CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

Abbreviated Analysis

California Assembly Bill 716: Emergency Ground Medical Transportation

Report to the 2023–2024
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SUMMARY

The California Assembly Committee on Health requested that the California Health Benefits Review Program (CHBRP)[1] conduct an evidence-based assessment of California Assembly Bill (AB) 716.

AB 716 would require that an enrollee or insured using a ground ambulance provider would not have to pay any higher cost sharing for a noncontracting provider than for a provider currently contracting with the enrollee's plan or insurer. The bill would prohibit a noncontracting ground ambulance provider from billing or sending to collections any higher amount above that cost-sharing amount. Furthermore, AB 716 would require California Department of Managed Health Care (DMHC)-regulated plans and California Department of Insurance (CDI)-regulated insurers to reimburse for ground ambulance services at the authorized rate for the specific exclusive operating area, unless it reaches another agreement with the noncontracting ground ambulance provider. The bill establishes a rate ceiling for self-pay and uninsured patients, by limiting rates to an amount not more than the established payment by Medi-Cal or Medicare fee-for-service amount, whichever is greater (which currently is Medicare). Finally, the bill would also establish increased visibility and transparency of payment rates to ground ambulance providers by publishing a report showing the allowable maximum rates for ground ambulance transportation services in each county, including trending the rates by county.

National Data on Ground Medical Transport and Emergency Ground Medical Transport. Ambulances bring 3 million privately insured people to an emergency room each year. Local fire departments and other government agencies provide nearly two-thirds (62%) of emergency ground ambulance rides.

Ground Medical Transport in California. At baseline, CHBRP estimates that there are approximately 0.6 per 1,000 GMT transports in 2024, operated by 715 public and private ambulance service providers. Ground medical transportation (GMT) is a nonemergency medical ambulance transportation service provided to individuals who are not in an emergency situation, but need more medical assistance and specialized equipment than other transportation options can provide. Around 3.6 million Americans miss medical appointments or must delay care because they don't have access to the proper transportation. GMT and emergency ground medical transport (EGMT) ambulance transportation charges are regulated at a local level and can vary considerably by county.

EGMT in California. CHBRP projects that there are approximately 2.5 per 1,000 EGMT out of network transports in 2024, operated by 715 public and private ambulance service providers. Ambulance transportation charges are regulated at a local level and can vary considerably by county. A variety of systems deliver GMT and EGMT, including public entities (fire departments, public ambulance districts, hospital systems) and private nonprofit or for-profit entities (hospitals and ambulance companies). Although 78% of the GMT and EGMT providers in California are in the public sector, these public entities only operate 19% of ambulances and account for 24% of 911 transports. A recent national analysis found that in 2018, 73% of EGMT transports in California included an out-of-network charge.

Policy Context. The 2020 federal No Surprises Act (in effect as of 2022) does not directly apply to EGMT. A "surprise medical bill" is a bill from an out-of-network provider or facility that was not expected by the patient or that came from an out-of-network provider not chosen by the patient. California already has protections in place against surprise billing by individual doctors that are not chosen by enrollees but are out-of-network. Current state law in California explicitly allows balance billing for medical transportation to be applied to enrollees in DMHC- and CDI-regulated plans and policies, though not Medi-Cal beneficiaries.

Although some Medi-Cal Managed Care Plans are subject to the bill, plans and beneficiaries

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

will not be impacted. For Medi-Cal beneficiaries, current law prohibits ambulance service providers from balance billing as well as generally prohibits the application of any cost sharing for accessed services.

Eleven other states have recent legislative activity around EGMT and GMT, and 10 states have enacted surprise billing rules for out-of-network Ground Ambulance Providers.

AB 716 would not require coverage for a new state benefit mandate and therefore does not exceed the definition of essential health benefits (EHBs) in California.

Impacts. Postmandate, health plans and insurers would pay more for out-of-network EGMT services because of the difference between higher out-of-network rates and contracted rates and lower enrollee cost sharing. The per-unit cost for EGMT would increase from $2,070 at baseline to $3,190 postmandate. The per-unit cost for GMT would increase from $2,180 at baseline to $3,340 postmandate. AB 716 could disincentivize negotiation between health plans, insurers, and EGMT providers because of the reimbursement levels it would set for nonparticipating providers.

Expenditures. CHBRP estimates that utilization of GMT and EGMT services will remain the same due to AB 716. The baseline and postmandate utilization of out-of-network EGMT services of 2.5 per 1,000 enrollees and is not estimated to increase as a result of AB 716. Utilization for GMT is 0.6 per 1,000, and is estimated to not increase as a result of AB 716.

AB 716 would increase total net annual expenditures by $67,335,000, or 0.05%, for enrollees with DMHC-regulated plans and CDI-regulated policies. This is due to a 0.0842% change in total premiums paid by employers and enrollees for newly covered benefits, adjusted by a decrease in enrollee expenses for covered and/or noncovered benefits.

POLICY CONTEXT

On February 14, 2023, The California Assembly Committee on Health requested that the California Health Benefits Review Program (CHBRP) conduct an evidence-based analysis of the impacts of Assembly Bill (AB) 716: Emergency Ground Medical Transportation (EGMT). CHBRP focused on fiscal and policy analysis, and did not conduct a medical effectiveness or public health analysis.

AB 716 would ensure that, for an enrollee or insured using a ground ambulance provider, cost sharing would be no more for a noncontracting provider than for a provider currently contracting with the enrollee's plan or insurer. The bill would also prohibit a noncontracting ground ambulance provider from billing or sending to collections any higher amount above that cost-sharing amount. The bill would also establish increased visibility and transparency of payment rates to ground ambulance providers, by requiring that on or before March 1, 2024 (and each year thereafter), the statewide Emergency Management Authority develop and publish on its Internet website a report showing the allowable maximum rates for ground ambulance transportation services in each county, including trending the rates by county. This report would be required to be submitted to the California Department of Insurance (CDI) and to the California Department of Managed Health Care (DMHC), as well as to the California Office of Health Care Affordability. The bill would require DMHC-regulated plans and CDI-regulated insurers to reimburse for ground ambulance services at the authorized rate for the specific exclusive operating area, unless it reaches another agreement with the noncontracting ground ambulance provider. Finally, the bill establishes a rate ceiling for self-pay and uninsured patients, by limiting rates to an amount not more than the established payment by Medi-Cal or Medicare fee-for-service amount, whichever is greater (which currently is Medicare).

Emergency Ground Medical Transport in California

California has 715 total public and private ambulance services statewide, with 3,600 licensed ambulances (CAA, 2022). There are 337 emergency ambulance service areas (zones) statewide, of which more than 220 are served by private ambulance companies.

The estimated total annual expenditures for ground ambulance services in California is approximately $2 billion (CAA, 2022).

Though the ACA does require health plans to cover out-of-network EGMT at usual and customary rates (UCR),[2] there are no specific standards regarding UCR. Health plans often set their UCR much lower than what an ambulance provider charges, leaving patients open to financial liability for the remainder of the charges (Chhabra et al., 2020).

For enrollees in DMHC-regulated plans and CDI-regulated policies, health professionals and facilities are categorized as in-network or out-of-network, based on whether they have an existing contract with specific health plans or insurers to provide service to their enrollees for a specific payment amount. In-network health facilities and professionals have a contract with the enrollee's plan or insurer that defines a contracted rate for payment for services (and no balance billing of the enrollee is allowed). However, when an out-of-network provider's billed charge is more than the plan/insurer will pay, the provider may then seek to recoup the difference, or balance bill, directly from the enrollee (Chhabra et al., 2020).

Another key interaction of AB 716 would be with existing state law and regulations contained within Basic Health Care Services: §1371.5 of the Knox-Keene Act (use of emergency response system). Health Care

[2] Source: www.healthcare.gov/glossary/ucr-usual-customary-and-reasonable/ Healthcare.gov defines UCR (usual, customary, and reasonable:
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Service Plans that provide basic health care services shall not require prior authorization or refuse to pay for any ambulance or ambulance transport services provided to an enrollee as a result of a 911 emergency response system request for assistance, if either of the following conditions apply:

- The request was made for an emergency medical condition, and ambulance transport services were required.
- An enrollee reasonably believed that the medical condition was an emergency medical condition and reasonably believed that the condition required ambulance transport services. The determination as to whether an enrollee reasonably believed that the medical condition was an emergency medical condition that required an emergency response shall not be based solely upon a retrospective analysis of the level of care eventually provided to, or a final discharge of, the person who received emergency assistance.[3]

A health care service plan shall not be required to pay for any ambulance or ambulance transport services if the health care service plan determines that the ambulance or ambulance transport services were never performed, the service was not requested in response to a reasonably perceived emergency, or upon findings of fraud, incorrect billings, the provision of services that were not covered under the member's current benefit plan, or membership that was invalid at the time services were delivered for the pending emergency claim.

Emergency health care services are defined in Knox-Keene in Section 1345 as those that include ambulance and ambulance transport services and out-of-area coverage. "Basic health care services" includes ambulance and ambulance transport services provided through the 911 emergency response system. Emergency health care services shall be available and accessible to enrollees on a 24-hours-a-day, 7-days-a-week basis within the health care service plan area. Emergency health care services shall include ambulance services for the area served by the plan, to transport the enrollee to the nearest 24-hour emergency facility with physician coverage, designated by the health care service plan.[4]

For enrollees in DMHC- and CDI-regulated plans and policies, current state law[5] explicitly allows balance billing for medical transportation. This bill would close this notable exemption.

For Medi-Cal beneficiaries, current law[6] prohibits ambulance service providers from "balance billing"[7] as well as generally prohibiting the application of any cost sharing for accessed services.

A "surprise medical bill" is a bill from an out-of-network provider or facility that was not expected by the patient or that came from an out-of-network provider not chosen by the patient (Garmon and Chartock, 2017). Surprise medical bills cause financial anxiety and have been linked to unavoidable medical debt (Hamel et al., 2016). California already has protections in place against surprise billing by individual doctors that are not chosen by enrollees but are out-of-network, such as anesthesiologists. However, the law does not currently apply to out-of-network EGMT and GMT services.[8]

[3] A December 19, 2017 All Plan Letter from DMHC clarifies that the "enrollee reasonably believed that the medical condition was an emergency medical condition and *reasonably believed* that the condition required ambulance transport services." [Emphasis added.] The standard articulated by the Knox-Keene Act in section 1371.4 and 1371.5 turns on whether the enrollee him/herself reasonably believed he/she had an emergency medical condition. This standard is not the objective "reasonable person" or "prudent layperson" standard that asks whether a reasonable person would have believed a medical emergency existed. Rather, the Knox-Keene Act's standard is subjective and takes into consideration whether the enrollee's belief was reasonable given the enrollee's age, personality, education, background, and other similar factors.
[4] HSC 1300.67. Scope of Basic Health Care Services.
[5] HSC 1367.11, INS 10352.
[6] WIC 14019.4.
[7] Personal Communication, W. White, DHCS, March 2020.
[8] For more background on surprise medical billing and prevalence, as well as impacts on public health (related to Emergency Services and Air Ambulances prior to enacted legislation), please see CHBRP's completed analysis of AB 1611 in 2019, and CHBRP's analysis of Air Ambulance Legislation AB 651, also completed in 2019.

AB 716 would not require coverage for a new state benefit mandate and therefore does not exceed the definition of EHBs in California.

Federal Policy

Federal agencies funded and oversaw emergency medical services (EMS) systems until 1981, when the federal government turned this authority over to states and their counties. (For more on this history, please see the *Background* section.) The federal Office of EMS, under the National Highway Traffic Safety Administration (NHTSA), currently provides guidance and leadership through data collection, publication of service guidelines, and convening stakeholders to define best practices in the EMS industry. Federal funding is provided through the Department of Health and Human Services (HHS) block grants, which states may choose to spend on EMS provision (Institute of Medicine, 2007).

Emergency medical services are not administered or overseen by any single U.S. federal department or agency. In addition to NHTSA's Office of EMS, other federal departments that support and regulate EMS include Defense, HHS, Homeland Security, and the Federal Communications Commission.

No Surprises Act

In December of 2020, Congress enacted the "No Surprises Act," which, starting in 2022, prohibits most surprise out-of-network bills when a patient receives out-of-network services during an emergency visit or at an in-network hospital without advance notice. In addition, the "No Surprises Act" includes air ambulances (Hoadley et al., 2020). However, the protections do not apply to ground ambulance services. Few states, to date, have implemented regulations in this area, which is complicated by the fact that many ground ambulance services are provided by local government entities, (Hoadley et al., 2020), as described later in this section. The law instead requires the Secretary of Health and Human Services, the Secretary of Labor, and the Secretary of the Treasury (the Secretaries) to establish and convene an advisory committee for the purpose of reviewing options to improve the disclosure of charges and fees for ground ambulance services, better inform enrollees (consumers) of insurance options for such services, and protect enrollees from balance billing. As of March 2023, the Advisory Committee has not been convened, however members have been selected (and deadlines set).

CARES Act

Through the 2023 calendar year, health care providers, including ambulance service providers, that accepted money from the federal Provider Relief Fund created by the March 2020 CARES Act are not allowed to balance bill patients for care if they have a suspected or confirmed case of COVID-19 (Rosato, 2021). While this only applies to presumptive or confirmed COVID-19 patients, the duration of this balance billing prohibition is unclear. In California, there are 58,846 health care providers that received CARES Act funding.

Ambulances / Medicare

Medicare has a considerable fiscal, regulatory, and policy role in financing and influencing EGMT throughout the country. Nationally, individuals 65 years and older were consistently the largest age group associated with emergency ground ambulance services, though their share of the distribution decreased from 37.7% in 2016 to 34% in 2020 (FAIR Health, 2022). Medicare covers medically necessary ground ambulance services for its beneficiaries meeting certain conditions.[9] While most Medicare transports are covered by the Medicare Part B medical benefit, transports involving inpatients at a hospital or other facility fall under the Part A hospital benefit. Medicare pays ambulance providers for Part B–covered transports using the Ambulance Fee Schedule (AFS). The AFS establishes a base rate that varies by the

[9] In addition to medical necessity, Medicare requires that (a) transports are to the nearest appropriate facility given the patient's condition, and (b) all other forms of transportation are contraindicated.

level of transport provided (e.g., basic life support vs. advanced life support level 1 or level 2) and whether the transport is emergency or nonemergency. The AFS also includes a per-mile rate applied to the distance traveled with the patient. The AFS incorporates a permanent add-on payment of a 50% increase in the standard mileage rate for ground ambulance transports that originate in rural areas where the travel distance is between 1 and 17 miles. Both base and mileage payments are only made when a patient is transported to an emergency department or other eligible destination—in other words, Medicare does not pay for ambulance responses to calls for service that do not result in a patient transport.

State Policy

State Oversight: At the state level, the Emergency Medical Services Authority enforces the statutes in the Emergency Medical Services Act, Health and Safety Code Division 2.5, and develops and implements regulations in California Code of Regulations, Title 22, Division 9: Prehospital Emergency Medical Services, to implement those laws. The Authority also approves local EMS plans submitted by the county's local EMS agency to ensure that they contribute to an organized statewide EMS system, comply with statute and regulation and meet the needs of the persons served. In addition, the Authority licenses and disciplines paramedics, regulates training programs, and coordinates disaster preparedness. serves as the pass-through for federal funds, and administers the statewide poison control system (Narad et al., 1994).

The California Commission on Emergency Medical Services is an 18-member body representing the wide variety of EMS stakeholders. The duties of the Commission include approving regulations and guidelines developed by the Authority and providing advice to the Authority on the assessment of emergency facilities and services. The Commission may also hear an appeal by a local EMS agency regarding a local EMS plan. The Commission meets quarterly at locations throughout the state. The California Ambulance Association holds a seat on the Commission.

In addition, the California Highway Patrol inspects each nongovernment ambulance for safety and basic equipment, and issues ambulance permits, and also conducts ambulance driver testing and issues ambulance driver certificates.

County Oversight: California's 33 local EMS agencies (LEMSAs) (7 multicounty LEMSAs and 26 single-county LEMSAs) exercise the most direct authority over the day-to-day operation of the state's emergency medical services. Organized on a county or multicounty basis, LEMSAs plan, implement, monitor, and evaluate local EMS systems and establish the roles and responsibilities of the various system participants in implementing the plan (Narad et al., 1994). LEMSAs also share responsibility with the state EMSA for regulating the local EMS workforce, EGMT providers, and 911 receiving hospitals. LEMSAs set the maximum charges for ambulance transportation. LEMSAs also write and enforce contract terms with public and private EMS providers, issue ambulance licenses, and grant exclusive operating area (EOA) rights to EGMT providers. The county performs other functions including disaster preparedness and certification of emergency medical technicians (California EMS Authority, 2022).

Other States

EGMT is often not addressed in legislation intended to address surprise billing, but it is increasingly a source of concern (U.S. GAO, 2012). Historically, most EGMT was provided by local government or by hospitals at prices close to Medicare reimbursement levels (Adler et al., 2023). As Medicare and Medicaid reimbursement levels for EGMT have remained below cost growth (while these payers simultaneously account for a rapidly growing share of the population using EGMT services), billed charges have increased considerably. Privatization of ambulance services and industry consolidation also may have contributed to price increases (U.S. GAO, 2012; Webb, 2019).

In January of 2020, Ohio enacted a law banning surprise medical bills starting in 2022 that mirrors the No Surprises Act but includes ground ambulances. In New York, out-of-network providers cannot bill insured

patients more than in-network rates in emergency situations, including for ground ambulances though not for transports between facilities. In Colorado, a 2019 law that recently went into effect bans private ambulances from balance billing patients, though public ambulances funded with taxpayer dollars are exempt. Maryland has a similar balance billing law that applies to ground ambulance services, but it applies only to those operated by local governments or volunteer fire departments and rescue squads (Rosato, 2021). Table 1 provides an overview of the 10 states with enacted laws related to surprise billing rules for out-of-network ground ambulance providers. In particular, they vary significantly in their regulation of reimbursement rates for out-of-network providers.

Table 1. State Surprise Billing Rules for Out-of-Network Ground Ambulance Providers

State (Year of Enactment)	Protects Enrollees From Balance Bills	Regulates Reimbursement Rates for Out-of-Network Providers	Protections Apply to Public/Private Providers?
Colorado (2019)	Yes	Yes	Private only
Delaware (2001)	Yes	No	Both
Florida (2016)	Yes	Yes	Both
Illinois (2011)	Yes	No	Both
Maine (2020)	Yes	Yes	Both
Maryland (2020)	Yes	No	Public only
New York (2015)	Yes	Yes	Both
Ohio (2020)	Yes, for emergency services	Yes	Both
Vermont (1994)	Yes, for emergency services	No	Both
West Virginia (1997)	Yes	Yes	Both

Source: O'Brien et al., 2021.

Table 2 summarizes the topic and status of seven other states that have recent (2021 and 2022) legislative activity around EGMT. Most activity relates to reimbursement rates or fee schedules related to emergency transport.

Table 2. Recent EGMT-Related Legislation in Other States

State	Year	Bill Number	Status	Summary
Georgia	2023	HB 286	Introduced	Provides for certain consumer protections against surprise billing for ambulance service; to provide for definitions; to require a healthcare plan to reimburse for ambulance service provided to a covered person by a nonparticipating ambulance provider; to provide for arbitration; to provide for a covered person's financial responsibilities; to provide for an effective date and

State	Year	Bill Number	Status	Summary
				applicability; to repeal conflicting laws; and for other purposes.
Oklahoma	2023	SB 881	Introduced	Creates the Surprise Billing Protection Act of 2023; defining terms; establishing provisions for reimbursement and certain cost-sharing requirements; The bill prohibits certain surprise billings and establishes a payment process and means for payments; provides for certain appeals.
Texas	2023	SB 2476	Introduced	An act relating to consumer protections against certain medical and health care billing by municipal ground ambulance service providers. Eliminates **surprise billing** for municipal **ground ambulance services** under certain health benefit plans.
Kentucky	2023	HB 403	Introduced	An act relating to emergency medical services and declaring an emergency. The department shall: calculate an assessment on **emergency ground transport**, apply uniformly to all assessed ground ambulance providers any annual changes to the assessment rate, evaluate current ground ambulance provider reimbursement rates paid by managed care organizations.
Washington	2022	HB 1688	Enacted	An act relating to protecting enrollees from charges for out-of-network health care services, by aligning state law and the federal no surprises act and addressing coverage of treatment for emergency conditions; Sec. 21. Further, the legislation requires a report and any recommendations to the appropriate policy and fiscal committees of the legislature as to how balance billing for ground ambulance services can be prevented and whether ground ambulance services should be subject to the balance billing restrictions of the legislation.
Rhode Island	2022	S 2476	Engrossed on 06/14/2022, died in chamber	Requires individual and group plans that provide coverage for emergency medical services to also provide coverage for transport to an alternative location facility. Requires plans to reimburse EMS transport to alternative facilities at the same rate as for nonemergency basic life support transports to EDs.
Idaho	2022	S 1283	Enacted	Provides supplemental Medicaid reimbursement for ground emergency medical transportation for Medicaid beneficiaries.
Massachusetts	2021	SB 731	Inactive	Requires insurers to directly pay out-of-network ambulance service providers at a rate equal to that established by the municipality where the patient was transported from.
Illinois	2022	HB 4944	Sine die	Requires that the base rate of reimbursement for Medicaid ground ambulance services be increased to at

State	Year	Bill Number	Status	Summary
				least 100% of Medicare Ambulance Fee Schedule rates for urban areas.
Nebraska	2021	LB 238	Indefinitely postponed	Establishes a supplemental reimbursement program for ground emergency transport services.

Source: California Health Benefits Review Program, 2023.

Key: ED = emergency department; EGMT = emergency ground medical transport.

Local Policy

Typical contract negotiations for health care services provided by contracted providers generally reflect the insurer's ability to steer patient volume to preferred providers and the provider's ability to use its purchasing leverage to refuse care to an insurer's enrollees without a contract. (Ho and Lee, 2019). However, for emergency ground ambulance services, neither party generally has such an ability. Patients rarely have any choice of which ambulance picks them up, many locations have only one provider, and ambulances typically must pick up and transport patients regardless of their ability to pay. (Adler et al., 2023).

At least partly as a result, many localities (often through the fire department) elect to directly staff and operate emergency ground ambulance services (accounting for roughly 60% of emergency transports in 2020). Some localities go further, refraining from the direct billing of local residents and treating emergency ground ambulance services as a public, taxpayer supported benefit similar to fire department services (Adler et al., 2023). Many local governments also subsidize ground ambulance services with taxpayer dollars by charging less than the costs.

Local fire departments and other government agencies provide nearly two-thirds (62%) of emergency ground ambulance rides (Amin et al., 2021). The services that government-owned ground ambulances provide as a public benefit may be different than those that private ground ambulances provide. Billing practices may also differ for government-based or private ground ambulances.

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 Persons

Because the change in average premiums does not exceed 1% for any market segment, CHBRP would expect no measurable change in the number of uninsured persons due to the enactment of AB 716.

Changes in Public Program Enrollment

CHBRP estimates that the mandate would produce no measurable impact on enrollment in publicly funded insurance programs due to the enactment of AB 716.

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

CHBRP assumes that enrollees who do not have benefit coverage pay for services directly (e.g., self-pay). In the case of AB 716, the EGMT and GMT services are already covered benefits, but due to the

nature of out-of-network medical transport services, the covered benefit may still have resulted in enrollee out-of-pocket spending in the form of cost sharing or balance billing. However, at baseline it is unlikely that all balance billed charges were actually paid, which may have resulted in charity care, provider bad debt, or payments by public programs. The prohibition on balance billing for EGMT and GMT services will result in balance billed charges being reduced to zero. The change in out-of-network allowed charge from an external benchmark to the LEMSA rates will result in health plans and insurers paying higher per-unit costs.

BACKGROUND ON GROUND MEDICAL TRANSPORT AND EMERGENCY GROUND MEDICAL TRANSPORTATION

As explained in the *Policy Context* section, emergency medical services (EMS) in the United States are strongly influenced by federal recommendations and guidelines, but EMS operations are largely regulated at the state and local levels. Accordingly, California's EMS Act of 1980 created provisions for state regulation of EMS, including extensive local delegation, in Division 2.5 of the Health and Safety code (sections 1797-1799) to local EMS agencies (LEMSAs) (California EMS Authority, 2019). For additional information on the history of EMS in the United States as well as contemporary EMS issues, please see the *Background* sections of CHBRP's abbreviated analyses of AB 2625 of 2020 and AB 2709 of 2022.[10]

GMT and EGMT Delivery Systems

GMT and EGMT Providers

Ground medical transport (GMT) and emergency ground medical transportation (EGMT) are both provided by emergency medical technicians (EMTs) and/or paramedics who staff ground ambulances. EMTs, who receive approximately 150 hours of training, can provide noninvasive basic life support (BLS) maneuvers such as oxygen therapy, cardiopulmonary resuscitation (CPR), and bleeding control. Paramedics, who receive approximately 1,100 hours of training beyond that of EMTs, can provide invasive advanced life support (ALS) treatments, such as intravenous (IV) therapy, medication administration, and breathing tube insertion. In California, broad training requirements and authorized skills are regulated by the EMS Authority, whereas EMT and paramedic scope of practice is set by each LEMSA. In response to 911 calls or nonemergency requests for GMT, trained emergency medical dispatchers use software to triage whether an emergency is life threatening (necessitating a paramedic-level ALS response) or non-life threatening (necessitating an EMT-level BLS response). BLS ambulances consist of two EMTs, whereas ALS ambulances are staffed by either two paramedics or one paramedic and one EMT.

In California, the most recent 2020 data suggests that 79% of 911 calls received an ALS or paramedic-level response while the remaining 21% received a BLS or EMT-level response (California EMS Authority, 2022).[11] Though only 59% of EMS responses led to subsequent EGMT transports, this data report did not specify whether the transports were at the ALS or BLS level. In some jurisdictions for example, paramedics may examine the patient and decide that the patient is non-life threatening so only a BLS transport is necessary. In other primarily urban jurisdictions, paramedics may respond to all 911 calls and exclusively provide paramedic-level ALS transports. Nationally, 51.5% of commercial and Medicare Advantage EGMT claims were associated with ALS services, whereas 48.5% of claims were associated with BLS services (FAIR Health, 2022). CHBRP was unable to locate data indicating the proportion of California EGMT or GMT ambulance transports that are provided at the ALS or BLS level.

GMT and EGMT Delivery

Payer reimbursement rates typically vary by patient acuity. Rates are higher for life-threatening emergencies with ALS ambulances than for non-life-threatening emergencies with BLS ambulances. In addition to the response and transportation charge, there are sometimes additional charges such as mileage, oxygen, and miscellaneous supplies (Los Angeles County EMS Agency, 2021). Plans and policies may adopt Medicare ambulance coverage polices, classifying GMT or EGMT reimbursement into BLS and two ALS levels: ALS Level 1 when a paramedic assessment or intervention is provided, or ALS

[10] Available at www.chbrp.org/completed_analyses/index.php.
[11] The most recent annual EMS data report includes data from all California counties with the exception of Los Angeles County.

Level 2 when a defined complex paramedic intervention is provided, such as endotracheal intubation or three intravenous injections (UnitedHealthcare Services Inc., 2022).

GMT and EGMT Billing

A variety of systems deliver GMT and EGMT, including public entities (fire departments, public ambulance districts, hospital systems) and private nonprofit or for-profit entities (hospitals and ambulance companies). Although 78% of the GMT and EGMT providers in California are in the public sector, these public entities only operate 19% of ambulances and account for 24% of 911 transports (Jacobs et al., 2017). While fire departments respond to most 911 medicals calls in California and employ EMTs and paramedics on their fire apparatus, most fire departments do not provide ambulance transport services. Two companies in the private sector (Global Medical Response and Falck and their subsidiaries) operate nearly half of private ambulances and provide over 75% of all California EGMT transports (Jacobs et al., 2017). When fire departments or public sector entities provide ambulance transport, this is almost exclusively EGMT; whereas private entities are responsible for nearly all GMT.

Ambulance transportation charges, including the response, mileage, and supplies components, are regulated at a local level by LEMSAs. LEMSAs set a maximum billed charge, which can vary considerably by county (Jacobs et al., 2017). The most recent comprehensive review of California's 33 LEMSAs, in 2014, reported that the maximum billed ambulance response charge, if inflated to 2022 dollars, can average up to $3,200 depending on the region (Los Angeles County EMS Agency, 2014). These maximum billed charges represent the ceiling; contracted or allowed rates may be substantially lower. However, the LEMSA's role in regulating maximum charges also serves to create a de facto maximum balance or surprise bill from out-of-network GMT or EGMT providers in each county. AB 716 may provide additional transparency of these county-level maximum charges starting in 2024 due to the requirement for the published internet report, as specified in the proposed Section 1797.124 of the Health and Safety Code.

Given the emergency nature of 911 calls, emergency medical dispatchers typically dispatch the closest ambulance to the scene. The patient does not have any choice in determining the EGMT ambulance provider. As such, the patient cannot choose an in-network contracted provider over an out-of-network ambulance provider. Furthermore, most ambulance providers do not routinely contract with insurance networks for EGMT. A recent national analysis of 2018 large-employer claims found that 73% of EGMT transports in California included an out-of-network charge (Amin et al., 2021). Another national study estimated that 51% of EGMT transports were considered out-of-network (Garmon and Chartock, 2017). As a result, patients often have increased cost-sharing responsibilities, and they may be subject to balance billing, where the patient is billed the difference between the ambulance provider's charges and the insurer's payment. These balance bills are routinely above $1,000, and sometimes over $2,000, depending on the provider and the insurer.

Ambulance transports can also include ground medical transport (GMT). GMT is nonemergency, scheduled transportation, which is primarily hospital-to-hospital transfers, transfers to/from skilled nursing facilities, and transfers to/from kidney dialysis facilities. These nonemergency, scheduled ambulance transports are also provided by EMTs and paramedics, and are regulated by California's EMS Act and county LEMSAs. Even though GMT is by its nature nonemergency and more likely to be scheduled with in-network GMT providers, most GMT claims are likely out-of-network (Adler et al., 2023). Though surprise billing or balance billing is still a possibility with GMT, it is slightly less common when compared to EGMT. An analysis of 2016-2017 commercial claims reported that 85.3% of EGMT was out-of-network, whereas 59.4% of nonemergent GMT was out-of-network (Adler et al., 2023). CHBRP was unable to determine why this scheduled, nonemergent GMT is often out-of-network, but GMT ownership structure and limited availability of GMT providers may contribute to this issue (Adler et al., 2023).

GMT and EGMT Workforce Issues

GMT and EGMT rely on an increasingly challenged workforce of EMTs and paramedics (EMS providers). As a result, many GMT and EGMT providers struggle with recruitment and retention of EMTs and paramedics nationally and particularly in California, with this issue worsening since the onset of the COVID-19 pandemic (Bates and Coffman, 2023). There are approximately 12,000 active employed EMTs and 10,000 employed paramedics in California according to recent 2021 data. However, there are more than twice as many currently certified or licensed EMTs or paramedics compared to actively employed providers; most EMTs and paramedics are likely employed in other professions or do not use their current certification or license (Bates and Coffman, 2023). Full-time EMTs earn approximately 80% of the median annual wage in California ($46,000), whereas paramedics earn approximately 110% of the median annual wage. Both EMTs and paramedics earn significantly less than firefighters, police officers, and registered nurses, with these other professions earning about twice the wage of EMTs and paramedics. In 2019, 87% of EMTs worked for private companies and 76% of paramedics worked for private companies, with the remainder employed by government agencies (Bates and Coffman, 2023).

EMTs and paramedics suffer from high rates of burnout, and this burnout is strongly associated with increased work absences and intentions of leaving the EMS profession (Crowe et al., 2018). A recent study from Texas during the COVID-19 pandemic suggested that over half of EMTs and paramedics surveyed reported high symptoms of burnout (Chavez et al., 2022). Most EMTs and paramedics in this study also reported increased workload and shortages of colleagues/staff as a result of the pandemic.

In California, the two largest GMT and EGMT providers, Global Medical Response and Falck, both struggle with current workforce issues. Global Medical Response ceased providing GMT in Los Angeles County in late 2022 due to staffing shortages and high workforce attrition (Kwon, 2022). Since assuming the citywide EGMT contract in San Diego, Falck has failed to meet minimum ambulance staffing requirements and response times as a result of the inability to hire and retain EMTs and paramedics (Garrick, 2022). These GMT and EGMT providers also claimed that inadequate insurance and Medi-Cal reimbursements contributed to the poor wages and subsequent recruitment/retention issues with the EMT and paramedic workforce (Garrick, 2022; Kwon, 2022).

Many private sector EGMT providers use the same ambulances and personnel for GMT and EGMT. Given the unpredictable nature of EGMT and inevitable downtime between emergency calls, EGMT crews can be used for GMT when they are not engaged in EGMT duties (Bates and Coffman, 2023). Likewise, GMT crews can supplement the 911 system when 911 calls temporarily overwhelm existing EGMT resources. These overlapping systems can help smooth work duties and ensure timely responses to both GMT and EGMT calls. However, the previously mentioned workforce shortages often result in insufficient GMT crews given that EGMT contracts typically mandate response times and minimum staffing, whereas GMT contracts do not (Garrick, 2022; Kwon, 2022). These workforce shortages increasingly lead to potentially avoidable 911 calls when GMT responses are delayed or not fulfilled (Garrick, 2022; Kwon, 2022). These likely nonemergency 911 EGMT responses further stress the increasingly stretched GMT and EGMT workforces. It is unclear how the proposed AB 716 could affect these workforce issues, given the potential increased EGMT revenues projected in the *Long-Term Impacts* section of this report.

Ambulance Delays, Diversion, and EGMT

EGMT utilization, charges, and ultimately balance billing may be influenced by ambulance delays and diversion. Patients utilizing EGMT often encounter delays in transfer of care from the ambulance to emergency department (ED) providers (Backer et al., 2019). This wait time interval from when an ambulance arrives at the ED to the time ED staff formally accept patient care responsibilities is commonly referred to as ambulance patient offload time (APOT), and prolonged APOT is associated with delays in treatment and longer hospital length of stay (Backer et al., 2019; Hanchate et al., 2022). Although a primary cause of APOT is ED overcrowding, there are numerous contributing factors, such as lack of inpatient hospital beds and hospital staffing shortages.

APOT is closely tied to ambulance diversion, whereby a hospital temporarily closes their ED to incoming ambulances, thus forcing the ambulance to divert to a different and likely further ED than intended (Hsuan et al., 2019). Like APOT, diversion is also associated with increased morbidity and mortality, especially for patients with time-sensitive conditions like stroke or acute myocardial infarction (Dawson et al., 2022; Hsuan et al., 2019). Although ambulance diversion is intended to reduce ED crowding and APOT, studies suggest that diversion is ineffective in reducing ED crowding, instead leading to "catastrophic delays in treatment for seriously ill or injured patients" (Burke et al., 2013; Institute of Medicine, 2007).

In addition to delaying treatment and worsening health outcomes, ambulance diversion is also associated with financial repercussions. Diversion may necessitate that an ambulance transport a patient to a more distant hospital, thus increasing the ambulance transportation mileage. As mileage is a component of total EGMT charges, diversion is likely associated with increased EGMT charges. If the EGMT provider is out-of-network, diversion and more distant ambulance transport can result in a potentially larger balance bill. Furthermore, ambulance diversion disproportionately affects racial and ethnic minorities, potentially leading to higher EGMT charges for racial and ethnic minorities (Hanchate et al., 2022). One study found that hospitals serving large minority populations were more likely to engage in ambulance diversion as compared to hospitals with smaller proportions of minorities, even after adjusting for various hospital characteristics (Hsia et al., 2012).

Ambulance Subscription Plans

Many EGMT providers do not contract with insurance networks, but some EGMT providers in California offer a subscription service to local residents within their jurisdiction. Though not insurance programs, these "ambulance plans" are regulated under the California Code of Regulations, Title 28 §1300.43.3. In exchange for an annual household fee, which is typically between $50 and $100, the EGMT provider agrees to accept the insurer's payment as payment in full, eliminating any potential out-of-pocket expenses (including surprise bills) billed from that provider. Ambulance subscriptions are likely marketed by EGMT providers and purchased by consumers and enrollees to avoid potential balance billing, so subscriptions may be unnecessary and less common under the proposed AB 716 and its consumer balance billing protections.

Mobile Integrated Health – Community Paramedicine and EGMT

An emerging area within the EMS field is mobile integrated health/community paramedicine (MIH-CP). MIH-CP utilizes EMTs and paramedics to function in a proactive public health role that supplements the traditional reactive function of 911 emergency response and transportation to hospital emergency departments. Many MIH-CP programs are intended to reduce the need for EGMT by treating a 911 patient at the emergency scene. For example, Los Angeles City Fire Department's MIH-CP program was able to treat 50% of patients at the scene or in-home by utilizing an expanded paramedic skillset (Sanko and Eckstein, 2021). Another MIH-CP program focused on enhanced hospice care reduced transports from 80.3% to 24.8% in Ventura County, California (Breyre et al., 2022). Accordingly, MIH-CP may significantly decrease EGMT expenditures and ambulance balance billing if MIH-CP can prevent or substitute for ambulance transport.

Financing for Mobile Integrated Health – Community Paramedicine

Many of these innovative MIH-CP and telemedicine programs are grant-funded and do not have stable reimbursement mechanisms. However, the Centers for Medicare & Medicaid Services recently introduced a new payment model for these services, dubbed Emergency Triage, Treat, and Transport (ET3), whereby eligible EGMT providers can now receive Medicare payments for alternative EGMT destinations (e.g., urgent care, mental health facility, primary care office) or telehealth-facilitated treatment at the emergency scene (Centers for Medicare & Medicaid Services, 2023). Though most insurers currently do not yet reimburse for transport to alternative EGMT destinations, policies and plans may begin to consider reimbursement for MIH-CP in line with Medicare's ET3 coverage determination. Successful MIH-CP programs may reduce the need for EGMT, thus reducing the financial burden of EGMT, ambulance

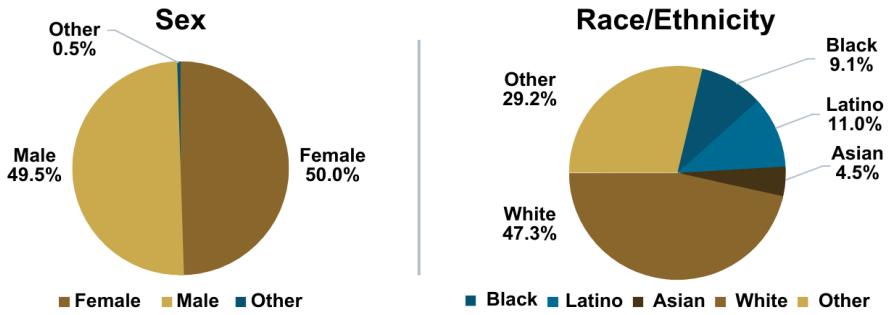
balance billing, and emergency department utilization as demonstrated by some pilot programs (Elden et al., 2022; Gingold et al., 2021).

GMT and EGMT Utilization in California

In California, there were approximately 2.9 million EGMT transports in 2020, operated by over 700 public and private ambulance service providers (California EMS Authority, 2022; Los Angeles County EMS Agency, 2021). CHBRP estimates that there were over 720,000 GMT transports in 2020, comprising 208,000 nonemergent medical transports and 513,000 interfacility transports (California EMS Authority, 2022).[12] Demographic data about EGMT ambulance transport are available for 75% of California's 2019 population; no demographic data were identified for the GMT transports (California EMS Authority, 2021).[13] The data in this section pertain to all Californians, as CHBRP was unable to limit the available utilization demographic data to enrollees subject to AB 716.

Approximately 4% of EGMT transports were for Californians under age 15 years, 53% were for Californians aged 15 through 63 years, and 43% were for Californians aged 64 years and older. About 85% of EGMT transports were for medical problems and 15% were for traumatic injuries. The most common medical problems were general weakness, abdominal pain/problems, behavioral/psychiatric crisis, altered level of consciousness, and body pain, whereas the most common traumatic injuries was fall and motor vehicle related (California EMS Authority, 2021). Approximately 49.5% of EGMT transports were for females, whereas 50% were for males and 0.5% were other or unknown genders. However, males were overrepresented in the under 64 population, whereas females were overrepresented in the 64 years and older population (California EMS Authority, 2021). A separate study using statewide data in 2019 (similarly included all counties except for Los Angeles County) examined EMS responses for Californians aged 50 years and older, finding that 9.1% of EMS responses were for Black patients, 11.0% were for Latino patients, 4.5% were for Asian patients, 47.3% were for White patients, and 29.2% were for Other or not recorded (Melgoza et al., 2021). No reports were identified describing race or ethnicity in EMS responses or transports for Californians younger than 50 years.

Chart 1. EGMT in California by Sex and Race/Ethnicity in 2019*



**Note*: This table includes all 911 EMS transports (except those in Los Angeles County) in calendar year 2019 for patients younger than 50 years.

[12] CHBRP was only able to identify GMT data for 57 of 58 counties. Los Angeles County independently reports 911 EGMT data and did not report California Emergency Medical Services Information System (CEMSIS) data including GMT transports. CHBRP utilized California EMS Authority's report to extrapolate Los Angeles County's GMT data, with the assumption that 2020 per-capita Los Angeles County GMT mirrored per-capita GMT of the remaining California counties.

[13] The California EMS Authority maintains a centralized data system to collect data about 911 EMS responses and transports, known as the California Emergency Medical Services Information System (CEMSIS). As of 2019, 32 of 33 LEMSAs, representing 57 of California's 58 counties (all but Los Angeles County) and approximately 75% of California's 39.4 million 2020 population, submitted data for inclusion in CEMSIS's most recent 2020 data report. Demographic information was only available from CEMSIS, but total California 2020 EGMT transports were compiled by adding data provided in Los Angeles County EMS Agency's annual data report (Los Angeles County EMS Agency, 2022). CEMSIS's 57 counties reported 2.18 million transports whereas Los Angeles County reported 0.75 million transports in calendar year 2020.

Table 3. EGMT in California by Age in 2019*

Age, Years	Counts	Percentages
0 to 14	68,373	3.8%
15 to 26	165,835	9.2%
27 to 44	320,347	17.9%
45 to 63	469,323	26.2%
64 and older	770,366	42.9%
Total	1,794,244	100.0%

Source: California Health Benefits Review Program, 2022.

**Note*: This table includes all 911 EMS transports (both medical and trauma) with recorded age in California in calendar year 2019, except those in Los Angeles County.

Key: EGMT = emergency ground medical transport; EMS = emergency medical service.

Disparities in Utilizing Emergency Ground Medical Transportation

Per statute, CHBRP includes discussion of disparities and social determinants of health (SDoH) when conducting public health analysis of introduced legislation. CHBRP completed a brief review of disparities literature as it relates to EGMT. Disparities are differences between groups that are modifiable. CHBRP found relevant literature identifying disparities by age, race/ethnicity, and income.

Age differences

Multiple studies found that older persons utilize EGMT more than younger persons. Statewide EGMT data indicate that older Californians are more frequent users of EGMT, with the 64 years and older population accounting for nearly 43% of EGMT, almost triple their representative proportion of the California population (California EMS Authority, 2022). In a national sample of 70 million emergency department (ED) visits in years 2004 to 2006 examining the mode of arrival to EDs, older adults aged 55 to 64 years were more than twice as likely to utilize ambulances as compared to young adults aged 18 to 24 years (Meisel et al., 2011). An earlier study among a national sample of 16.2 million ED visits in 2003 found that ambulance utilization increased gradually as age increased (Burt et al., 2006). Another study using 2008-2010 data reported that frequent EGMT users were more likely than nonfrequent EGMT users to be 45 years or older (Knowlton et al., 2013).

Racial or ethnic differences

EGMT utilization did not vary significantly by race/ethnicity when adjusted by factors including age, insurance, health status, and geography. Significant racial disparities in ambulance utilization were not identified in a national sample of ED visits examining mode of arrival to EDs (Meisel et al., 2011). Another national study found that Black patients were significantly more likely than White patients to arrive at the ED via ambulance, whereas Asian patients were significantly less likely than White patients to arrive at the ED via ambulance (Burt et al., 2006). However, these disparities did not persist after accounting for confounding variables such as insurance status and age. A detailed survey of Massachusetts patients also found that racial and ethnic disparities in ambulance utilization did not persist in a fully adjusted, multivariate analysis (Rucker et al., 1997). Nevertheless, Black and Hispanic patients were more likely to identify costs as a barrier to accessing EGMT (Farcas et al., 2022).

However, while overall utilization disparities were not identified, several studies demonstrated that racial and ethnic minorities may experience longer wait times for ambulances after calling 911. A national study of 2014 EMS data reported that patients with cardiac arrest located in lower-income neighborhoods with

larger proportions of non-White populations had significantly longer 911 ambulance response times than similar patients in higher-income neighborhoods with smaller proportions of non-White populations (Hsia et al., 2018). An older study of stroke patients in Kentucky also found that ambulance response times were longer for Black patients than White patients (Kleindorfer et al., 2006). Finally, two recent studies found that Black and Hispanic patients were more likely to be transported via ambulance to safety-net hospitals than were White patients (Hanchate et al., 2019, 2022).

Income differences

Only one study from 30 years ago was identified that directly incorporated patient-level income, however several studies used ZIP Code or census tract data to infer income. A 1993 survey questionnaire of ED patients in Massachusetts found that patients reporting lower income were more likely to arrive via ambulance at the ED (Rucker et al., 1997). A study of Houston, Texas, patients necessitating ambulance transport for asthma attacks identified that lower-income census tracts used ambulances for this condition significantly more than higher-income census tract areas (Raun et al., 2015). However, the 2011 study of national ED visits reported no significant difference in ambulance utilization among patients from lower-income ZIP Codes as compared to patients from higher-income ZIP Codes (Meisel et al., 2011). A recent national study examined the most severe type of life-threatening EGMT call, cardiac arrest, finding that patients in lower-income neighborhoods were significantly less likely to survive (Chan et al., 2020). As most cardiac arrest patients are not ultimately transported by EGMT due to lack of survival, lower income is likely associated with lower EGMT utilization in this subset of EGMT responses. A study in Massachusetts suggested that lower-income patients were more likely to be transported to a more distant or safety-net hospital, as compared to higher-income patients, potentially leading to a larger EGMT bill on account of the mileage charge (Hanchate et al., 2022).

CHBRP did not identify any literature or reports that explicitly discussed demographics or disparities in ambulance balance billing. Nevertheless, the disparities described above may suggest that balance billing disproportionately impacts older adults and (when unadjusted) Black patients as these populations are more likely to utilize EGMT.

IMPACTS

Table 4. AB 716 Impacts on Benefit Coverage, Utilization, and Cost, 2024

	Baseline (2024)	Postmandate Year 1 (2024)	Increase/ Decrease	Change Postmandate
Benefit coverage				
Total enrollees with health insurance subject to state-level benefit mandates (a)	22,842,000	22,842,000	0	0.00%
Total enrollees with health insurance subject to AB 716	14,025,000	14,025,000	0	0.00%
Percentage of enrollees with coverage for EGMT and non-EGMT	100%	100%	0%	0.00%
Number of enrollees for whom balanced billing for EGMT and non-EGMT is prohibited	0%	0%	0	0.00%
Utilization and cost				
Emergency transport & response				
Utilization per 1,000	2.5	2.5	0.00	0%
Average insurer paid	$710	$2,910	$2,200	310%
Average enrollee financial responsibility	$1,360	$280	−$1,080	−79%
Enrollee cost sharing (deductibles, copayments, etc.)	$460	$280	−$180	−39%
Balance billing	$900	$0	−$900	−100%
Nonemergency transport				
Utilization per 1,000	0.6	0.6	0.00	0%
Average insurer paid	$1,030	$3,020	$1,990	193%
Average enrollee financial responsibility	$1,150	$320	−$830	−72%
Enrollee cost sharing (deductibles, copayments, etc.)	$400	$320	−$80	−20%
Balance billing	$750	$0	−$750	−100%
Expenditures				
Premiums				
Employer-sponsored (b)	$57,647,993,000	$57,713,036,000	$65,043,000	0.11%
CalPERS employer (c)	$6,158,262,000	$6,163,497,000	$5,235,000	0.09%
Medi-Cal (excludes COHS) (d)	$29,618,383,000	$29,618,383,000	$0	0.00%
Enrollee premiums (expenditures)				
Enrollees, individually purchased insurance	$21,229,233,000	$21,250,518,000	$21,285,000	0.10%
Outside Covered California	$4,867,955,000	$4,873,020,000	$5,065,000	0.10%
Through Covered California	$16,361,278,000	$16,377,498,000	$16,220,000	0.10%
Enrollees, group insurance (e)	$18,263,775,000	$18,284,083,000	$20,308,000	0.11%
Enrollee out-of-pocket expenses				
Cost-sharing for covered benefits (deductibles, copayments, etc.)	$13,857,141,000	$13,850,061,000	−$7,080,000	−0.05%
Expenses for noncovered benefits (f) (g)	$37,456,000	$0	−$37,456,000	−100.00%
Total expenditures	$146,812,243,000	$146,879,578,000	$67,335,000	0.05%

Source: California Health Benefits Review Program, 2023.

Notes: (a) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, and Medi-Cal.

(b) In some cases, a union or other organization. Excludes CalPERS.

(c) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 51.1% are state retirees, state employees, or their dependents. About one in five (22.5%) of these enrollees has a pharmacy benefit not subject to DMHC. CHBRP has projected no impact for those enrollees. However, CalPERS could, postmandate, require equivalent coverage for all its members (which could increase the total impact on CalPERS).

(d) Includes only Medi-Cal beneficiaries enrolled in DMHC-regulated plans. In addition, CHBRP is estimating it seems likely that there would also be a proportional increase of $0 million for Medi-Cal beneficiaries enrolled in COHS managed care.

(e) Enrollee premium expenditures include contributions by enrollees to employer (or union or other organization)-sponsored health insurance, health insurance purchased through Covered California, and any contributions to enrollment through Medi-Cal to a DMHC-regulated plan.

(f) Includes only expenses paid directly by enrollees (or other sources) to providers for services related to the mandated benefit that are not covered by insurance at baseline. 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.

(g) For covered benefits, such expenses would be eliminated, although enrollees with newly compliant benefit coverage might pay some expenses if benefit coverage is denied (through utilization management review).

Key: CalPERS = California Public Employees' Retirement System Health Maintenance Organizations; CDI = California Department of Insurance; COHS = County Operated Health Systems; DMHC = Department of Managed Health Care; EGMT = emergency ground medical transport; GMT = ground medical transport.

BENEFIT COVERAGE, UTILIZATION, AND COST IMPACTS

As discussed in the *Policy Context* section, AB716 would require an enrollee or insured who receives covered services from a non-contracting ground ambulance provider to pay no more than the same cost sharing amount that the enrollee or insured would pay for the same covered services received from a contracting ground ambulance provider. The bill would also prohibit a noncontracting ground ambulance provider from billing or sending to collections any higher amount above that cost sharing amount. The bill would also require the statewide Emergency Management Authority to develop and publish a report showing the allowable maximum rates for ground ambulance transportation services in each county. The bill applies to health plans and health policies regulated by the Department of Managed Health Care (DMHC) or the California Department of insurance (CDI).

In addition to commercial enrollees, more than 73% of enrollees associated with the California Public Enrollees' Retirement System (CalPERS) and more than 80% of Medi-Cal beneficiaries are enrolled in DMHC-regulated plans.[14] As noted in the *Policy Context* section, AB 716 would apply to the benefit coverage of CalPERS enrollees but would exempt from compliance the benefit coverage of Medi-Cal beneficiaries enrolled in DMHC-regulated plans.

For commercial/CalPERS enrollees in plans and policies regulated by DMHC and CDI, but also for other persons, AB 716 would prohibit balance billing by providers of GMT and EGMT.

This section reports the potential incremental impacts of AB 716 on estimated baseline benefit coverage, utilization, and overall cost. For the purposes of describing AB 716's impact, CHBRP has used the following terms and definitions:

- In-Network Allowed Charge – Health plans/insurers have contracts with in-network providers to pay an agreed upon "allowed charge." The amount is then shared between the plan's payment and the enrollee cost sharing. The enrollee is responsible for the in-network cost sharing.
- Out-of-Network (OON) Allowed Charge – 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, which is typically higher than in-network cost sharing.
- Billed Charge – The amount billed for services by providers. Health plans generally only pay out-of-network providers a portion of their billed charges. Billed charges are typically higher than in-network allowed charges, out-of-network allowed charges, or local Medicare rates.
- Balance Bill – This term refers to the practice of providers billing enrollees for the difference between the billed charge and the out-of-network allowed charge. This is the amount a provider may send as a bill directly to a patient. Balance billing is not allowed for in-network providers and Medi-Cal beneficiaries.

Analytic Approach and Key Assumptions

The following key assumptions and considerations were made when providing this abbreviated analysis of AB 716:

1) Potentially, large-group CDI plans may not cover emergency services since they are exempt from basic health care services (definitions provided further in this section). However, CHBRP has

[14] For more detail, see CHBRP's resource, *Sources of Health Insurance in California*, available at http://chbrp.org/other_publications/index.php.

assumed that 100% of these plans do provide coverage for the EGMT and GMT referenced in AB 716.

2) Medi-Cal enrollees do not pay out-of-pocket for emergency ground medical transportation, and balance billing is prohibited for Medi-Cal beneficiaries. So AB 716 would not impact the experience of any Medi-Cal beneficiary, including those enrolled in DMHC-regulated plans.

3) Both emergency ground medical transportation (EGMT) and ground medical transportation (GMT) cases for the California commercial population were identified using procedure codes identified in Milliman's 2019 Consolidated Health Cost Guidelines Sources Database (CHSD) and included in this analysis. Mileage and supplies were included in the associated cost per case. The procedure codes used to identify EGMT claims are in Appendix B.

4) At baseline, this analysis uses the average out-of-network allowed charge to assess the cost of out-of-network services to the health insurer or plan and the related enrollee cost sharing. The average out-of-network billed charge is used to assess balance billing paid by the enrollee.

5) All balance-billed charges are not ultimately collected by health care providers. Consumers may not pay at all (in which case, their bill may be sent to debt collection) or they may reach a discounted agreement to pay part of the bill or establish a payment plan (which is not documented in commercial claims data). EGMT and GMT balance billing collection data is not available, but it is estimated that emergency physicians collect 65% of charged amounts for likely surprise bills (Biener et al., 2021). CHBRP calculated a discounted rate of collections that assumed 65% of out-of-network EGMT billed charges are collected. After removing the insurer and enrollee cost-sharing portions of the billed charge, we estimate 43% of EGMT and GMT balance-billed charges are paid by the enrollee.

6) AB 716 requires the statewide Emergency Management Authority develop and publish maximum rates for EGMT and GMT. At baseline, maximum rates are set by local emergency medical services agencies (LEMSAs). The billed charges at baseline are less than LEMSA maximum rates. CHBRP assumed the per-unit billed charge for out-of-network EGMT and GMT services at baseline will be the out-of-network charge postmandate.

7) The **in-network cost sharing** (deductibles, coinsurances, and out-of-pocket maximums) is applied to the **billed charge** to determine the enrollee cost sharing for out-of-network EGMT and GMT services as required by AB 716. By applying the in-network cost-sharing amounts to the in-network billed charges, the enrollee cost sharing for the out-of-network EGMT and GMT services may be greater than enrollee cost sharing for in-network services because the total cost of the out-of-network service is more expensive. This is similar to how an enrollee would pay more in cost sharing for a more expensive in-network EGMT or GMT provider compared to a less expensive in-network EGMT or GMT provider.

8) Because consumers and enrollees are typically unaware of the potential for balance billing for EGMT services, and payment is typically requested after receipt of services, we assumed that there would be no detectable change in demand for and utilization of EGMT services as a direct result of AB 716. Instead, the impact of AB 716 would be apparent for insurers and enrollees while claims were being processed, rather than at the point of service because of the unplanned nature of emergency services.

For further details on the underlying data sources and methods used in this analysis, please see Appendix B.

Baseline and Postmandate Benefit Coverage

At baseline, 100% of enrollees with health insurance that would be subject to AB 716 have coverage for EGMT and GMT services. Although benefit coverage would not increase due to AB 716, prices paid by all health plans, insurers, and enrollees for out-of-network EGMT and GMT services would change for two reasons:

- The EGMT and GMT services' per-unit cost for out-of-network claims would be based on the billed charge; and
- Enrollees pay in-network cost sharing for out-of-network EGMT and GMT services. For many plans/insurers, this would result in lower deductibles, copayments, and coinsurance amounts. The lower deductibles and coinsurances are applied to the billed charge.

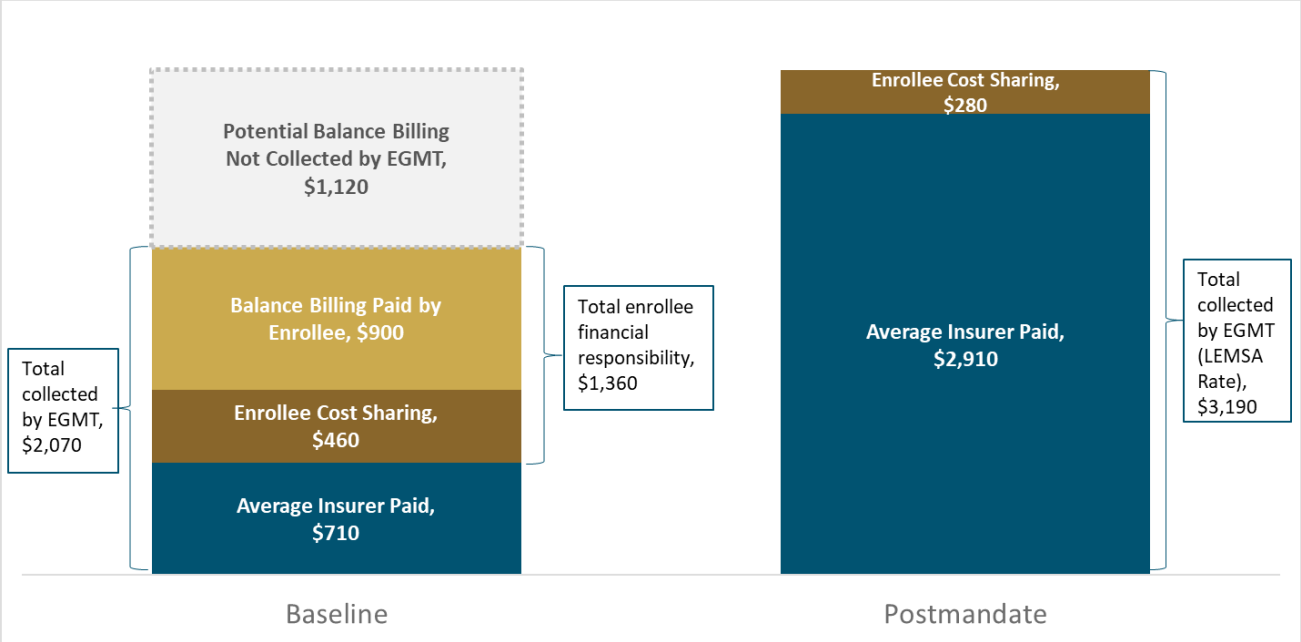
Baseline and Postmandate Utilization

The baseline utilization rates of out-of-network EGMT services, 2.5 per 1,000 enrollees, and out-of-network GMT services, 0.6 per 1,000 enrollees, are not estimated to increase postmandate because of AB 716.

Baseline and Postmandate Per-Unit Cost

EGMT

Figure 1. EGMT Baseline and Postmandate Average Per Unit Cost by Payer, California, 2024



The average billed charge for EGMT is $3,190, according to the 2019 Milliman CHSD trended to 2024. At baseline, the out-of-network allowed charge is $1,170 per unit of out-of-network EGMT services. Health plans and insurers pay on average $710 of the allowed amount with the remaining $460 paid by enrollee cost sharing in the form of deductibles, copayments, and coinsurances.

At baseline, the difference between the billed charge and the out-of-network allowed charge can be billed to the enrollee. The remaining portion of the billed charge that could be balance billed is $2,020. CHBRP estimates enrollees pay $900 per unit of EGMT services in the form of balance billing. The remaining $1,120 is potentially balance billed but not collected by the EGMT provider.

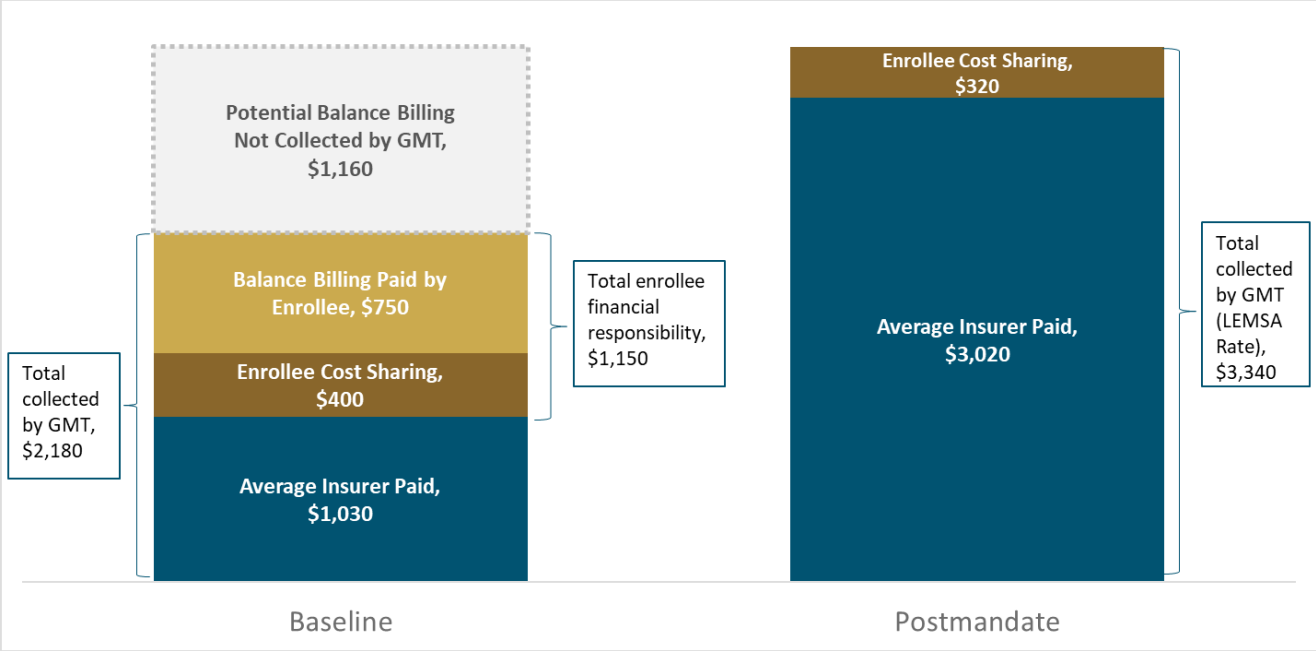
Enrollees pay a total of $1,360 per unit for out-of-network EGMT services, with $460 counted as cost sharing and $900 due to balance billing by out-of-network providers. Overall, the per-unit cost collected by the EGMT provider when combining the insurer payment, enrollee cost share, and enrollee balance billing payments at baseline are $2,070 (Table 1).

Postmandate, the cost per unit of out-of-network EGMT services is equal to the billed charge. CHBRP estimates the allowed amount will increase from $1,170 to $3,190. The average insurer payment per unit would increase $2,200, from $710 to $2,910 and the cost sharing paid by enrollees would decrease $180, from $460 to $280 (Table 1). Balance billing would be prohibited, further reducing enrollee expenses $900 per unit of EGMT services. Overall, the per-unit cost when combining the insurer payment enrollee cost-sharing amounts is $3,190, which represents a 54% increase in per-unit cost paid to EGMT providers postmandate.

Overall, health plans and insurers will pay an additional $2,200 per unit, while enrollees would see a $1,080 decrease in their per-unit cost due to a $180 reduction in cost sharing and a $900 reduction in balance-billed charges.

GMT

Figure 2. GMT Baseline and Postmandate Average Per Unit Cost by Payer, California, 2024



The average billed charge for GMT is $3,340, according to the 2019 Milliman CHSD trended to 2024. At baseline, the out-of-network allowed charge is $1,430 per unit of out-of-network GMT services. Health plans and insurers pay on average $1,030 of the allowed amount with the remaining $400 paid by enrollee cost sharing in the form of deductibles, copayments, and coinsurances.

At baseline, the difference between the billed charge and the out-of-network allowed charge can be billed to the enrollee. The remaining portion of the billed charge that could be balance billed is $1,910. CHBRP

estimates enrollees pay $750 per unit of GMT services in the form of balance billing. The remaining $1,160 is potentially balance billed, but not collected, by the GMT provider.

Enrollees pay a total of $1,150 per unit for out-of-network GMT services, with $400 counted as cost sharing and $750 due to balance billing by out-of-network providers. Overall, the per-unit cost collected by the EGMT provider when combining the insurer payment, enrollee cost share, and enrollee balance billing payments at baseline is $2,180 (Table 1).

Postmandate, the cost per unit of out-of-network GMT services is equal to the billed charge. CHBRP estimates the allowed amount will increase from $1,430 to $3,340. The average insurer payment per unit would increase $1,990, from $1,030 to $3,020, and the cost sharing paid by enrollees would decrease $80, from $400 to $320 (Table 1). Balance billing would be prohibited, offsetting enrollee expenses $750 per unit of GMT services. Overall, the per-unit cost when combining the insurer payment and enrollee cost-sharing amounts is $3,340, which represents a 53% increase in per-unit cost paid to GMT providers postmandate.

Overall, health plans and insurers will pay an additional $1,990 per unit, while enrollees would see an $830 reduction in their per-unit cost due to an $80 reduction in cost sharing and a $750 reduction in balance-billed charges.

See Appendix B for additional details on per-unit cost calculations and trends.

Baseline and Postmandate Expenditures

Table 5 and Table 6 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, and total expenditures (premiums as well as enrollee expenses).

AB 716 would increase total net annual expenditures by total net annual $67,335,000, or total net annual 0.05%, for enrollees with DMHC-regulated plans and CDI-regulated policies. This is due to a $111,871,000 increase in total health insurance premiums paid by employers and enrollees for newly covered benefits, adjusted by a $44,536,000 decrease in enrollee expenses for covered and noncovered benefits.

Premiums

Changes in premiums as a result of AB716 would vary by market segment. Note that such changes are related to the number of enrollees (see Table 1, Table 5, and Table 6) with health insurance that would be subject to AB 716.

In the DMHC-regulated commercial plans, the largest premium increase (0.1141%) would occur for the small-group market, while the individual market would face the smallest premium increase (0.0997%). Within the individual DMHC-regulated market, health plans offered by Covered California would experience a 0.0986% premium increase.

Among CDI-regulated commercial plans, the largest premium increase would be for the large-group market (0.1183%), and the smallest would occur for the small-group market (0.1077%). Covered California individual market plans regulated by CDI would experience a 0.1221% increase in premiums.

CalPERS Health Maintenance Organization plans would experience a 0.0850% premium increase due to AB 716.

Enrollee Expenses

AB 716–related changes in cost sharing for covered benefits (deductibles, copays, etc.) and out-of-pocket expenses for noncovered benefits would vary by market segment. Note that such changes are related to the number of enrollees (see Table 1, Table 5, and Table 6) with health insurance that would be subject to AB 716 expected to use the relevant services during the year after enactment.

In all DMHC- and CDI-regulated plans and policies, and in CalPERS, enrollee expenses would decrease due to the prohibition on balance billing by EGMT and GMT providers more than offsetting possible increased cost sharing. The increase in cost sharing is due to in-network deductibles and coinsurances being applied to a larger amount postmandate. For enrollees with low deductibles, coinsurances, or copayment, their cost sharing would remain the same or decrease postmandate. Expenses for noncovered benefits would decrease by $0.22 PMPM across CalPERS, DMHC-, and CDI-regulated markets, while cost-sharing increases varied from a reduction of $0.0817 PMPM for large-group DMHC enrollees to a high of $0.0640 PMPM in the individual CDI-regulated market.

It is possible that some enrollees incurred expenses related to services for which coverage was denied, but CHBRP cannot estimate the frequency with which such situations occur and so cannot offer a calculation of impact. However, due to the emergency nature of EGMT and GMT services, it is unlikely that services were denied, rather they were considered out-of-network at baseline and incurred higher cost-sharing and balance-billed amounts.

Average enrollee out-of-pocket expenses per user

The potential decrease in balance billing at the person level for some users of EGMT or GMT Services could free up resources for those affected. However, CHBRP is not able to measure how these resources would be spent.

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.

Table 5. Baseline Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2024

	DMHC-Regulated						CDI-Regulated			
	Commercial Plans (by Market) (a)			Publicly Funded Plans			Commercial Plans (by Market) (a)			
	Large Group	*Small Group*	*Individual*	*CalPERS (b)*	Medi-Cal (Excludes COHS) (c) *Under 65*	*65+*	*Large Group*	*Small Group*	*Individual*	**TOTAL**
Enrollee counts										
Total enrollees in plans/policies subject to state mandates (d)	7,780,000	2,212,000	2,618,000	882,000	8,043,000	774,000	371,000	35,000	127,000	22,842,000
Total enrollees in plans/policies subject to AB 716	7,780,000	2,212,000	2,618,000	882,000	0	0	371,000	35,000	127,000	14,025,000
Premium costs										
Average portion of premium paid by employer (e)	$473.17	$417.10	$0.00	$581.85	$254.61	$543.16	$490.57	$517.32	$0.00	$93,424,638,000
Average portion of premium paid by enrollee	$122.17	$180.13	$645.33	$113.49	$0.00	$0.00	$180.61	$168.99	$626.90	$39,493,007,000
Total premium	**$595.34**	**$597.23**	**$645.33**	**$695.34**	**$254.61**	**$543.16**	**$671.18**	**$686.31**	**$626.90**	**$132,917,645,000**
Enrollee expenses										
Cost-sharing for covered benefits (deductibles, copays, etc.)	$40.98	$127.06	$168.73	$49.17	$0.00	$0.00	$99.22	$184.48	$208.51	$13,857,141,000
Expenses for noncovered benefits (f)	$0.21	$0.23	$0.23	$0.22	$0.00	$0.00	$0.27	$0.27	$0.27	$37,456,000
Total expenditures	**$636.54**	**$724.53**	**$814.30**	**$744.72**	**$254.61**	**$543.16**	**$770.66**	**$871.06**	**$835.67**	**$146,812,242,000**

Source: California Health Benefits Review Program, 2023.

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

(b) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 51.7% are state retirees, state employees, or their dependents. About one in five (22.5%) of these enrollees has a pharmacy benefit not subject to DMHC. CHBRP has projected no impact for those enrollees. However, CalPERS could, postmandate, require equivalent coverage for all its members (which could increase the total impact on CalPERS).

(c) Includes only Medi-Cal beneficiaries enrolled in DMHC-regulated plans. Includes those who are also Medicare beneficiaries.

(d) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.

(e) In some cases, a union or other organization - or Medi-Cal for its beneficiaries.

(f) 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 covered by insurance at baseline. This only includes those expenses that will be newly covered, postmandate. Other components of expenditures in this table includes all health care services covered by insurance.

Key: CalPERS = California Public Employees' Retirement System Health Maintenance Organizations; CDI = California Department of Insurance; COHS = County Operated Health System; DMHC = Department of Managed Health.

Table 6. Postmandate Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2024

	DMHC-Regulated						CDI-Regulated			
	Commercial Plans (by Market) (a)			Publicly Funded Plans			Commercial Plans (by Market) (a)			
	Large Group	*Small Group*	*Individual*	*CalPERS (b)*	Medi-Cal (excludes COHS) (c) *Under 65*	*65+*	*Large Group*	*Small Group*	*Individual*	**TOTAL**
Enrollee counts Total enrollees in plans/policies subject to state mandates (d)	7,780,000	2,212,000	2,618,000	882,000	8,043,000	774,000	371,000	35,000	127,000	22,842,000
Total enrollees in plans/policies subject to AB 716	7,780,000	2,212,000	2,618,000	882,000	0	0	371,000	35,000	127,000	14,025,000
Premium costs										
Average portion of premium paid by employer (e)	$0.5312	$0.4757	$0.0000	$0.4947	$0.0000	$0.0000	$0.5804	$0.5571	$0.0000	$70,279,000
Average portion of premium paid by enrollee	$0.1372	$0.2055	$0.6436	$0.0965	$0.0000	$0.0000	$0.2137	$0.1820	$0.7002	$41,594,000
Total premium	$0.6684	$0.6812	$0.6436	$0.5911	$0.0000	$0.0000	$0.7940	$0.7390	$0.7002	$111,874,000
Enrollee expenses										
Cost-sharing for covered benefits (deductibles, copays, etc.)	-$0.0817	-$0.0025	$0.0231	$0.0000	$0.0000	$0.0000	−$0.0508	$0.0329	$0.0640	−$7,080,000
Expenses for noncovered benefits (f)	-$0.2130	-$0.2347	-$0.2330	-$0.2192	$0.0000	$0.0000	−$0.2665	−$0.2665	−$0.2665	−$37,456,000
Total expenditures	$0.3738	$0.4439	$0.4337	$0.3720	$0.0000	$0.0000	$0.4767	$0.5054	$0.4976	$67,337,000
Postmandate percent change										
Percent change insured premiums	0.1123%	0.1141%	0.0997%	0.0850%	0.0000%	0.0000 %	0.1183%	0.1077%	0.1117%	0.0842%
Percent change total expenditures	0.0587%	0.0613%	0.0533%	0.0499%	0.0000%	0.0000 %	0.0619%	0.0580%	0.0595%	0.0459%

Source: California Health Benefits Review Program, 2023.

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

(b) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 51.7% are state retirees, state employees, or their dependents. About one in five (22.5%) of these enrollees has a pharmacy benefit not subject to DMHC. CHBRP has projected no impact for those enrollees. However, CalPERS could, postmandate, require equivalent coverage for all its members (which could increase the total impact on CalPERS).

(c) Includes only Medi-Cal beneficiaries enrolled in DMHC-regulated plans. Includes those who are also Medicare beneficiaries.

(d) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.

(e) In some cases, a union or other organization - or Medi-Cal for its beneficiaries.

(f) 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 covered by insurance at baseline. This only includes those expenses that will be newly covered, postmandate. Other components of expenditures in this table includes all health care services covered by insurance.

Key: CalPERS = California Public Employees' Retirement System Health Maintenance Organizations; CDI = California Department of Insurance; COHS = County Operated Health Systems; DMHC = Department of Managed Health.

LONG-TERM IMPACTS

In this section, CHBRP estimates the long-term impact of AB 716, 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 typically 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

In the long term, enrollees could begin using EGMT and GMT services at a higher rate/more willingly as enrollees are made aware of the elimination of balance billing.

It is possible that insureds who are not enrolled in DMHC- and CDI-regulated plans and policies (e.g., ERISA plans) learn about the elimination of balance billing and believe that it applies to their plan and utilize services at a higher rate thereby increasing their exposure to balance billing.

Cost Impacts

Enactment of AB 716 would prohibit balance billing for E/GMT services and establish a maximum charge to be to be billed to health plans and insurers for payment for out-of-network E/GMT services. The overall per-unit cost paid to EGMT providers will increase from a total of $2,070 at baseline to $3,190 postmandate, and the per-unit cost for GMT providers will increase from $2,180 to $3,340. The payment to E/GMT providers will come from different sources postmandate, with a larger share coming from health plans and insurers, and a smaller share coming from enrollee cost sharing due to the requirement to apply in-network cost sharing to out-of-network E/GMT services. The payment collected by E/GMT service providers postmandate is over 50% greater than the payment amount per unit that E/GMT service providers receive at baseline.

AB 716 could disincentivize negotiation (and potentially, contracting) between health plans and insurers and in-network E/GMT providers because of the ceiling set by AB 716 by LEMSAs. Health Plans may be unable to negotiate a lower amount that would generally be reflected by in-network providers, because the E/GMT providers can essentially set their own rates. The higher per-unit cost of E/GMT services will increase total carrier payments. The increased carrier payments will result in premium increases.

TEXT OF BILL ANALYZED

On February 14, 2023, the California Assembly Committee on Health requested that CHBRP analyze AB 716 as introduced on February 13, 2023.

ASSEMBLY BILL **NO. 716**

Introduced by Assembly Member Boerner Horvath

February 13, 2023

An act to add Sections 1371.56, 1797.124, and 1797.232 to, and to repeal Section 1367.11 of, the Health and Safety Code, and to add Section 10126.66 to, and to repeal Section 10352 of, the Insurance Code, relating to emergency medical transportation.

LEGISLATIVE COUNSEL'S DIGEST

AB 716, as introduced, Boerner Horvath. Emergency ground medical transportation.

Existing law creates the Emergency Medical Services Authority to coordinate various state activities concerning emergency medical services. Existing law requires the authority to report specified information, including reporting ambulance patient offload time twice per year to the Commission on Emergency Medical Services.

This bill would require the authority to annually report the allowable maximum rates for ground ambulance transportation services in each county, including trending the rates by county, as specified.

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 plan contracts and health insurance policies provide coverage for certain services and treatments, including emergency medical transportation services, and requires a policy or contract to provide for the direct reimbursement of a covered medical transportation services provider if the provider has not received payment from another source.

This bill would delete that direct reimbursement requirement and would require a health care service plan contract or a health insurance policy issued, amended, or renewed on or after January 1, 2024, to require an enrollee or insured who receives covered services from a noncontracting ground ambulance provider to pay no more than the same cost-sharing amount that the enrollee or insured would pay for the same covered services received from a contracting ground ambulance

provider. The bill would prohibit a noncontracting ground ambulance provider from billing or sending to collections a higher amount, and would prohibit a ground ambulance provider from billing an uninsured or self-pay patient more than the established payment by Medi-Cal or Medicare fee-for-service amount, whichever is greater. The bill would require a plan or insurer to reimburse for ground ambulance services at the authorized rate for the specific exclusive operating area, unless it reaches another agreement with the noncontracting ground ambulance provider. Because a willful violation of the bill's requirements relative to a health care service plan would be a crime, the bill would impose a state-mandated local program.

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.

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

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

SECTION 1. Section 1367.11 of the Health and Safety Code is repealed.

~~1367.11.(a) Every health care service plan issued, amended, or renewed on or after January 1, 1987, that offers coverage for medical transportation services, shall contain a provision providing for direct reimbursement to any provider of covered medical transportation services if the provider has not received payment for those services from any other source.~~

~~(b) Subdivision (a) shall not apply to any transaction between a provider of medical transportation services and a health care service plan if the parties have entered into a contract providing for direct payment.~~

~~(c) For purposes of this subdivision, "direct reimbursement" means the following:~~

~~The enrollee shall file a claim for the medical transportation service with the plan; the plan shall pay the medical transportation provider directly; and the medical transportation provider shall not demand payment from the enrollee until having received payment from the plan, at which time the medical transportation provider may demand payment from the enrollee for any unpaid portion of the provider's fee.~~

SEC. 2. Section 1371.56 is added to the Health and Safety Code, to read:

1371.56. (a) (1) Notwithstanding Section 1367.11, a health care service plan contract issued, amended, or renewed on or after January 1, 2024, shall require an enrollee who receives covered services from a noncontracting ground ambulance provider to pay no more than the same cost-sharing amount that the enrollee would pay for the same covered services received from a

contracting ground ambulance provider, unless otherwise required to do so by Section 1371.9. This amount shall be referred to as the "in-network cost-sharing amount."

(2) An enrollee shall not owe the noncontracting ground ambulance 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) (1) The in-network cost-sharing amount paid by the enrollee pursuant to this section shall count toward the limit on annual out-of-pocket expenses established under Section 1367.006.

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

(3) The in-network cost-sharing amount 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 ground ambulance provider shall only advance to collections the in-network cost-sharing amount, as determined by the plan pursuant to subdivision (a), that the enrollee failed to pay.

(1) A noncontracting ground ambulance provider, or an entity acting on its behalf, including a debt buyer or assignee of the debt, shall not report adverse information to a consumer credit reporting agency or commence civil action against the enrollee for a minimum of 150 days after the initial billing regarding amounts owed by the enrollee pursuant to subdivision (a).

(2) With respect to an enrollee, a noncontracting ground ambulance provider, or an entity acting on its behalf, including an assignee of the debt, shall not use wage garnishments or liens on primary residences as a means of collecting unpaid bills pursuant to this section.

(d) (1) Unless otherwise agreed to by the noncontracting ground ambulance provider and the health care service plan, the plan shall reimburse for ground ambulance services at the authorized rate for the specific exclusive operating area pursuant to Section 1797.201 or 1797.224.

(2) A payment made by the health care service plan to the noncontracting ground ambulance provider for services as required in subdivision (a), plus the applicable cost sharing owed by the enrollee, shall constitute payment in full for services rendered.

(3) Notwithstanding any other law, the amounts paid by a health care service plan for services under this section shall not constitute the prevailing or customary charges, the usual fees to the general public, or other charges for other payers for an individual ground ambulance provider.

(e) This section does not affect the balance billing protections for Medi-Cal beneficiaries under Section 14019.4 of the Welfare and Institutions Code.

(f) This section does not apply to a Medi-Cal managed health care service plan or any entity that enters into a contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), and Chapter 8.75 (commencing with Section 14591) of Part 3 of Division 9 of the Welfare and Institutions Code.

SEC. 3. Section 1797.124 is added to the Health and Safety Code, to read:

1797.124. (a) On or before March 1, 2024, and on or before each January 1 thereafter, the authority shall annually develop and publish on its internet website a report showing the allowable maximum rates for ground ambulance transportation services in each county, including trending the rates by county.

(b) The authority shall annually submit each report to the Department of Insurance and the Department of Managed Health Care for purposes of rate review, as well as to the Office of the Health Care Affordability.

SEC. 4. Section 1797.232 is added to the Health and Safety Code, to read:

1797.232. (a) A ground ambulance provider shall not require an uninsured patient or self-pay patient to pay an amount more than the established payment by Medi-Cal or Medicare fee-for-service amount, whichever is greater.

(b) (1) A ground ambulance provider shall only advance to collections the Medicare or Medi-Cal payment amount, as determined pursuant to subdivision (a), that the patient failed to pay.

(2) The ground ambulance provider, or an entity acting on its behalf, including a debt buyer or assignee of the debt, shall not report adverse information to a consumer credit reporting agency or commence civil action against the individual for a minimum of 150 days after the initial billing regarding amounts owed by the individual pursuant to subdivision (a).

(3) With respect to an uninsured patient or self-pay patient, the ground ambulance provider, or an entity acting on its behalf, including an assignee of the debt, shall not use wage garnishments or liens on primary residences as a means of collecting unpaid bills pursuant to this section.

SEC. 5. Section 10126.66 is added to the Insurance Code, to read:

10126.66. (a) (1) Notwithstanding Section 10352, a health insurance policy issued, amended, or renewed on or after January 1, 2024, shall require an insured who receives covered services from a noncontracting ground ambulance provider to pay no more than the same cost-sharing amount that the insured would pay for the same covered services received from a contracting ground ambulance provider. This amount shall be referred to as the “in-network cost-sharing amount.”

(2) An insured shall not owe the noncontracting ground ambulance 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 and the noncontracting provider of the in-network cost-sharing amount owed by the insured.

(b) (1) The in-network cost-sharing amount paid by the insured pursuant to this section shall count toward the limit on annual out-of-pocket expenses established under Section 10112.28.

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

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

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

(1) A noncontracting ground ambulance provider, or an entity acting on its behalf, including a debt buyer or assignee of the debt, shall not report adverse information to a consumer credit reporting agency or commence civil action against the insured for a minimum of 150 days after the initial billing regarding amounts owed by the insured pursuant to subdivision (a).

(2) With respect to an insured, a noncontracting ground ambulance provider, or an entity acting on its behalf, including an assignee of the debt, shall not use wage garnishments or liens on primary residences as a means of collecting unpaid bills pursuant to this section.

(d) (1) Unless otherwise agreed to by the noncontracting ground ambulance provider and the health insurer, the insurer shall reimburse for ground ambulance services at the authorized rate for the specific exclusive operating area pursuant to Section 1797.201 or 1797.224 of the Health and Safety Code.

(2) A payment made by the health insurer to the noncontracting ground ambulance provider for services as required in subdivision (a), plus the applicable cost sharing owed by the insured, shall constitute payment in full for services rendered.

(3) Notwithstanding any other law, the amounts paid by a health insurer for services under this section shall not constitute the prevailing or customary charges, the usual fees to the general public, or other charges for other payers for an individual ground ambulance provider.

(e) This section does not affect the balance billing protections for Medi-Cal beneficiaries under Section 14019.4 of the Welfare and Institutions Code.

SEC. 6. Section 10352 of the Insurance Code is repealed.

~~10352.(a)Every policy of disability insurance issued, amended, or renewed on and after January 1, 1987, that offers coverage for medical transportation services, shall contain a provision providing for direct reimbursement to any provider of covered medical transportation services if the provider has not received payment for those services from any other source.~~

~~(b)Subdivision (a) shall not apply to any transaction between a provider of medical transportation services and the insurer under a disability insurance policy if the parties have entered into a contract providing for direct payment.~~

~~(c)For purposes of this subdivision, "direct reimbursement" means the following:~~

~~The insured shall file a claim for the medical transportation service with the insurer; the insurer shall pay the medical transportation provider directly; and the medical transportation provider shall not demand payment from the insured until having received payment from the insurer, at which time the medical transportation provider may demand payment from the insured for any unpaid portion of the provider's fee.~~

SEC. 7. 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

Analysis-Specific Data Sources

For this analysis, CHBRP relied on CPT codes to identify services related to AB 716. CPT copyright 2023 American Medical Association. All rights reserved. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. CPT is a registered trademark of the American Medical Association.

Analysis-Specific Caveats and Assumptions

Assumptions for Baseline Benefit Coverage

- The population subject to the mandated offering includes individuals covered by DMHC-regulated commercial insurance plans, CDI-regulated policies, and CalPERS plans subject to the requirements of the Knox-Keene Health Care Service Plan Act.
- We assumed 100% of the population subject to mandated offerings currently offer some form of ambulance coverage and are subject to AB 716.

Methodology and Assumptions for Baseline Utilization and Cost

- The average cost and utilization rates for emergency ground transportation and non-emergency ground ambulance transportation are based on the 2019 Consolidated Health Cost Guidelines Sources Database (CHSD). The data were limited to California commercial enrollees. The nonemergency ground ambulance transportation utilization was adjusted to reflect the mix of closed network health maintenance organization members.
- "Emergency transportation" cases were identified using the following CPT codes: A0225, A0427, A0429, A0433, A0998, S0207, S0208.[15]
- "Nonemergency transportation" cases were identified using the following CPT codes: A0426, A0428, A0434.[16]
- "Mileage" and "supplies" associated with the transportation cases were included in the cost per case. These services were identified by the following CPT codes: A0021, A0380, A0382, A0384, A0390, A0392, A0394, A0396, A0398, A0420, A0422, A0424, A0425, A0432, A0888, A0999.[17] No other procedure codes were included in the cost per case.
- All cases were identified as in-network or out-of-network based on the network status of the "emergency transportation" or "non-emergency transportation" procedure codes. Only out-of-network utilization was included in our analysis.

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[17] CPT copyright 2022 American Medical Association. All rights reserved.

- Utilization was trended from 2019 to 2024 using a 0% annualized trend. Billed and allowed costs per case were trended using a 7.25% trend from the Milliman Health Cost Guidelines.

Methodology and Assumptions for Baseline Cost Sharing

- The paid-to-allowed ratios for emergency transportation and emergency response services were calculated for in and out of network services using the CHSD database.
- To adjust for average plan benefit differentials by line of business, factors were calculated by comparing paid-to-allowed ratios of each line of business to the overall paid to allowed ratios of the California commercial population in the CHSD database.
- The emergency and non-emergency ground ambulance transportation paid-to-allowed ratios were multiplied by the line of business factors to calculate line of business specific emergency and nonemergency ground ambulance transportation paid-to-allowed ratios.
- One minus the line of business adjusted **out-of-network** paid-to-allowed ratio was multiplied by the out-of-network allowed cost to determine the enrollee share of cost.
- The plan cost was calculated as the out-of-network allowed amount minus the enrollee share of cost.
- The balance billing component, labeled as 'non-covered benefits' in the cost model, was calculated as the out-of-network billed charge minus the out-of-network allowed amount.
- Providers are not always able to collect the full balance billed charge. EGMT balance billing collection data is not available, but it is estimated that emergency physicians collect 65% of charged amounts for likely surprise bills (Biener et al., 2021). Assuming EGMT collection is similar to emergency physician collection, we assumed the total collected amount is 65% of billed charges. We calculated the amount collected from balance billing as the total collected amount net insurance payments and enrollee cost-sharing in the form of deductibles, copayments, and coinsurances. The balance-billed amount paid by the enrollee is estimated to be 43% of EGMT balance-billed charges.

Methodology and Assumptions for Postmandate Utilization

- We did not assume emergency ground transportation utilization would increase as a result of AB 716.

Methodology and Assumptions for Postmandate Cost

- AB 716 requires the plan to reimburse for ground ambulance services at the maximum authorized rate for the specific exclusive operating area. The billed charge at baseline must be below the maximum authorized rate therefore the assumed postmandate cost per service is equal to the average billed charged at baseline.

Methodology and Assumptions for Postmandate Cost Sharing

- One minus the line of business adjusted **in-network** paid-to-allowed ratio was multiplied by the out-of-network billed charge to determine the enrollee share of cost.
- The plan cost was calculated as the out-of-network billed charge minus the enrollee share of cost.
- The balance billing component, labeled as “noncovered benefits” in the cost model, is $0 because balance billing is not allowed under AB 716.

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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.

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** works with Task Force members in preparing parts of the analysis, and manages 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. 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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