fund established by the EMATA. For Medi-Cal beneficiaries in managed care, air ambulance service providers are reimbursed similar transport and mileage rates — but receive no EMATA supplement. Postmandate, AB 651 would require that the Medi-Cal FFS base transport rate be equal to the current transport rate plus the current EMATA supplement or the Medicare rural rate, whichever is higher. For this analysis, CHBRP has assumed that the Medi-Cal base transport rate will increase to 100% of the Medicare rural rate and that the EMATA supplement will have been phased out.

Because AB 651 would require matched reimbursements from Medi-Cal managed care, a change in Medi-Cal FFS rates would result in changed rates for Medi-Cal beneficiaries in managed care. Table 2 shows average unit costs for the transport and mileage rates for air ambulance services delivered to Medi-Cal beneficiaries enrolled in DMHC-regulated plans. .

Table 2. Components of Air Ambulance Transportation Reimbursement for Medi-Cal Beneficiaries Enrolled in DMHC-Regulated Plans

Transport Type	Premandate Average Transport Unit Cost	Average Mileage Unit Cost per Transport	Composite Unit Cost per Transport
Premandate	\$1,524	\$1,160	\$2,684
Postmandate	\$5,851	\$1,160	\$7,011

Source: California Health Benefits Review Program, 2019.

For the Med-Cal beneficiaries in managed care, CHBRP estimates that the current average air ambulance transport rate for Medi-Cal beneficiaries is \$1,524 and will increase to \$5,851 postmandate, when AB 651 requires managed care rates to match FFS rates. Mileage rates are expected to remain unchanged.

Baseline and Postmandate Expenditures

Tables 6 and 7 present baseline and postmandate expenditures by market segment for DMHC-regulated plans and CDI-regulated policies. The tables present per member per month (PMPM) premiums, enrollee expenses for both covered and noncovered benefits (balance billing), and total expenditures (premiums as well as enrollee expenses).

For commercial/CalPERS enrollees, AB 651 would decrease enrollee expenses by (1) eliminating balance billing and (2) making OON cost sharing the same as in-network cost sharing for air ambulance services. AB 651’s balance billing prohibition would have no measurable impact on premiums, because balance billing is generally outside of plan/insurer costs and so does not generally affect premiums. For this analysis, CHBRP has assumed that providers will be paid less as a result of the balance billing prohibition. AB 651’s cost-sharing requirement would be expected to increase premiums, because enrollees would pay less in cost sharing, which generally results in higher premiums.

Overall, AB 651 would increase total net annual expenditures by \$8.0 million or 0.0050% for enrollees in CDI-regulated policies and DMHC-regulated plans (including Medi-Cal enrollees). This is due to

- Changes for commercial/CalPERS enrollees including
 - An \$18,400 increase in total commercial/CalPERS health insurance premiums paid by employers and enrollees due to a decrease in enrollee expenses;
 - A \$10,211,000 increase in expenditures for the 7.6 million Medi-Cal beneficiaries in DMHC-regulated plans;
 - A \$15,300 decrease in enrollee expenses for covered benefits (as OON cost sharing will be reduced to the same as in-network cost sharing); and
 - A \$2,174,700 decrease in enrollee expenses for noncovered benefits (balance billing);
- As well as a \$10,211,000 increase in expenditures for the 7.6 million Medi-Cal beneficiaries in DMHC-regulated plans.

Considering other Medi-Cal beneficiaries, CHBRP would expect a similar per capita impact for AB 651 for the 1.6 million Medi-Cal beneficiaries enrolled in County Operated Health System (COHS) managed care, resulting in an additional \$2,200,000 increase in expenditures (not represented in Table 1, because COHS are not regulated by DMHC). CHBRP would also expect that the new rates required by AB 651 would require, for the 1.4 million Medi-Cal beneficiaries in the FFS program, a further \$1,800,000 expenditure as Medi-Cal must pay the amount that had been supplied by EMATA supplements.¹⁷

Premiums

As noted in Table 7, changes in premiums for enrollees in DMHC-regulated plans and CDI-regulated policies as a result of AB 651 would vary by market segment.

Enrollee Expenses

When possible, CHBRP estimates the impact of the bill on enrollee expenses for noncovered and covered benefits. CHBRP defines the first as uncovered medical expenses paid by the enrollee (in this case, balance bills) and the second as out-of-pocket expenses related to covered medical expenses (e.g., deductibles, copayments, and coinsurance). AB 651–related changes in enrollee expenses are primarily related to balance billing.

Enrollee expenses for covered benefits

As noted in Table 1, CHBRP estimates that 450 commercial/CalPERS enrollees would see a reduction of \$15,300 for covered benefits (in the form of copayments, deductibles, etc.) because they would pay in-network cost sharing for OON air ambulance services. Table 4 shows that, on average, each of the 450 commercial/CalPERS enrollees with OON air ambulance claims will have a \$30 reduction in cost sharing as a result of AB 651.

There is no cost sharing for these services for Medi-Cal beneficiaries and so no change for them is expected as a result of AB 651.

¹⁷ Medi-Cal FFS utilization rates supplied by the California Department of Health Care Services, personal communication, D. Merwin, March 21, 2019, and April 10, 2019.

Table 3. Cost-Sharing Impact of AB 651, 2020

Cost-Sharing Impact	
Estimated number of commercial/CalPERS enrollees using an OON air ambulance (a)	450
Estimated per enrollee reduction in cost sharing for commercial/CalPERS enrollees using an OON air ambulance (b)	\$30

Source: California Health Benefits Review Program, 2019.

Notes: (a) Benefit coverage for Medi-Cal beneficiaries does not generally include any cost sharing, which would not be changed by AB 651..

(b) Does not include noncovered benefits, such as balance billing.

Key: CalPERS = California Public Employees' Retirement System; OON = out of network.

Enrollee expenses for noncovered benefits (balance billing)

As noted in Table 1, CHBRP estimates a \$2,174,700 reduction in enrollee expenses for noncovered expenses (balance billing). Table 5 shows that for the estimated upper threshold of 90 commercial/CalPERS enrollees projected to have an OON air ambulance claim in 2020 with balance billing, AB 651 could result in average reductions of \$24,200 in expenses for noncovered benefits (balance billing). The estimated number of enrollees receiving a balance bill represents an upper threshold because not every OON provider will balance bill, and if they do, they may not bill the full amount (the billed charge less what is paid by the plan/insurer and less what is paid by the enrollee through cost-sharing). Similarly, not every enrollee who receives a balance bill will pay or will pay the full amount.

Balance billing is generally prohibited for Medi-Cal beneficiaries and so no change for them is expected as a result of AB 651.

Table 4. Balance Billing Impact of AB 651, 2020

Balance Billing Impact	
Estimated upper threshold commercial/CalPERS enrollees using an OON air ambulance an receiving a balance bill (a)	90
Estimated per enrollee reduction in balance billing (b)	\$24,200

Source: California Health Benefits Review Program, 2019.

Notes: (a) Balance billing of Medi-Cal beneficiaries is generally prohibited.

b) Does not include covered benefit expenses, such as copays, coinsurance, or deductibles.

Key: CalPERS = California Public Employees' Retirement System; OON = out of network

Potential Cost Offsets or Savings in the First 12 Months After Enactment

As CHBRP does not project any change in utilization of air ambulance services, CHBRP does not project any cost offsets or savings in health care that would result because of the enactment of provisions in AB 651.

Postmandate Administrative Expenses and Other Expenses

CHBRP estimates that the increase in administrative costs of DMHC-regulated plans and/or CDI-regulated policies will remain proportional to the increase in premiums. CHBRP assumes that if health care costs increase as a result of increased utilization or changes in unit costs, there is a corresponding proportional increase in administrative costs. CHBRP assumes that the administrative cost portion of premiums is unchanged. All health plans and insurers include a component for administration and profit in their premiums.

Other Considerations for Policymakers

In addition to the impacts a bill may have on benefit coverage, utilization, and cost, related considerations for policymakers are discussed below.

Postmandate Changes in the Number of Uninsured Persons¹⁸

Because the change in average premiums does not exceed 1% for any market segment (see Tables 1, 6, and 7), CHBRP would expect no measurable change in the number of uninsured persons due to the enactment of AB 651.

Changes in Public Program Enrollment

CHBRP estimates that the enactment of AB 651 would produce no measurable impact on enrollment in publicly funded insurance programs.

How Lack of Benefit Coverage Results in Cost Shifts to Other Payers

Currently, commercial/CalPERS enrollees who use OON air ambulance services may receive balance bills from providers because and be expected to pay the difference between the provider's billed charges and amounts that the provider receives from the health plan or insurer. Many of these enrollees may seek financial assistance from public entities to pay these bills.

¹⁸ See also CHBRP's [Uninsured: Criteria and Methods for Estimating the Impact of Mandates on the Number of Individuals Who Become Uninsured in Response to Premium Increases \(December 2015\)](http://chbrp.com/analysis_methodology/cost_impact_analysis.php), available at http://chbrp.com/analysis_methodology/cost_impact_analysis.php.

Table 5. Baseline Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2020

	DMHC-Regulated						CDI-Regulated			Total
	Privately Funded Plans (by Market) (a)			Publicly Funded Plans			Privately Funded Plans (by Market) (a)			
	Large Group	Small Group	Individual	CalPERS HMOs (b)	MCMC (Under 65) (c)	MCMC (65+) (c)	Large Group	Small Group	Individual	
Enrollee counts										
Total enrollees in plans/policies subject to state mandates (d)	10,565,000	3,099,000	2,184,000	523,000	6,796,000	795,000	318,000	108,000	102,000	24,490,000
Total enrollees in plans/policies subject to AB 651	10,565,000	3,099,000	2,184,000	523,000	6,796,000	795,000	318,000	108,000	102,000	24,490,000
Premiums										
Average portion of premium paid by employer	\$555.35	\$341.99	\$0.00	\$493.71	\$268.13	\$694.55	\$710.92	\$462.84	\$0.00	\$118,029,198,500
Average portion of premium paid by employee	\$39.66	\$205.44	\$437.39	\$94.04	\$0.00	\$0.00	\$250.37	\$202.64	\$475.67	\$26,521,717,500
Total premium	\$595.01	\$547.43	\$437.39	\$587.76	\$268.13	\$694.55	\$961.29	\$665.48	\$475.67	\$144,550,916,000
Enrollee expenses										
For covered benefits (deductibles, copays, etc.)	\$46.18	\$121.03	\$115.38	\$48.33	\$0.00	\$0.00	\$162.44	\$186.84	\$168.51	\$14,750,879,700
For noncovered benefits (e)	\$0.01	\$0.01	\$0.01	\$0.01	\$0.00	\$0.00	\$0.01	\$0.01	\$0.01	\$2,174,700
Total expenditures	\$641.20	\$668.47	\$552.78	\$636.09	\$268.13	\$694.55	\$1,123.74	\$852.33	\$644.19	\$159,303,970,300

Source: California Health Benefits Review Program, 2019.

Notes: (a) Includes enrollees with grandfathered and nongrandfathered health insurance acquired outside or through Covered California (the state's health insurance marketplace).

(b) As of October 2018, 56% of CalPERS HMO members were state retirees under age 65, state employees or their dependents. CHBRP assumes the same ratio for 2020.

(c) Medi-Cal Managed Care Plan expenditures for members over 65 include those who also have Medicare coverage. This population does not include enrollees in COHS.

(d) This population includes both persons who obtain health insurance using private funds (group and individual) and through public funds (e.g., CalPERS HMOs, Medi-Cal Managed Care Plans). Only those enrolled in health plans or policies regulated by the DMHC or CDI are included. Population includes all enrollees in state-regulated plans or policies aged 0 to 64 years, and enrollees 65 years or older covered by employer-sponsored health insurance.

(e) Includes only those expenses that are paid directly by enrollees or other sources to providers for services related to the mandated benefit that are not currently covered by insurance. This only includes those expenses that will be newly covered, postmandate. Other components of expenditures in this table include all health care services covered by insurance.

Key: CalPERS HMOs = California Public Employees' Retirement System Health Maintenance Organizations; CDI = California Department of Insurance; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care; MCMC = Medi-Cal Managed Care.

Table 6. Postmandate Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2020

	DMHC-Regulated						CDI-Regulated			Total
	Privately Funded Plans (by Market) (a)			Publicly Funded Plans			Privately Funded Plans (by Market) (a)			
	Large Group	Small Group	Individual	CalPERS HMOs (b)	MCMC (Under 65) (c)	MCMC (65+) (c)	Large Group	Small Group	Individual	
Enrollee counts										
Total enrollees in plans/policies subject to state mandates (d)	10,565,000	3,099,000	2,184,000	523,000	6,796,000	795,000	318,000	108,000	102,000	24,490,000
Total enrollees in plans/policies subject to AB 651	10,565,000	3,099,000	2,184,000	523,000	6,796,000	795,000	318,000	108,000	102,000	24,490,000
Premiums										
Average portion of premium paid by employer	\$0.0001	\$0.0001	\$0.0000	\$0.0001	\$0.1121	\$0.1121	\$0.0001	\$0.0001	\$0.0000	\$10,224,500
Average portion of premium paid by employee	\$0.0000	\$0.0000	\$0.0001	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0.0000	\$0.0001	\$4,900
Total premium	\$0.0001	\$0.0001	\$0.0001	\$0.0001	\$0.1121	\$0.1121	\$0.0001	\$0.0001	\$0.0001	\$10,229,400
Enrollee expenses										
For covered benefits (deductibles, copays, etc.)	-\$0.0001	-\$0.0001	-\$0.0001	-\$0.0001	\$0.0000	\$0.0000	-\$0.0001	-\$0.0001	-\$0.0001	-\$15,300
For noncovered benefits (e)	-\$0.0107	-\$0.0107	-\$0.0107	-\$0.0107	\$0.0000	\$0.0000	-\$0.0107	-\$0.0107	-\$0.0107	-\$2,174,700
Total expenditures	-\$0.0107	-\$0.0107	-\$0.0107	-\$0.0107	\$0.1121	\$0.1121	-\$0.0107	-\$0.0107	-\$0.0107	\$8,039,500
Percent change										
Premiums	0.0000%	0.0000%	0.0000%	0.0000%	0.0418%	0.0161%	0.0000%	0.0000%	0.0000%	0.0071%
Total expenditures	-0.0017%	-0.0016%	-0.0019%	-0.0017%	0.0418%	0.0161%	-0.0010%	-0.0013%	-0.0017%	0.0050%

Source: California Health Benefits Review Program, 2019.

Notes: (a) Includes enrollees with grandfathered and nongrandfathered health insurance acquired outside or through Covered California (the state's health insurance marketplace).

(b) As of October 2018, 56% of CalPERS HMO members were state retirees under age 65, state employees or their dependents. CHBRP assumes the same ratio for 2020.

(c) Medi-Cal Managed Care Plan expenditures for members over 65 include those who also have Medicare coverage. This population does not include enrollees in COHS.

(d) This population includes both persons who obtain health insurance using private funds (group and individual) and through public funds (e.g., CalPERS HMOs, Medi-Cal Managed Care Plans). Only those enrolled in health plans or policies regulated by the DMHC or CDI are included. Population includes all enrollees in state-regulated plans or policies aged 0 to 64 years, and enrollees 65 years or older covered by employer-sponsored health insurance.

(e) Includes only those expenses that are paid directly by enrollees or other sources to providers for services related to the mandated benefit that are not currently covered by insurance. This only includes those expenses that will be newly covered, postmandate. Other components of expenditures in this table include all health care services covered by insurance.

Key: CalPERS HMOs = California Public Employees' Retirement System Health Maintenance Organizations; CDI = California Department of Insurance; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care; MCMC = Medi-Cal Managed Care.

LONG-TERM IMPACTS

In this section, CHBRP estimates the long-term impact¹⁹ of AB 651, which CHBRP defines as impacts occurring beyond the first 12 months after implementation. These estimates are qualitative and based on the existing evidence available in the literature. CHBRP does not provide quantitative estimates of long-term impacts because of unknown improvements in clinical care, changes in prices, implementation of other complementary or conflicting policies, and other unexpected factors.

Long-Term Utilization and Cost Impacts

Utilization Impacts

CHBRP does not anticipate changes in utilization due to AB 651. CHBRP assumes that the demand of this service is quite inelastic from the perspective of the patient (Ellis et al., 2017). Providers may choose to not provide care if they consider the reimbursement rates to be too low, and they are not bound by law to respond. However, although AB 651 would result in a decrease in reimbursement for services provided to commercial/CalPERS enrollees AB 651 would also result in a greater increase in reimbursement for Medi-Cal beneficiaries. Therefore, CHBRP did not model any change in the supply of providers in the short-term and would not expect AB 651 to cause any in the long-term.

For enrollees insured by Medi-Cal, CHBRP projects no additional long-term utilization impacts. Currently, Medi-Cal enrollees do not face balance billing. As a result, the balance billing prohibition does not reduce the “price” to enrollees and should not be associated with additional use. For this reason, CHBRP does not expect additional long-term utilization impacts for Medi-Cal.

By contrast, the commercial market could experience an increase in use. To the extent that balance billing currently exists in this market, prohibiting balance billing could serve as a price reduction for enrollees. However, research has found that emergency spending has an extremely low price elasticity. Thus, CHBRP expects that even if there were a price reduction (through the removal of balanced billing), the increase in use would not be large (because there is not a lot of price-sensitive discretionary use among these emergency services).

Cost Impacts

For the Medi-Cal enrollees, there are no expected additional long-term costs. For the commercial market, there may be slight cost increases in the long term if the “price-sensitive” part of the air ambulance market is affected by the removal of balance billing.

CHBRP observed lower allowed charges for OON providers than in-network providers for air ambulance services in Milliman’s CHSD data. Although currently, commercial/CalPERS OON providers can make additional revenue by balance billing patients up to their billed amounts, when balance billing is prohibited, OON providers will be paid less unless they become in-network providers. It is not clear that health plans will have a financial incentive to contract with these OON providers to become in-network providers, so CHBRP has assumed that OON providers will continue to be paid by health plans using the same allowed charges postmandate. CHBRP assumes this dynamic will continue to hold in the long term.

¹⁹ See also CHBRP’s *Criteria and Guidelines for the Analysis of Long-Term Impacts on Healthcare Costs and Public Health*, available at http://www.chbrp.org/analysis_methodology/cost_impact_analysis.php.

APPENDIX A TEXT OF BILL ANALYZED

On February 25, 2019, the California Assembly Committee on Health requested that CHBRP analyze AB 651.

Below is the bill language as introduced on February 15, 2019. Immediately following is the April 8, 2019, amended language.

CHBRP's analysis is relevant to the amended language.

ASSEMBLY BILL

No. 651

Introduced by Assembly Member Grayson

February 15, 2019

An act to amend, add, and repeal Section 76000.10 of the Government Code, to add Section 1371.6 to the Health and Safety Code, to add Section 10126.65 to the Insurance Code, and to add Section 14124.15 to the Welfare and Institutions Code, relating to air ambulance services.

LEGISLATIVE COUNSEL'S DIGEST

AB 651, as introduced, Grayson. Air ambulance services.

(1) Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires that health care service plans and health insurance policies, as specified, provide coverage for certain services and treatments, including emergency medical transportation services.

This bill would require a health care service plan contract or a health insurance policy issued, amended, or renewed on or after January 1, 2020, to provide that if an enrollee, insured, or subscriber, as applicable, receives covered services from a noncontracting air ambulance provider, the enrollee, insured, or subscriber shall pay no more than the same cost sharing that the enrollee, insured, or subscriber would pay for the same covered services received from a contracting air ambulance provider, referred to as the in-network cost-sharing amount. The bill would specify that an enrollee, subscriber, or insured would not owe the noncontracting provider

more than the in-network cost-sharing amount for services subject to the bill, as specified. The bill would allow a noncontracting provider to advance to collections only the in-network cost-sharing amount, as determined by the health care service plan or insurer, that the enrollee, insured, or subscriber has failed to pay. The bill would authorize a health care service plan, health insurer, or provider to seek relief in any court for the purpose of resolving a payment dispute, and would not prohibit a provider from using a health care service plan's or health insurer's existing dispute resolution processes. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.

(2) Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive healthcare services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law provides for the federal Medicare Program, which is a public health insurance program for persons 65 years of age and older and specified persons with disabilities who are under 65 years of age.

This bill would, commencing July 1, 2020, require the department to set and maintain the Medi-Cal fee rate for air ambulance services provided by either fixed or rotary wing aircraft that is equal to a percentage of the rural Medicare rates for those services, as described, and to the extent federal financial participation is available and necessary federal approvals have been obtained. The bill would specify that, commencing July 1, 2020, the amounts a noncontract emergency medical transport provider could collect if the beneficiary received medical assistance other than through enrollment in a Medi-Cal managed care health plan pursuant to a specified federal law would be the resulting fee-for-service payment schedule amounts after the application of the rate established pursuant to the bill.

(3) Existing law, the Emergency Medical Air Transportation Act, effective until January 1, 2022, imposes a penalty of \$4 until January 1, 2020, upon every conviction for a violation of the Vehicle Code or a local ordinance adopted pursuant to the Vehicle Code, other than a parking offense. The act requires the county or the court that imposed the fine to transfer the moneys collected pursuant to that act to the Treasurer for deposit into the Emergency Medical Air Transportation and Children's Coverage Fund.

Under the act, moneys in the fund are made available, upon appropriation by the Legislature, to the State Department of Health Care Services for children's healthcare coverage and administrative costs relating to emergency medical air transportation provider payments, with the appropriated moneys remaining after payment of the administrative costs to be used as follows: (A) 20% of the amount for offsetting the state portion of the Medi-Cal reimbursement rate for emergency medical air transportation services, and (B) 80% of the amount for augmenting emergency medical air transportation reimbursement payments made through the Medi-Cal program.

This bill, if the rate change to the Medi-Cal fee rate for air ambulance services is implemented pursuant to paragraph (2), would delete the authorization to use the moneys appropriated from the fund for augmenting Medi-Cal emergency medical air transportation reimbursement payments, while maintaining the authorization to use the moneys for offsetting the state portion of the Medi-Cal reimbursement rate for those services. The bill would preserve the authorization to use the moneys for augmentation of payments for purposes of emergency medical air transportation that was provided before July 1, 2020, as specified. The bill would make conforming changes by deleting or amending related provisions. The bill would repeal these provisions on January 1, 2023.

(4) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

DIGEST KEY

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: yes

BILL TEXT

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1.

Section 76000.10 of the Government Code is amended to read:

76000.10. (a) This section shall be known, and may be cited, as the Emergency Medical Air Transportation Act.

(b) For purposes of this section:

- (1) “Department” means the State Department of Health Care Services.
- (2) “Director” means the Director of Health Care Services.
- (3) “Provider” means a provider of emergency medical air transportation services.
- (4) “Rotary wing” means a type of aircraft, commonly referred to as a helicopter, that generates lift through the use of wings, known as rotor blades, that revolve around a mast.

(5) “Fixed wing” means a type of aircraft, commonly referred to as an airplane, that generates lift through the use of the forward motion of the aircraft and wings that do not revolve around a mast but are fixed in relation to the fuselage of the aircraft.

(6) “Air mileage rate” means the per-mileage reimbursement rate paid for services rendered by rotary-wing and fixed-wing providers.

(c) (1) For purposes of implementing this section, a penalty of four dollars (\$4) shall be imposed upon every conviction for a violation of the Vehicle Code or a local ordinance adopted pursuant to the Vehicle Code, except parking offenses subject to Article 3 (commencing with Section 40200) of Chapter 1 of Division 17 of the Vehicle Code.

(2) The penalty described in this subdivision is in addition to the state penalty assessed pursuant to Section 1464 of the Penal Code. However, this penalty shall not be included in the base fine used to calculate the state penalty assessment pursuant to subdivision (a) of Section 1464 of the Penal Code, the state surcharge levied pursuant to Section 1465.7 of the Penal Code, and the state court construction penalty pursuant to Section 70372 of this code, and to calculate the other additional penalties levied pursuant to this chapter.

(d) The county or the court that imposed the fine shall, in accordance with the procedures set out in Section 68101, transfer moneys collected pursuant to this section to the Treasurer for deposit into the Emergency Medical Air Transportation and Children’s Coverage Fund, which is hereby established in the State Treasury. Notwithstanding Section 16305.7, the Emergency Medical Air Transportation and Children’s Coverage Fund shall include interest and dividends earned on money in the fund. Any law that references the Emergency Medical Air Transportation Act Fund, as previously established by this subdivision, shall be construed to reference the Emergency Medical Air Transportation and Children’s Coverage Fund, effective January 1, 2018.

(e) (1) The Emergency Medical Air Transportation and Children’s Coverage Fund shall be administered by the State Department of Health Care Services. Moneys in the Emergency Medical Air Transportation and Children’s Coverage Fund shall be made available, upon appropriation by the Legislature, to the department for any of the following purposes:

(A) For children’s health care coverage.

(B) For emergency medical air transportation provider payments, as follows:

(i) For payment of the administrative costs of the department in administering emergency medical air transportation provider payments.

(ii) Twenty percent of the appropriated money remaining after payment of administrative costs pursuant to clause (i) shall be used to offset the state portion of the Medi-Cal reimbursement rate for emergency medical air transportation services.

(iii) Eighty percent of the appropriated money remaining after payment of administrative costs pursuant to clause (i) shall be used to augment emergency medical air transportation reimbursement payments made through the Medi-Cal program, as set forth in paragraphs (2) and (3).

(2) If money in the Emergency Medical Air Transportation and Children's Coverage Fund is made available to the department for the purpose described in subparagraph (B) of paragraph (1), both of the following shall occur:

(A) The department shall seek to obtain federal matching funds by using the moneys in the Emergency Medical Air Transportation and Children's Coverage Fund for the purpose of augmenting Medi-Cal reimbursement paid to emergency medical air transportation providers.

(B) The director shall augment emergency medical air transportation provider payments in accordance with a federally approved reimbursement methodology. The director may seek federal approvals or waivers as may be necessary to implement this section and to obtain federal financial participation to the maximum extent possible for the payments under this section.

(3) (A) Upon appropriation by the Legislature, the department shall use moneys in the Emergency Medical Air Transportation and Children's Coverage Fund and any federal matching funds to do any of the following:

(i) Fund children's health care coverage.

(ii) Increase the Medi-Cal reimbursement for emergency medical air transportation services in an amount not to exceed normal and customary charges charged by the providers.

(B) Notwithstanding any other law, and pursuant to this section, if money in the Emergency Medical Air Transportation and Children's Coverage Fund is made available to the department for the purpose described in subparagraph (B) of paragraph (1), the department shall increase the Medi-Cal reimbursement for emergency medical air transportation services if both of the following conditions are met:

(i) Moneys in the Emergency Medical Air Transportation and Children's Coverage Fund will cover the cost of increased payments pursuant to clause (iii) of subparagraph (B) of paragraph (1).

(ii) The state does not incur any General Fund expense to pay for the Medi-Cal emergency medical air transportation services increase.

(f) The assessment of penalties pursuant to this section shall terminate on January 1, 2020. Penalties assessed before January 1, 2020, shall continue to be collected, administered, and distributed pursuant to this section until exhausted or until June 30, 2021, whichever occurs first. On June 30, 2021, moneys remaining unexpended and unencumbered in the Emergency Medical Air Transportation and Children's Coverage Fund shall be transferred to the General Fund, to be

available, upon appropriation by the Legislature, for the purposes of augmenting Medi-Cal reimbursement for emergency medical air transportation and related costs, generally, or funding children's health care coverage.

(g) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2, the department may implement, interpret, or make specific this section and any applicable federal waivers and state plan amendments by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions without taking regulatory action.

~~(h) This section shall remain in effect only until January 1, 2022, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2022, deletes or extends that date.~~

(h) This section shall remain in effect only until the earlier of either of the following:

(1) The date on which the rate change to the Medi-Cal fee rate for air ambulance service is implemented pursuant to Section 14124.15 of the Welfare and Institutions Code, and as of that date is repealed.

(2) January 1, 2022, and as of that date is repealed.

SEC. 2.

Section 76000.10 is added to the Government Code, to read:

76000.10. (a) This section shall be known, and may be cited, as the Emergency Medical Air Transportation Act.

(b) For purposes of this section:

(1) "Department" means the State Department of Health Care Services.

(2) "Director" means the Director of Health Care Services.

(3) "Provider" means a provider of emergency medical air transportation services.

(4) "Rotary wing" means a type of aircraft, commonly referred to as a helicopter, that generates lift through the use of wings, known as rotor blades, that revolve around a mast.

(5) "Fixed wing" means a type of aircraft, commonly referred to as an airplane, that generates lift through the use of the forward motion of the aircraft and wings that do not revolve around a mast but are fixed in relation to the fuselage of the aircraft.

(6) "Air mileage rate" means the per-mileage reimbursement rate paid for services rendered by rotary-wing and fixed-wing providers.

(c) (1) For purposes of implementing this section, a penalty of four dollars (\$4) shall be imposed upon every conviction for a violation of the Vehicle Code or a local ordinance adopted pursuant to the Vehicle Code, except parking offenses subject to Article 3 (commencing with Section 40200) of Chapter 1 of Division 17 of the Vehicle Code.

(2) The penalty described in this subdivision is in addition to the state penalty assessed pursuant to Section 1464 of the Penal Code. However, this penalty shall not be included in the base fine used to calculate the state penalty assessment pursuant to subdivision (a) of Section 1464 of the Penal Code, the state surcharge levied pursuant to Section 1465.7 of the Penal Code, and the state court construction penalty pursuant to Section 70372 of this code, and to calculate the other additional penalties levied pursuant to this chapter.

(d) The county or the court that imposed the fine shall, in accordance with the procedures set out in Section 68101, transfer moneys collected pursuant to this section to the Treasurer for deposit into the Emergency Medical Air Transportation and Children's Coverage Fund, which is hereby established in the State Treasury. Notwithstanding Section 16305.7, the Emergency Medical Air Transportation and Children's Coverage Fund shall include interest and dividends earned on money in the fund. Any law that references the Emergency Medical Air Transportation Act Fund, as previously established by this subdivision, shall be construed to reference the Emergency Medical Air Transportation and Children's Coverage Fund, effective January 1, 2018.

(e) The Emergency Medical Air Transportation and Children's Coverage Fund shall be administered by the State Department of Health Care Services. Moneys in the Emergency Medical Air Transportation and Children's Coverage Fund shall be made available, upon appropriation by the Legislature, to the department for any of the following purposes:

(1) For children's healthcare coverage.

(2) For emergency medical air transportation provider payments, as follows:

(A) For payment of the administrative costs of the department in administering emergency medical air transportation provider payments.

(B) The appropriated money remaining after payment of administrative costs pursuant to subparagraph (A) shall be used to offset the state portion of the Medi-Cal reimbursement rate for emergency medical air transportation services.

(f) The assessment of penalties pursuant to this section shall terminate on January 1, 2020. Penalties assessed before January 1, 2020, shall continue to be collected, administered, and distributed pursuant to this section until exhausted or until June 30, 2021, whichever occurs first. On June 30, 2021, moneys remaining unexpended and unencumbered in the Emergency Medical Air Transportation and Children's Coverage Fund shall be transferred to the General Fund, to be available, upon appropriation by the Legislature, for the purposes of offsetting the state portion

of the Medi-Cal reimbursement rate for emergency medical air transportation and related costs, generally, or funding children's healthcare coverage.

(g) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2, the department may implement, interpret, or make specific this section and any applicable federal waivers and state plan amendments by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions without taking regulatory action.

(h) (1) This section shall become operative only if, and on the date upon which, the rate change to the Medi-Cal fee rate for air ambulance services is implemented pursuant to Section 14124.15 of the Welfare and Institutions Code.

(2) (A) Except as described in subdivision (f), moneys in the Emergency Medical Air Transportation and Children's Coverage Fund shall remain available, upon appropriation by the Legislature, to be used to augment emergency medical air transportation reimbursement payments made through the Medi-Cal program for purposes of emergency medical air transportation that was provided before July 1, 2020, and that is therefore not eligible for the Medi-Cal rate change made pursuant to Section 14124.15 of the Welfare and Institutions Code. The emergency medical air transportation reimbursement payments may be augmented pursuant to this subparagraph using moneys deposited in the fund within 90 calendar days following July 1, 2020.

(B) Moneys in the Emergency Medical Air Transportation and Children's Coverage Fund shall not be available to be used to augment emergency medical air transportation reimbursement payments made through the Medi-Cal program for purposes of emergency medical air transportation that is provided on or after July 1, 2020, and that is therefore eligible for the Medi-Cal rate change made pursuant to Section 14124.15 of the Welfare and Institutions Code.

(i) This section shall remain in effect only until January 1, 2023, and as of that date is repealed.

SEC. 3.

Section 1371.6 is added to the Health and Safety Code, to read:

1371.6. (a) (1) Notwithstanding Section 1367.11, a health care service plan contract issued, amended, or renewed on or after January 1, 2020, shall provide that if an enrollee receives covered services from a noncontracting air ambulance provider, the enrollee shall pay no more than the same cost sharing that the enrollee would pay for the same covered services received from a contracting air ambulance provider. This amount shall be referred to as the "in-network cost-sharing amount."

(2) An enrollee shall not owe the noncontracting provider more than the in-network cost-sharing amount for services subject to this section. At the time of payment by the plan to the

noncontracting provider, the plan shall inform the enrollee and the noncontracting provider of the in-network cost-sharing amount owed by the enrollee.

(b) The following shall apply for purposes of this section:

(1) Any cost sharing paid by the enrollee for the services subject to this section shall count toward the limit on annual out-of-pocket expenses established under Section 1367.006.

(2) Cost sharing arising from services subject to this section shall be counted toward any deductible in the same manner as cost sharing would be attributed to a contracting provider.

(3) The cost sharing paid by the enrollee pursuant to this section shall satisfy the enrollee's obligation to pay cost sharing for the health service.

(c) A noncontracting provider may advance to collections only the in-network cost-sharing amount, as determined by the plan pursuant to subdivision (a), that the enrollee has failed to pay.

(d) A health care service plan or a provider may seek relief in any court for the purpose of resolving a payment dispute. A provider is not prohibited from using a health care service plan's existing dispute resolution processes.

(e) Air ambulance service providers remain subject to the balance billing protections for Medi-Cal beneficiaries under Section 14019.4 of the Welfare and Institutions Code.

SEC. 4.

Section 10126.65 is added to the Insurance Code, to read:

10126.65. (a) (1) Notwithstanding Section 10352, a health insurance policy issued, amended, or renewed on or after January 1, 2020, shall provide that if an insured or subscriber receives covered services from a noncontracting air ambulance provider, the insured or subscriber shall pay no more than the same cost sharing that the insured or subscriber would pay for the same covered services received from a contracting air ambulance provider. This amount shall be referred to as the "in-network cost-sharing amount."

(2) A subscriber or insured shall not owe the noncontracting provider more than the in-network cost-sharing amount for services subject to this section. At the time of payment by the insurer to the noncontracting provider, the insurer shall inform the insured or subscriber and the noncontracting provider of the in-network cost-sharing amount owed by the insured or subscriber.

(b) The following shall apply for purposes of this section:

(1) Any cost sharing paid by the insured or subscriber for the services subject to this section shall count toward the limit on annual out-of-pocket expenses established under Section 10112.28.

(2) Cost sharing arising from services subject to this section shall be counted toward any deductible in the same manner as cost sharing would be attributed to a contracting provider.

(3) The cost sharing paid by the insured or subscriber pursuant to this section shall satisfy the insured's or subscriber's obligation to pay cost sharing for the health service.

(c) A noncontracting provider may advance to collections only the in-network cost-sharing amount, as determined by the insurer pursuant to subdivision (a), that the insured or subscriber has failed to pay.

(d) A health insurer or a provider may seek relief in any court for the purpose of resolving a payment dispute. A provider is not prohibited from using a health insurer's existing dispute resolution processes.

SEC. 5.

Section 14124.15 is added to the Welfare and Institutions Code, to read:

14124.15. (a) The department shall set and maintain the Medi-Cal fee rate for air ambulance services provided by either fixed or rotary wing aircraft that is equal to a percentage, as specified in subdivision (b), of the rural Medicare rates for those services.

(b) The final rate shall either meet or exceed the sum of the air ambulance service rate as provided in the Medi-Cal program on December 31, 2017, and the supplemental payment offered in the year 2017 pursuant to Section 76000.10 of the Government Code.

(c) Each applicable Medi-Cal managed care health plan shall satisfy its obligation under Section 438.114(c) of Title 42 of the Code of Federal Regulations for emergency medical transports and shall provide payment to noncontract emergency medical transport providers consistent with Section 1396u-2(b)(2)(D) of Title 42 of the United States Code. Commencing July 1, 2020, and for each state fiscal year thereafter for which this chapter is operative, the amounts a noncontract emergency medical transport provider could collect if the beneficiary received medical assistance other than through enrollment in a Medi-Cal managed care health plan pursuant to Section 1396u-2(b)(2)(D) of Title 42 of the United States Code shall be the resulting fee-for-service payment schedule amounts after the application of this section.

(d) This section shall become operative July 1, 2020, and shall be implemented only to the extent federal financial participation is available and only if necessary federal approvals have been obtained.

SEC. 6.

No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or

changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

ASSEMBLY BILL (AS AMENDED)

No. 651

Introduced by Assembly Member Grayson
(Coauthor: Assembly Member Wood)
(Coauthor: Senator Dodd)

February 15, 2019

An act to ~~amend, add, and repeal~~ *amend* Section 76000.10 of the Government Code, to add Section ~~1371.6~~ *1371.55* to the Health and Safety Code, to add Section 10126.65 to the Insurance Code, and to add Section 14124.15 to the Welfare and Institutions Code, relating to air ambulance services.

LEGISLATIVE COUNSEL'S DIGEST

AB 651, as amended, Grayson. Air ambulance services.

(1) Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires that health care service ~~plans~~ *plan contracts* and health insurance ~~policies, as specified,~~ *policies* provide coverage for certain services and treatments, including emergency medical transportation services.

This bill would require a health care service plan contract or a health insurance policy issued, amended, or renewed on or after January 1, 2020, to provide that if an enrollee, insured, or ~~subscriber, as applicable,~~ *subscriber (individual)* receives covered services from a noncontracting air ambulance provider, the ~~enrollee, insured, or subscriber~~ *individual* shall pay no more than the same cost sharing that the ~~enrollee, insured, or subscriber~~ *individual* would pay for

the same covered services received from a contracting air ambulance provider, referred to as the in-network cost-sharing amount. The bill would ~~specify provide~~ that an ~~enrollee, subscriber, or insured individual~~ would not owe the noncontracting provider more than the in-network cost-sharing amount for ~~services subject to the bill, as specified.~~ *services*. The bill would ~~allow authorize~~ a noncontracting provider to advance to collections only the in-network cost-sharing ~~amount, as determined by the health care service plan or insurer, that the enrollee, insured, or subscriber~~ *amount that the individual* has failed to pay. The bill would authorize a health care service plan, health insurer, or provider to seek relief in any court for the purpose of resolving a payment dispute, and would not prohibit a provider from using a health care service plan's or health insurer's existing dispute resolution processes. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.

(2) Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive ~~healthcare services.~~ *health care services, including medical transportation services*. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. *Existing law authorizes the Director of Health Care Services to limit rates of payment for health care services, and requires the director to adopt regulations as are necessary for carrying out these provisions. Existing regulations provide for the maximum reimbursement rates for medical transportation services, including air ambulance services.* Existing *federal* law provides for the federal Medicare Program, which is a public health insurance program for persons 65 years of age and older and specified persons with disabilities who are under 65 years of age.

This bill would, commencing ~~July~~ *January* 1, 2020, ~~and to the extent that federal financial participation is available and necessary federal approvals have been obtained,~~ require the department to set and maintain the Medi-Cal fee rate for air ambulance services provided by either fixed or rotary wing aircraft that is equal to a percentage of the rural Medicare rates for those ~~services, as described, and to the extent federal financial participation is available and necessary federal approvals have been obtained.~~ *services*. The bill would ~~specify that, commencing July~~ *provide, commencing January* 1, 2020, the amounts a noncontract emergency medical transport provider ~~could~~ *may* collect if the beneficiary received medical assistance other than through enrollment in a Medi-Cal managed care health plan pursuant to a specified federal law would be the resulting fee-for-service payment schedule amounts after the application of the ~~rate established pursuant to the bill.~~ *newly established rate*.

(3) Existing law, the Emergency Medical Air Transportation Act, effective until January 1, 2022, imposes a penalty of \$4 until January 1, 2020, upon every conviction for a violation of the Vehicle Code or a local ordinance adopted pursuant to the Vehicle Code, other than a parking offense. The act requires the county or the court that imposed the fine to transfer the moneys collected pursuant to that act to the Treasurer for deposit into the Emergency Medical Air Transportation and Children's Coverage Fund.

Under the act, moneys in the fund are made available, upon appropriation by the Legislature, to the State Department of Health Care Services for children's ~~healthcare~~ *health care* coverage and administrative costs relating to emergency medical air transportation provider ~~payments,~~ *with payments.* ~~Existing law provides that 80% of the appropriated moneys money~~ remaining after payment of the administrative costs *is* to be used ~~as follows: (A) 20% of the amount for offsetting the state portion of the Medi-Cal reimbursement rate for emergency medical air transportation services, and (B) 80% of the amount for augmenting emergency medical air transportation reimbursement payments made through the Medi-Cal program.~~ *to augment the Medi-Cal program's emergency medical air transportation reimbursement payments.*

~~This bill, if the rate change to the Medi-Cal fee rate for air ambulance services is implemented pursuant to paragraph (2), would delete the authorization to use the moneys appropriated from the fund for augmenting Medi-Cal bill would provide that the payment augmentation would only apply to emergency medical air transportation reimbursement payments, while maintaining the authorization to use the moneys for offsetting the state portion of the Medi-Cal reimbursement rate for those services. The bill would preserve the authorization to use the moneys for augmentation of payments for purposes of emergency medical air transportation that was provided before July 1, 2020, as specified. The bill would make conforming changes by deleting or amending related provisions. The bill would repeal these provisions on January 1, 2023.~~ *services that are provided on a date of service that predates the implementation of the new Medi-Cal fee rate for air ambulance services described in paragraph (2).*

(4) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

DIGEST KEY

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: yes

BILL TEXT

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1.

Section 76000.10 of the Government Code is amended to read:

76000.10. (a) This section shall be known, and may be cited, as the Emergency Medical Air Transportation Act.

(b) For purposes of this section:

(1) “Department” means the State Department of Health Care Services.

(2) “Director” means the Director of Health Care Services.

(3) “Provider” means a provider of emergency medical air transportation services.

(4) “Rotary wing” means a type of aircraft, commonly referred to as a helicopter, that generates lift through the use of wings, known as rotor blades, that revolve around a mast.

(5) “Fixed wing” means a type of aircraft, commonly referred to as an airplane, that generates lift through the use of the forward motion of the aircraft and wings that do not revolve around a mast but are fixed in relation to the fuselage of the aircraft.

(6) “Air mileage rate” means the per-mileage reimbursement rate paid for services rendered by rotary-wing and fixed-wing providers.

(c) (1) For purposes of implementing this section, a penalty of four dollars (\$4) shall be imposed upon every conviction for a violation of the Vehicle Code or a local ordinance adopted pursuant to the Vehicle Code, except parking offenses subject to Article 3 (commencing with Section 40200) of Chapter 1 of Division 17 of the Vehicle Code.

(2) The penalty described in this subdivision is in addition to the state penalty assessed pursuant to Section 1464 of the Penal Code. However, this penalty shall not be included in the base fine used to calculate the state penalty assessment pursuant to subdivision (a) of Section 1464 of the Penal Code, the state surcharge levied pursuant to Section 1465.7 of the Penal Code, and the state court construction penalty pursuant to Section 70372 of this code, and to calculate the other additional penalties levied pursuant to this chapter.

(d) The county or the court that imposed the fine shall, in accordance with the procedures set out in Section 68101, transfer moneys collected pursuant to this section to the Treasurer for deposit into the Emergency Medical Air Transportation and Children’s Coverage Fund, which is hereby established in the State Treasury. Notwithstanding Section 16305.7, the Emergency Medical Air Transportation and Children’s Coverage Fund shall include interest and dividends earned on money in the fund. Any law that references the Emergency Medical Air Transportation Act Fund, as previously established by this subdivision, shall be construed to reference the Emergency Medical Air Transportation and Children’s Coverage Fund, effective January 1, 2018.

(e) (1) The Emergency Medical Air Transportation and Children’s Coverage Fund shall be administered by the State Department of Health Care Services. Moneys in the Emergency Medical Air Transportation and Children’s Coverage Fund shall be made available, upon appropriation by the Legislature, to the department for any of the following purposes:

(A) For children's health care coverage.

(B) For emergency medical air transportation provider payments, as follows:

(i) For payment of the administrative costs of the department in administering emergency medical air transportation provider payments.

(ii) Twenty percent of the appropriated money remaining after payment of administrative costs pursuant to clause (i) shall be used to offset the state portion of the Medi-Cal reimbursement rate for emergency medical air transportation services.

(iii) *(I)* Eighty percent of the appropriated money remaining after payment of administrative costs pursuant to clause (i) shall be used to augment emergency medical air transportation reimbursement payments made through the Medi-Cal program, as set forth in paragraphs (2) and (3).

(II) A payment augmentation made pursuant to subclause (I) shall apply only to emergency medical air transportation services that were provided on a date of service that predates the implementation of the Medi-Cal fee rate for air ambulance services, as specified in subdivision (a) of Section 14124.15 of the Welfare and Institutions Code.

(2) If money in the Emergency Medical Air Transportation and Children's Coverage Fund is made available to the department for the purpose described in subparagraph (B) of paragraph (1), both of the following shall occur:

(A) The department shall seek to obtain federal matching funds by using the moneys in the Emergency Medical Air Transportation and Children's Coverage Fund for the purpose of augmenting Medi-Cal reimbursement paid to emergency medical air transportation providers.

(B) The director shall augment emergency medical air transportation provider payments in accordance with a federally approved reimbursement methodology. The director may seek federal approvals or waivers as may be necessary to implement this section and to obtain federal financial participation to the maximum extent possible for the payments under this section.

(3) (A) Upon appropriation by the Legislature, the department shall use moneys in the Emergency Medical Air Transportation and Children's Coverage Fund and any federal matching funds to do any of the following:

(i) Fund children's health care coverage.

(ii) Increase the Medi-Cal reimbursement for emergency medical air transportation services in an amount not to exceed normal and customary charges charged by the providers.

(B) Notwithstanding any other law, and pursuant to this section, if money in the Emergency Medical Air Transportation and Children's Coverage Fund is made available to the department for the purpose described in subparagraph (B) of paragraph (1), the department shall increase the Medi-Cal reimbursement for emergency medical air transportation services if both of the following conditions are met:

(i) Moneys in the Emergency Medical Air Transportation and Children's Coverage Fund will cover the cost of increased payments pursuant to clause (iii) of subparagraph (B) of paragraph (1).

(ii) The state does not incur any General Fund expense to pay for the Medi-Cal emergency medical air transportation services increase.

(f) The assessment of penalties pursuant to this section shall terminate on January 1, 2020. Penalties assessed before January 1, 2020, shall continue to be collected, administered, and distributed pursuant to this section until exhausted or until June 30, 2021, whichever occurs first. On June 30, 2021, moneys remaining unexpended and unencumbered in the Emergency Medical Air Transportation and Children's Coverage Fund shall be transferred to the General Fund, to be available, upon appropriation by the Legislature, for the purposes of augmenting Medi-Cal reimbursement for emergency medical air transportation and related costs, generally, or funding children's health care coverage.

(g) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2, the department may implement, interpret, or make specific this section and any applicable federal waivers and state plan amendments by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions without taking regulatory action.

~~(h) This section shall remain in effect only until the earlier of either of the following:~~

~~(1) The date on which the rate change to the Medi-Cal fee rate for air ambulance service is implemented pursuant to Section 14124.15 of the Welfare and Institutions Code, and as of that date is repealed.~~

~~(2) January 1, 2022, and as of that date is repealed.~~

~~(h) This section shall remain in effect only until January 1, 2022, and as of that date is repealed.~~

~~SEC. 2. Section 76000.10 is added to the Government Code, to read:
76000.10.~~

~~(a) This section shall be known, and may be cited, as the Emergency Medical Air Transportation Act.~~

~~(b) For purposes of this section:~~

~~(1)“Department” means the State Department of Health Care Services.~~

~~(2)“Director” means the Director of Health Care Services.~~

~~(3)“Provider” means a provider of emergency medical air transportation services.~~

~~(4)“Rotary wing” means a type of aircraft, commonly referred to as a helicopter, that generates lift through the use of wings, known as rotor blades, that revolve around a mast.~~

~~(5)“Fixed wing” means a type of aircraft, commonly referred to as an airplane, that generates lift through the use of the forward motion of the aircraft and wings that do not revolve around a mast but are fixed in relation to the fuselage of the aircraft.~~

~~(6)“Air mileage rate” means the per-mileage reimbursement rate paid for services rendered by rotary-wing and fixed-wing providers.~~

~~(c)(1)For purposes of implementing this section, a penalty of four dollars (\$4) shall be imposed upon every conviction for a violation of the Vehicle Code or a local ordinance adopted pursuant to the Vehicle Code, except parking offenses subject to Article 3 (commencing with Section 40200) of Chapter 1 of Division 17 of the Vehicle Code.~~

~~(2)The penalty described in this subdivision is in addition to the state penalty assessed pursuant to Section 1464 of the Penal Code. However, this penalty shall not be included in the base fine used to calculate the state penalty assessment pursuant to subdivision (a) of Section 1464 of the Penal Code, the state surcharge levied pursuant to Section 1465.7 of the Penal Code, and the state court construction penalty pursuant to Section 70372 of this code, and to calculate the other additional penalties levied pursuant to this chapter.~~

~~(d)The county or the court that imposed the fine shall, in accordance with the procedures set out in Section 68101, transfer moneys collected pursuant to this section to the Treasurer for deposit into the Emergency Medical Air Transportation and Children’s Coverage Fund, which is hereby established in the State Treasury. Notwithstanding Section 16305.7, the Emergency Medical Air Transportation and Children’s Coverage Fund shall include interest and dividends earned on money in the fund. Any law that references the Emergency Medical Air Transportation Act Fund, as previously established by this subdivision, shall be construed to reference the Emergency Medical Air Transportation and Children’s Coverage Fund, effective January 1, 2018.~~

~~(e)The Emergency Medical Air Transportation and Children’s Coverage Fund shall be administered by the State Department of Health Care Services. Moneys in the Emergency Medical Air Transportation and Children’s Coverage Fund shall be made available, upon appropriation by the Legislature, to the department for any of the following purposes:~~

~~(1)For children’s healthcare coverage.~~

~~(2)For emergency medical air transportation provider payments, as follows:~~

~~(A) For payment of the administrative costs of the department in administering emergency medical air transportation provider payments.~~

~~(B) The appropriated money remaining after payment of administrative costs pursuant to subparagraph (A) shall be used to offset the state portion of the Medi-Cal reimbursement rate for emergency medical air transportation services.~~

~~(f) The assessment of penalties pursuant to this section shall terminate on January 1, 2020. Penalties assessed before January 1, 2020, shall continue to be collected, administered, and distributed pursuant to this section until exhausted or until June 30, 2021, whichever occurs first. On June 30, 2021, moneys remaining unexpended and unencumbered in the Emergency Medical Air Transportation and Children's Coverage Fund shall be transferred to the General Fund, to be available, upon appropriation by the Legislature, for the purposes of offsetting the state portion of the Medi-Cal reimbursement rate for emergency medical air transportation and related costs, generally, or funding children's healthcare coverage.~~

~~(g) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2, the department may implement, interpret, or make specific this section and any applicable federal waivers and state plan amendments by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions without taking regulatory action.~~

~~(h)(1) This section shall become operative only if, and on the date upon which, the rate change to the Medi-Cal fee rate for air ambulance services is implemented pursuant to Section 14124.15 of the Welfare and Institutions Code.~~

~~(2)(A) Except as described in subdivision (f), moneys in the Emergency Medical Air Transportation and Children's Coverage Fund shall remain available, upon appropriation by the Legislature, to be used to augment emergency medical air transportation reimbursement payments made through the Medi-Cal program for purposes of emergency medical air transportation that was provided before July 1, 2020, and that is therefore not eligible for the Medi-Cal rate change made pursuant to Section 14124.15 of the Welfare and Institutions Code. The emergency medical air transportation reimbursement payments may be augmented pursuant to this subparagraph using moneys deposited in the fund within 90 calendar days following July 1, 2020.~~

~~(B) Moneys in the Emergency Medical Air Transportation and Children's Coverage Fund shall not be available to be used to augment emergency medical air transportation reimbursement payments made through the Medi-Cal program for purposes of emergency medical air transportation that is provided on or after July 1, 2020, and that is therefore eligible for the Medi-Cal rate change made pursuant to Section 14124.15 of the Welfare and Institutions Code.~~

~~(i) This section shall remain in effect only until January 1, 2023, and as of that date is repealed. SEC. 3. Section 1371.6 is added to the Health and Safety Code, to read:
1371.6.~~

SEC. 2.

Section 1371.55 is added to the Health and Safety Code, to read:

1371.55. (a) (1) Notwithstanding Section 1367.11, a health care service plan contract issued, amended, or renewed on or after January 1, 2020, shall provide that if an enrollee receives covered services from a noncontracting air ambulance provider, the enrollee shall pay no more than the same cost sharing that the enrollee would pay for the same covered services received from a contracting air ambulance provider. This amount shall be referred to as the “in-network cost-sharing amount.”

(2) An enrollee shall not owe the noncontracting provider more than the in-network cost-sharing amount for services subject to this section. At the time of payment by the plan to the noncontracting provider, the plan shall inform the enrollee and the noncontracting provider of the in-network cost-sharing amount owed by the enrollee.

(b) The following shall apply for purposes of this section:

(1) Any cost sharing paid by the enrollee for the services subject to this section shall count toward the limit on annual out-of-pocket expenses established under Section 1367.006.

(2) Cost sharing arising from services subject to this section shall be counted toward any deductible in the same manner as cost sharing would be attributed to a contracting provider.

(3) The cost sharing paid by the enrollee pursuant to this section shall satisfy the enrollee’s obligation to pay cost sharing for the health service.

(c) A noncontracting provider may advance to collections only the in-network cost-sharing amount, as determined by the plan pursuant to subdivision (a), that the enrollee ~~has~~ failed to pay.

(d) A health care service plan or a provider may seek relief in any court for the purpose of resolving a payment dispute. A provider is not prohibited from using a health care service plan’s existing dispute resolution processes.

(e) Air ambulance service providers remain subject to the balance billing protections for Medi-Cal beneficiaries under Section 14019.4 of the Welfare and Institutions Code.

~~SEC. 4.~~ **SEC. 3.**

Section 10126.65 is added to the Insurance Code, to read:

10126.65. (a) (1) Notwithstanding Section 10352, a health insurance policy issued, amended, or renewed on or after January 1, 2020, shall provide that if an insured or subscriber receives covered services from a noncontracting air ambulance provider, the insured or subscriber shall pay no more

than the same cost sharing that the insured or subscriber would pay for the same covered services received from a contracting air ambulance provider. This amount shall be referred to as the “in-network cost-sharing amount.”

(2) A subscriber or insured shall not owe the noncontracting provider more than the in-network cost-sharing amount for services subject to this section. At the time of payment by the insurer to the noncontracting provider, the insurer shall inform the insured or subscriber and the noncontracting provider of the in-network cost-sharing amount owed by the insured or subscriber.

(b) The following shall apply for purposes of this section:

(1) Any cost sharing paid by the insured or subscriber for the services subject to this section shall count toward the limit on annual out-of-pocket expenses established under Section 10112.28.

(2) Cost sharing arising from services subject to this section shall be counted toward any deductible in the same manner as cost sharing would be attributed to a contracting provider.

(3) The cost sharing paid by the insured or subscriber pursuant to this section shall satisfy the insured’s or subscriber’s obligation to pay cost sharing for the health service.

(c) A noncontracting provider may advance to collections only the in-network cost-sharing amount, as determined by the insurer pursuant to subdivision (a), that the insured or subscriber ~~has~~ failed to pay.

(d) A health insurer or a provider may seek relief in any court for the purpose of resolving a payment dispute. A provider is not prohibited from using a health insurer’s existing dispute resolution processes.

~~SEC. 5.~~ **SEC. 4.**

Section 14124.15 is added to the Welfare and Institutions Code, to read:

14124.15. (a) The department shall set and maintain the Medi-Cal fee rate for air ambulance services provided by either fixed or rotary wing aircraft that is equal to a percentage, as specified in subdivision (b), of the rural Medicare rates for those services.

(b) The final rate shall either meet or exceed the sum of the air ambulance service rate as provided in the Medi-Cal program on December 31, 2017, and the supplemental payment offered in the year 2017 pursuant to Section 76000.10 of the Government Code.

(c) Each applicable Medi-Cal managed care health plan shall satisfy its obligation under Section 438.114(c) of Title 42 of the Code of Federal Regulations for emergency medical transports and shall provide payment to noncontract emergency medical transport providers consistent with Section 1396u-2(b)(2)(D) of Title 42 of the United States Code. Commencing ~~July~~ **January** 1,

2020, and for each state fiscal year thereafter for which this ~~chapter~~ *section* is operative, the amounts a noncontract emergency medical transport provider ~~could collect~~ *may collect*, if the beneficiary received medical assistance other than through enrollment in a Medi-Cal managed care health plan pursuant to Section 1396u-2(b)(2)(D) of Title 42 of the United States ~~Code~~ *Code*, shall be the resulting fee-for-service payment schedule amounts after the application of this section.

(d) This section shall become operative ~~July~~ *January* 1, 2020, and shall be implemented only to the extent federal financial participation is available and only if necessary federal approvals have been obtained.

~~SEC. 6.~~ **SEC. 5.**

No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

APPENDIX B COST IMPACT ANALYSIS: DATA SOURCES, CAVEATS, AND ASSUMPTIONS

The cost analysis in this report was prepared by the members of the cost team, which consists of CHBRP task force members and contributors from the University of California, Los Angeles, and the University of California, Davis, as well as the contracted actuarial firm, Milliman, Inc.²⁰

Information on the generally used data sources and estimation methods, as well as caveats and assumptions generally applicable to CHBRP's cost impacts analyses are available at CHBRP's website.²¹

This appendix describes analysis-specific data sources, estimation methods, caveats and assumptions used in preparing this cost impact analysis.

Analysis-Specific Caveats and Assumptions

This subsection discusses the caveats and assumptions relevant to specifically to an analysis of AB 651.

- CHBRP assumes that the amount that air ambulance service providers could balance bill an enrollee for air ambulance services is the total billed amount less the total OON effective rate. However, not all providers balance bill, or do so whenever possible. Similarly, not all enrollees who receive such a bill pay in full or at all. For this analysis, as an upper threshold, CHBRP assumes that only 20% of commercial/CalPERS enrollees receiving air ambulance services from an out-of-network (OON) provider would receive and pay a balance bill in 2020.
- CHBRP assumes that the initial air ambulance transportation fee schedule established by Medi-Cal would be 100% of the Medicare rural rate, or the current Medi-Cal rate plus the EMATA supplemental payment if the Medical rural rate is lower than that minimum requirement. Services included in an air ambulance bill include: Emergency Air Transport, Mileage, and Wait Time. Milliman's Consolidated Health Cost Guidelines Sources Database did not include claim lines for wait time. Therefore, costs for wait times are not included in the analysis.
- CHBRP assumes a 2% allowed cost trend and a 10% billed charge trend for commercial/CalPERS claims costs (based on Milliman's trend research) and a 0% trend for the Medi-Cal fee because the fee schedules are updated infrequently.

²⁰ CHBRP's authorizing statute, available at http://chbrp.com/CHBRP%20authorizing%20statute_2018_FINAL.pdf, requires that CHBRP use a certified actuary or "other person with relevant knowledge and expertise" to determine financial impact.

²¹ See method documents posted here, http://chbrp.com/analysis_methodology/cost_impact_analysis.php; in particular, see *2019 Cost Analyses: Data Sources, Caveats, and Assumptions*.

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CALIFORNIA HEALTH BENEFITS REVIEW PROGRAM COMMITTEES AND STAFF

A group of faculty, researchers, and staff complete the analysis that informs California Health Benefits Review Program (CHBRP) reports. The CHBRP **Faculty Task Force** comprises rotating senior faculty from University of California (UC) campuses. In addition to these representatives, there are other ongoing researchers and analysts who are **Task Force Contributors** to CHBRP from UC that conduct much of the analysis. The **CHBRP staff** coordinates the efforts of the Faculty Task Force, works with Task Force members in preparing parts of the analysis, and manages all external communications, including those with the California Legislature. As required by CHBRP's authorizing legislation, UC contracts with a certified actuary, **Milliman**, to assist in assessing the financial impact of each legislative proposal mandating or repealing a health insurance benefit.

The **National Advisory Council** provides expert reviews of draft analyses and offers general guidance on the program to CHBRP staff and the Faculty Task Force. CHBRP is grateful for the valuable assistance of its National Advisory Council. CHBRP assumes full responsibility for the report and the accuracy of its contents.

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Stephen L. Clancy, MLS, AHIP, of the University of California, Irvine conducted the literature search. Kevin Lee, MPH, of the University of California, Berkeley, prepared the background section. Jeffrey Hoch, PhD, of the University of California, Davis, and Donna Kalin, FSA, MAAA, of Milliman, Inc, prepared the cost impact analysis. John Lewis, MPA, of CHBRP staff prepared the Policy Context and synthesized the individual sections into a single report. A subcommittee of CHBRP's National Advisory Council (see final pages of this report) and a member of the CHBRP Faculty Task Force, Nadereh Pourat, PhD, all of the University of California, Los Angeles, reviewed the analysis for its accuracy, completeness, clarity, and responsiveness to the Legislature's request.

CHBRP assumes full responsibility for the report and the accuracy of its contents. All CHBRP bill analyses and other publications are available at www.chbrp.org.

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Please direct any questions concerning this document to: California Health Benefits Review Program; MC 3116; Berkeley, CA 94720-3116, info@chbrp.org, or www.chbrp.org.