CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

# Abbreviated Analysis

# California Assembly Bill 2625: Emergency Ground Medical Transportation

Summary to the 2019–2020
California State Legislature
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# SUMMARY[1]

The California Assembly Committee on Health requested that the California Health Benefits Review Program (CHBRP)[2] conduct an abbreviated evidence-based assessment of California Assembly Bill (AB) 2625 focused on cost projections and policy analysis. AB 2625 relates to patient cost sharing for emergency ground medical transportation (EGMT). This bill would require a health care service plan contract or a health insurance policy (on or after January 1, 2021) to ensure that the enrollee's share of cost for in-network EGMT services be applied to out-of-network EGMT services. AB 2625 would not require plans to change the out-of-network allowed charge, nor would it require that EGMT providers stop balance billing the beneficiary.

In California, there were approximately 2.4 million EGMT transports in 2013, operated by 3,600 licensed ambulances. A variety of systems deliver EGMT, including public entities (fire departments, public ambulance districts, hospital systems) and private nonprofit or for-profit entities (hospitals and ambulance companies). Ambulance transportation billed charges are regulated at a local level in California and vary considerably. A recent national study found that over half of EGMT transports were considered out-of-network. Nonemergency and/or routine ambulance transportation is not within the scope of AB 2625.

**Benefit coverage.** CHBRP estimates that 100% of enrollees in Department of Managed Health Care (DMHC) and California Department of Insurance (CDI)-regulated plans and policies have coverage for emergency ground medical transport (EGMT). AB 2625 would affect the health insurance of enrollees in DMHC-regulated plans and CDI-regulated policies as well as the insurance of Medi-Cal Managed Care beneficiaries regulated by DMHC that currently have coverage for EGMT. All plans and policies subject to state-level benefit mandates, with the exception of CDI large group, are required to cover EGMT. AB 2625 would not exceed the definition of essential health benefits (EHBs) in California.

While Medi-Cal Managed Care is subject to AB 2625, this bill is focused on reducing the enrollee share of cost for out-of-network EGMT services. Because Medi-Cal Managed Care beneficiaries do not incur copayments or coinsurances, CHBRP assumed no impact.

**Baseline utilization and charge.** In 2021, CHBRP estimates 3.6 out-of-network emergency response and transport cases per 1,000 commercial enrollees. The average billed charge for an out-of-network EGMT case for a commercial enrollee is $2,198. The average out-of-network allowed charge (i.e. the plan/insurer payment and the enrollee share of cost not including balance billing) is $698. The enrollee may be responsible for the remaining $1,500 in the form of balance billing.

**Postmandate expenditures.** CHBRP assumed the average billed amount and the average out-of-network allowed charge do not change. Postmandate billed charge per emergency response and transport case for commercial beneficiaries remains $2,198. Under AB 2625, plans/insurers will pay an additional $243 of the average out-of-network allowed charge due to in-network enrollee cost sharing being lower than out-of-network cost sharing. This results in an average plan/insurer payment of $605 postmandate. The average enrollee share of cost in the form of deductibles, copays, and coinsurance will be $93 which is $243 less than baseline. The beneficiary could still be responsible for $1,500 in the form of balance billing (when charged); this results in the total beneficiary financial responsibility of $1,593 postmandate.

CHBRP estimates total expenditures as a result of AB 2625 to be $2.3 million in 2021.

**At the time of this CHBRP analysis, there is substantial uncertainty regarding the impact of the COVID-19 pandemic on premium rates and health plan enrollment, including how the pandemic will impact health care costs in 2021. Because the variance of potential outcomes is significant, CHBRP does not take these effects into account as any projections at this point would be speculative, subject to federal and state decisions and guidance currently being developed and released. In addition, insurers', providers', and consumers' responses are uncertain and rapidly evolving to the public health emergency and market dynamics.**

[1] Refer to CHBRP's full report for full citations and references.
[2] CHBRP's authorizing statute is available at http://chbrp.org/faqs.php.

**Table 1. AB 2625 Impacts on Benefit Coverage, Utilization, and Cost, 2021**

| | Baseline (2021) | Postmandate Year 1 (2021) | Increase/ Decrease | Percentage Change |
|---|---|---|---|---|
| **Benefit coverage** | | | | |
| Total enrollees with health insurance subject to state-level benefit mandates (a) | 21,719,000 | 21,719,000 | 0 | 0.00% |
| Total enrollees with health insurance coverage subject to AB 2625 | 21,719,000 | 21,719,000 | 0 | 0.00% |
| Total percentage of enrollees with coverage for AB 2625 | 100% | 100% | 0% | 0.00% |
| **Utilization and cost for commercial and CalPERS populations** | | | | |
| **Out-of-network emergency ground medical transport & response** | | | | |
| Utilization per 1,000 | 3.6 | 3.6 | 0.0 | 0.00% |
| Average insurer paid | $362 | $605 | $243 | 67.17% |
| Average enrollee financial responsibility | $1,836 | $1,593 | −$243 | −13.25% |
| Enrollee cost sharing (deductibles, copayments, etc.) | $336 | $93 | −$243 | −72.34% |
| Balance billing | $1,500 | $1,500 | $0 | 0.00% |
| **Expenditures** | | | | |
| *Premium (expenditures) by payer* | | | | |
| Private employers for group insurance | $54,037,059,000 | $54,045,918,000 | $8,859,000 | 0.02% |
| CalPERS HMO employer expenditures (b) (c) | $3,264,098,000 | $3,264,573,000 | $475,000 | 0.01% |
| Medi-Cal Managed Care Plan expenditures | $29,218,820,000 | $29,218,820,000 | $0 | 0.00% |
| *Enrollee premiums (expenditures)* | | | | |
| Enrollees for individually purchased insurance | $15,689,758,000 | $15,691,726,000 | $1,968,000 | 0.01% |
| Individually purchased – outside exchange | $4,412,875,000 | $4,413,484,000 | $609,000 | 0.01% |
| Individually purchased – Covered California | $11,276,883,000 | $11,278,242,000 | $1,359,000 | 0.01% |
| Enrollees with group insurance, CalPERS HMOs, Covered California, and Medi-Cal Managed Care (c) | $15,867,227,000 | $15,869,804,000 | $2,577,000 | 0.02% |
| *Enrollee out-of-pocket expenses* | | | | |
| For covered benefits (deductibles, copayments, etc.) | $12,776,801,000 | $12,765,216,000 | −$11,585,000 | −0.09% |
| For noncovered benefits (d) (e) | $71,423,000 | $71,423,000 | $0 | 0.00% |
| **Total expenditures** | **$130,925,186,000** | **$130,927,480,000** | **$2,294,000** | **0.00%** |

*Source:* California Health Benefits Review Program, 2020.

*Notes:* (a) Enrollees in plans and policies regulated by DMHC or CDI aged 0 to 64 years as well as enrollees 65 years or older in employer-sponsored health insurance. This group includes commercial enrollees (including those associated with Covered California or CalPERS) and Medi-Cal beneficiaries enrolled in DMHC-regulated plans.

(b) Of the increase in CalPERS employer expenditures, about 57.4% or $272,000 would be state expenditures for CalPERS members who are state employees or their dependents.

(c) Enrollee premium expenditures include contributions by employees to employer-sponsored health insurance, health insurance purchased through Covered California, and contributions to Medi-Cal Managed Care. CHBRP does not anticipate a premium impact to Medi-Cal Managed Care.

(d) Includes only expenses paid directly by enrollees (or other sources) to providers for services related to the mandated benefit that are not currently covered by insurance, including balance billing by the provider. 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.

(e) Although enrollees with newly compliant benefit coverage may have paid for some services before AB2625, CHBRP cannot estimate the frequency with which such situations may have occurred and therefore cannot estimate the related expense. Postmandate, such expenses would be eliminated, though enrollees with newly compliant benefit coverage might, postmandate, pay for some services for which coverage is denied (through utilization management review), as some enrollees who always had compliant benefit coverage may have done and may continue to do, postmandate.

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

# POLICY CONTEXT

On February 25, 2020, the California Assembly Committee on Health requested that the California Health Benefits Review Program (CHBRP) conduct an evidence-based fiscal assessment of the impacts of Assembly Bill (AB) 2625: Emergency Ground Medical Transportation. Per the Committee's request, CHBRP focused on fiscal and policy analysis and did not conduct a medical effectiveness or public health analysis.

AB 2625 would require a health care service plan contract or a health insurance policy issued, amended, or renewed on or after January 1, 2021, that offers coverage for emergency ground medical transportation (EGMT) services to apply in-network cost sharing to out-of-network services and would require the plan or insurer to pay those services at the contracted rate pursuant to the plan contract or policy. AB 2625 requires the enrollee's share of cost for in-network EGMT services be applied to out-of-network EGMT services. Further, CHBRP assumes that AB 2625 does not require insurers/plans to change the out-of-network allowed charge, and that AB 2625 does not require EGMT providers to discontinue balance billing beneficiaries for out-of-network services in cases where the provider's billed charge exceeds the combined plan payment and enrollee cost sharing. CHBRP also assumes that AB 2625's requirement to pay at the contracted rate would not require EGMT providers to enter into contracts with payers or become in-network providers.

The bill applies to DMHC-regulated plans (including DMHC-regulated Medi-Cal Managed Care plans) and California Department of Insurance (CDI) policies that provide coverage for emergency services. 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, for the purposes of this analysis, we have assumed that 100% of these plans do provide coverage for the EGMT referenced in AB 2625.

## Emergency Ground Medical Transport in California

Though the federal Affordable Care Act (ACA) does require health plans to cover out-of-network EGMT at usual and customary rates (UCR), there are no specific standards as to what usual and customary should be. Health plans often set their UCR much lower than what an ambulance provider charges, leaving patients open to liability for the remainder of the charges.

For enrollees in DMHC-regulated plans and CDI-regulated policies, health professionals and facilities are categorized as in-network or out-of-network. 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 enrollees 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 (Fedor, 2006).

The Affordable Care Act requires nongrandfathered, group health plans to cover emergency services at out-of-network hospitals at the same copayment or coinsurance level as in-network hospitals.[3] This requirement, however, does not extend to ambulance services, including EGMT. EGMT is not included in this definition of emergency services because it is not provided in *an emergency department of a hospital*.

Another key interaction of AB 2625 is 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 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:

[3] 29 CFR § 2590.715-2719A(b).

- 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.

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, an emergency condition did not exist, 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 that shall be available and accessible to enrollees on a 24-hour 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. § 1300.67. Scope of Basic Health Care Services.

Current state law (HSC 1367.11 and INC 10352) explicitly allows balance billing for medical transportation for DMHC- and CDI-regulated plans and policies.

Within Medi-Cal, current law (Welfare and Institutions Code 14019.4) prohibits ambulance service providers from "balance billing" Medi-Cal beneficiaries[4] in addition to the beneficiaries generally not having any cost sharing requirements.

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 consumers but are out-of-network, such as anesthesiologists. However, the law does not currently apply to out-of-network EGMT services.[5]

AB 2625 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

[4] Personal Communication, W. White, DHCS, March 2020.
[5] 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.

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 (EMS) is not led 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.

## State Policy

**State Oversight:** The California Emergency Medical Services Authority (EMSA) serves as the pass-through for federal funds, and oversees county and multicounty local EMS agencies (LEMSAs). EMSA manages licensing and practice standards for the California EMS workforce, publishes standards for and approves LEMSA implementation plans, coordinates EMS services among LEMSA jurisdictions, regulates the statewide trauma system, and directs the statewide poison control system (Narad et al., 1994).

**County Oversight:** California's 33 local EMS agencies (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 set the maximum cost of ambulance transportation. LEMSAs also write and enforce contract terms with public and private providers, issue ambulance licenses, and grant exclusive operating area (EOA) rights to EGMT providers.

### 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., 2019). 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 may have also contributed to price increases (U.S. GAO, 2012). Table 2 summarizes the topic and status of 11 other states that have recent legislative activity around EGMT. Most activity relates to developing funding sources for increasing rates paid for Medicaid beneficiaries, or requirements that insurers make reimbursement directly to ambulance providers (direct assignment of benefits).

**Table 2. EGMT-Related Legislation in Other States in Current Legislative Session**

| State | Bill No. | Summary | Status |
|---|---|---|---|
| **Legislation** | | | |
| Colorado | HB19-1174 | Form a committee to study and implement a payment approach for private ambulance companies that are out-of-network in which patients do not face surprise billing | Currently pending |
| Illinois | SB1811 | Conduct a plan to implement a payment program for ambulance services to ensure that there is sufficient access to emergency transport for patients and incentives to | Currently pending |

| | | | |
|---|---|---|---|
| | | provide services efficiently and cost-effectively | |
| Kentucky | HB86 | Require that ground ambulance service providers pay quarterly Medicaid ambulance service provider assessments and establish an ambulance service assessment fund in which assessments, donations, and appropriations are deposited to increase fee-for-service rates and reimburse providers | Introduced in 2019; left pending in committee |
| Texas | HB2333 | Require ground transport emergency medical services providers to make quarterly payments based on net patient revenue and to submit annual reports | Introduced in 2019; left pending in committee |
| Texas | SB2134 | Establish supplemental payment programs for ambulance provider reimbursement under Medicaid | Introduced in 2019; referred to Health & Human Services |
| Tennessee | HB2184 | Require ambulance service providers to submit annual reports outlining cost and utilization | Currently pending |
| Alabama | SB272 | Increase reimbursement rates for specific ambulance services for Medicaid beneficiaries who are ineligible for Medicare | Currently pending |
| Washington | SB6534 | Provide quality assurance fees for emergency ambulance services providers and establish an ambulance transport fund to receive and distribute funds | Currently pending |
| Massachusetts | SD1663 | Require insurers to directly pay ambulance service providers that provide emergency transport services for an insured patient, even if the provider is out-of-network | Currently pending |
| Hawaii | HB1453 | Establish emergency ground transportation fees and authorize Medicaid coverage for emergency medical services | Currently pending |
| Missouri | SB267 | Require carriers and managed care insurance plans to directly pay ground ambulance services | Introduced in 2019; action postponed |

# BACKGROUND ON EMERGENCY GROUND MEDICAL TRANSPORTATION

Prior to the 1960s, ambulance services in the United States were largely provided by hearses staffed with minimally trained funeral home personnel (Office of EMS, 2020). *Accidental Death and Disability: The Neglected Disease of Modern Society,* often termed "the white paper," was published by the National Academy of Sciences in 1966 and served as the impetus for civilian emergency medical services (EMS) in the United States. This report noted that severely injured American soldiers in Vietnam had significantly greater survival rates than Americans injured in motor vehicle collisions, and this was attributed to the existence of a comprehensive military EMS system. Congress quickly acted in 1966 by establishing what would become the National Highway Traffic Safety Administration (NHTSA) and its Office of EMS. The federal government took the lead in developing educational curricula for EMS personnel and system infrastructure issues were later addressed in the Emergency Medical Services System Act of 1973. Eventually, many of these responsibilities were delegated to states. In response to the lack of any central authority in California, the Emergency Medical Services System and Prehospital Emergency Care Personnel Act (the EMS Act) was signed into law in 1980 (California EMS Authority, 2019). The EMS Act created provisions for state regulation, including extensive local delegation, of EMS in Division 2.5 of the Health and Safety Code (sections 1977-1799) to local EMS agencies (LEMSAs).

## EGMT Delivery Systems

Emergency ground medical transportation (EGMT) is provided by emergency medical technicians (EMTs) and/or paramedics who staff 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 EMTs, can provide invasive advanced life support (ALS), such as intravenous (IV) therapy, medication administration, and breathing tube insertion. In response to 911 calls, 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. Payer reimbursement rates typically are higher for life-threatening emergencies with ALS ambulances than for non–life-threatening emergencies with BLS ambulances. In addition to the transportation charge, there are sometimes additional charges such as mileage, oxygen, and miscellaneous supplies (Jacobs et al., 2017).

In California, there were approximately 2.4 million EGMT transports in 2013, operated by 3,600 licensed ambulances (California Ambulance Association, 2014). A variety of systems deliver EMS, 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 EMTs and paramedics in California are employed in the public sector, the public sector only operates 19% of ambulances and services 24% of 911 transports. Though 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 services. The private sector, dominated by two companies that provide nearly half of private ambulances, provides over 75% of all California EGMT transports (Jacobs et al., 2017). Ambulance transportation charges are regulated at a local level by LEMSAs, with LEMSAs typically setting a maximum billed charge, which can vary considerably by county (Los Angeles County EMS Agency, 2014).

Ambulance transports can also include nonemergency, scheduled transportation, which are primarily hospital-to-hospital transfers, transfers to/from skilled nursing facilities, and transfers to/from kidney dialysis facilities. These nonemergency, scheduled ambulance transports are regulated by the EMS Act and are also provided by EMTs and paramedics; however, these non-EGMT transports are typically reimbursed in a different manner, and they are not within the scope of AB 2625.

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 ambulance service 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. One recent study found 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.

Though most EGMT providers do not contract with insurance networks, some offer a subscription service to local residents within their jurisdiction. 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. These subscription services generally discharge any patient financial responsibility for copayments, coinsurance, deductibles, and potential balance billing. However, these ambulance subscriptions only cover EGMT from the specific provider, and they do not provide any benefits outside of the area or if a different EGMT provider completes the ambulance transport (Shanks, 2019).

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 public health role that supplements the traditional function of 911 emergency response and transportation to hospital emergency departments. Though many programs have been introduced around the United States over the past 10 years, these pilot programs are traditionally grant-funded and do not have a stable reimbursement mechanism. Recognizing this, the Centers for Medicare & Medicaid Services recently introduced a new payment model, Emergency Triage, Treat, and Transport (ET3), whereby selected EGMT providers can now receive Medicare payments for alternative EGMT destinations (e.g., urgent care, primary care offices) or telehealth-facilitated treatment at the emergency scene (Centers for Medicare & Medicaid Services, 2020). While most payers currently do not reimburse for alternative EGMT destinations, it is likely that these payers will adopt Medicare's ET3 reimbursement model, as commonly occurs following other Medicare coverage determinations (Foote and Town, 2007).

## Disparities in Accessing 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 emergency ground medical transportation. Disparities are differences between groups that are modifiable. CHBRP found relevant literature identifying disparities by race/ethnicity and age.

### *Age differences*

Multiple studies found that older persons utilize EGMT more than younger persons. 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).

### *Race or ethnic differences*

EGMT utilization did not vary significantly by race/ethnicity when properly adjusted. 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.

# POPULATION AFFECTED

## Effect on Population

If enacted, AB 2640 would affect the health insurance of approximately 21.7 million enrollees (54.8% of all Californians). This represents 100% of the 21.7 million Californians who will have health insurance regulated by the state that may be subject to any state health benefit mandate law — health insurance regulated by the California Department of Managed Health Care (DMHC) or the California Department of Insurance (CDI). If enacted, the law would affect the health insurance of enrollees in DMHC-regulated plans and CDI-regulated policies (with the exception of CDI large group), as well as the insurance of Medi-Cal Managed Care beneficiaries regulated by DMHC.

# BENEFIT COVERAGE, UTILIZATION, AND COST IMPACTS

This section reports the estimated incremental impacts of AB 2625 on emergency ground medical transportation (EGMT) utilization and cost. For the purposes of describing AB 2625's impact, CHBRP has used the following terms and definitions:

- Billed Charge — The amount billed for services by providers. Health plans/insurers have contracts with in-network providers to pay an agreed upon "allowed charge," which is usually lower than the billed charge. 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.
- 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.
- 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. AB 2625 does not address balance billing.

EGMT services were identified for the California commercial population in Milliman's Consolidated Health Cost Guidelines Sources Database (CHSD). All mileage and supplies were included in the cost of the response or transportation service. The services were summarized separately by in-network and out-of-network.

In the baseline and postmandate calculations, CHBRP assumed the average out-of-network allowed charge is the average cost per out-of-network service. The out-of-network allowed charge includes both the plan/insurer payment and patient cost sharing. The difference between the average billed charge and the average out-of-network allowed charge is the balance bill amount in the baseline and post mandate calculation.

In the baseline calculation, CHBRP assumed the plan/insurer payment is the average plan/insurer payment for **out-of-network** EGMT services in CHSD. The difference between the out-of-network

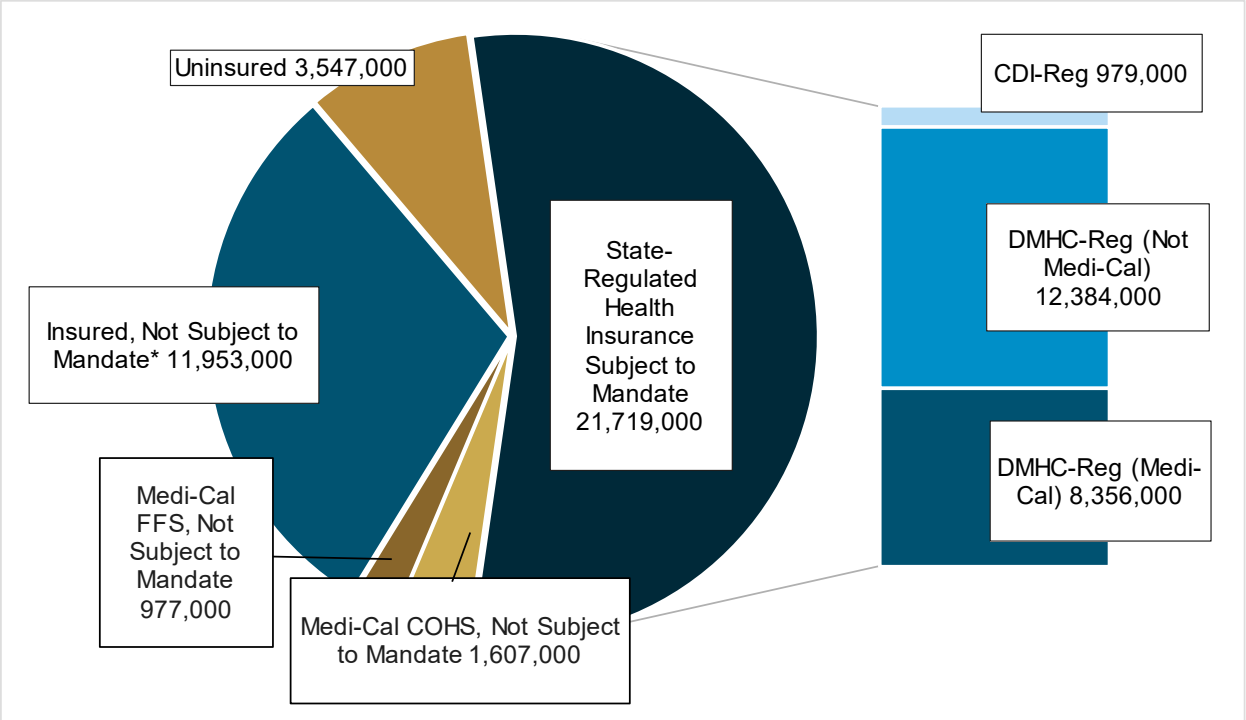
allowed charge and the plan/insurer payment is the average enrollee share of cost in the form of deductibles, copayments, and coinsurances.

For the postmandate calculation, CHBRP calculated the insurer percentage share of cost for **in-network** EGMT services applied to the **out-of-network** allowed charge is the average plan/insurer payment. The difference between the out-of-network allowed charge and the plan/insurer payment is the average enrollee share of cost in the form of deductibles, copayments, and coinsurances.

## Baseline and Postmandate Benefit Coverage

Currently, there are 21,719,000 enrollees with health insurance that would be subject to AB 2625. If enacted, the law would affect the health insurance of enrollees in DMHC-regulated plans and CDI-regulated policies as well as the insurance of Medi-Cal Managed Care beneficiaries regulated by DMHC that currently have coverage for EGMT. As discussed in the Existing State Requirements section, all enrollees with health coverage subject to state-level benefit mandates, with the exception of CDI Large Group, are required to cover EGMT.

There are 645,000 enrollees with CDI large group policies who are exempt from basic health care services, If these enrollees have EGMT coverage, they may be impacted by AB 2625. CHBRP assumed that 100% of enrollees subject to state benefit mandates, including those with a CDI large group policy, currently have EGMT coverage. This assumption overstates the number of enrollees impacted by AB 2625 to the extent that CDI large group enrollees do not have coverage for EGMT.




* Includes Medicare beneficiaries and enrollees in self-insured plans.

## Baseline and Postmandate Utilization

CHBRP assumed enrollees do not consider the out-of-network enrollee share of cost when using EGMT services and out-of-network EGMT utilization would not increase as a result of AB 2625. In 2021, CHBRP

estimates 3.6 out-of-network emergency response and transport cases per 1,000 enrollees in California for the populations impacted by AB 2625. CHBRP assumed no change in the utilization of out-of-network EGMT services postmandate.

## Baseline and Postmandate Per-Unit Cost

For commercial/CalPERS beneficiaries, baseline costs per emergency response and transport case were estimated using CHSD claims and enrollment data for California in 2017 and trended to 2021. The average billed charge for an out-of-network emergency response and transport case is $2,198. The average out-of-network allowed charge is $698. CHBRP estimated that of this amount, $362 will be paid by the plan and $336 will be paid by the beneficiary in the form of deductibles, copays, and coinsurance.

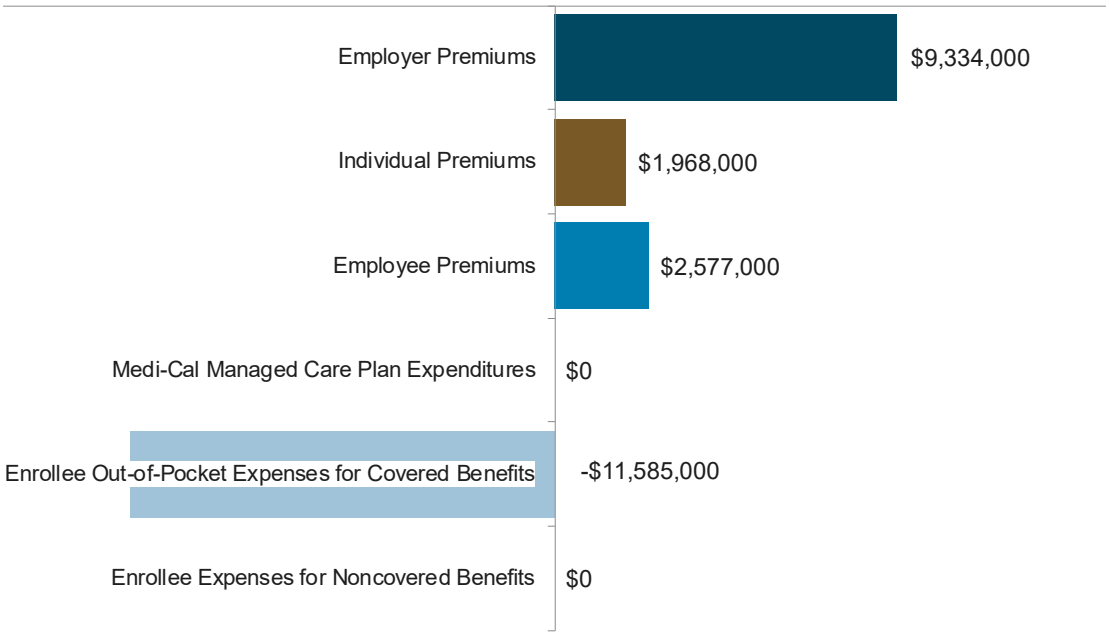
The beneficiary may also be financially responsible for the remaining $1,500 in the form of balance billing. It is up to the provider's discretion to balance bill the patient. The patient may also not be able to pay the full balance billed amount. There is insufficient data to determine the percentage of patients who are balance billed for out-of-network EGMT services or what the percentage of the balance bill amount is recovered by the provider. CHBRP is assuming all providers balance bill for the full amount. The enrollee cost share plus the balance billed amount brings the total beneficiary financial responsibility to $1,836 in the baseline.

CHBRP assumed no change in the cost per unit of out-of-network EGMT services postmandate. Postmandate billed charge per emergency response and transport case for commercial beneficiaries remains $2,198. CHBRP does not expect the average billed amount or average out-of-network allowed charge to change from the baseline period to the postmandate period. The plan will pay an additional $243 of the average out-of-network allowed charge due to in-network enrollee cost sharing being lower than out-of-network cost sharing. This results in an average plan paid amount of $605 postmandate. The beneficiary's average cost sharing in the form of deductibles, copays, and coinsurance will be $93 which is $243 less than baseline. The beneficiary will still be responsible for $1,500 in the form of balance billing; this results in the total beneficiary financial responsibility of $1,593 postmandate.

Medi-Cal Managed Care beneficiaries pay no cost sharing and current law prohibits ambulance service providers from balance billing them. AB 2625 will have no impact on Medi-Cal Managed Care beneficiaries.

## Baseline and Postmandate Expenditures

AB 2625 would increase total net annual expenditures by $2,294,000, or 0.002%, for enrollees with health insurance subject to state-level benefit mandates. This is due to a $13,879,000 increase in total premiums in total health insurance premiums paid by employers and enrollees for out-of-network EGMT services becoming reimbursed at in-network average charges and an $11,585,000 or 0.09% decrease in enrollee share of cost for out-of-network EGMT services. Enrollee balance billing expenses are the same for both baseline and postmandate at $71,423,000.


Employer Premiums
$9,334,000
Individual Premiums
$1,968,000
Employee Premiums
$2,577,000
Medi-Cal Managed Care Plan Expenditures
$0
Enrollee Out-of-Pocket Expenses for Covered Benefits
-$11,585,000
Enrollee Expenses for Noncovered Benefits
$0

# APPENDIX A TEXT OF BILL ANALYZED

On February 25, 2020, the California Assembly Committee on Health requested that CHBRP analyze AB 2625.

ASSEMBLY BILL NO. 2625

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Introduced by Assembly Member Boerner Horvath

February 20, 2020

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An act to add Section 1371.56 to the Health and Safety Code, and to add Section 10126.7 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 2625, as introduced, Boerner Horvath. Emergency ground medical transportation.

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.

This bill would require a health care service plan contract or a health insurance policy issued, amended, or renewed on or after January 1, 2021, that offers coverage for emergency ground medical transportation services to include those services as in-network services and would require the plan or insurer to pay those services at the contracted rate pursuant to the plan contract or policy. 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 1371.56 is added to the Health and Safety Code, to read:

1371.56. A health care service plan contract issued, amended, or renewed on or after January 1, 2021, that offers coverage for emergency ground medical transportation services shall include those services as in-network services and shall pay those services at contracted rates pursuant to the plan contract.

SEC. 2. Section 10126.7 is added to the Insurance Code, to read:

10126.7. A health insurance policy issued, amended, or renewed on or after January 1, 2021, that offers coverage for emergency ground medical transportation services shall include those services as in-network services and shall pay those services at contracted rates pursuant to the policy.

SEC. 3. 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, METHODOLOGY AND ASSUMPTIONS

## Methodology and Assumptions for Baseline Benefit Coverage

- The population subject to the mandated offering includes individuals covered by DMHC-regulated commercial insurance plans, CDI-regulated policies, CalPERS plans subject to the requirements of the Knox-Keene Health Care Service Plan Act, and Medi-Cal HMOs.
- CHBRP assumed 100% of the population subject to mandated offerings currently offer some form of ambulance coverage and are subject to AB 2625.
- CHBRP assumed Medi-Cal enrollees do not pay for Emergency Ground Medical Transportation (EGMT). Although Medi-Cal HMOs are subject to the bill, enrollees will not have a cost impact.

## Methodology and Assumptions for Baseline Utilization and Cost

- The average cost and utilization rates for EGMT are based on the 2017 Consolidated Health Cost Guidelines Sources Database (CHSD). The data were limited to California commercial enrollees.
- 'Emergency transportation' and 'emergency response' cases were identified using procedure codes. 'Mileage' and 'supplies' associated with the emergency response and transportation cases were included in the cost per case. The procedure codes used to identify EGMT claims are in **Table 1.** No other procedure codes were included in the cost per case.
- All cases were identified as in-network or out-of-network emergency transportation. Only out-of-network utilization was included in our analysis.
- Utilization was trended from 2017 to 2021 using 1.5% trend. Billed and allowed costs per case were trended using 4.5% trend.

## 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 transportation and response paid-to-allowed ratios were multiplied by the line of business factors to calculate line of business specific emergency transportation and response paid-to-allowed ratios.
- One minus the line of business adjusted **out-of-network** paid-to-allowed ratio was applied multiplicatively to 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 "noncovered benefits" in Table 1, 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. CHBRP did not make an adjustment for this.

## Methodology and Assumptions for Postmandate Utilization

- CHBRP did not assume EGMT utilization would increase as a result of AB 2625.

## Methodology and Assumptions for Postmandate Cost

- CHBRP did not assume EGMT costs would increase as a result of AB 2625.

## Methodology and Assumptions for Postmandate Cost Sharing

- One minus the line of business adjusted **in-network** paid-to-allowed ratio was applied multiplicatively to 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 Table 1, 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. CHBRP did not make an adjustment for this.

**Table 3. Emergency Ground Medical Transportation Procedure Codes**

| CPT/HCPCS | Long Description | Category |
|---|---|---|
| A0998 | Ambulance response and treatment, no transport | Emergency response |
| S0207 | Paramedic intercept, non-hospital-based ALS service (nonvoluntary), nontransport | Emergency response |
| S0208 | Paramedic intercept, hospital-based ALS service (nonvoluntary), nontransport | Emergency response |
| A0225 | Ambulance service, neonatal transport, base rate, emergency transport, one way | Emergency transportation |
| A0427 | Ambulance service, advanced life support, emergency transport, level 1 (ALS 1 - emergency) | Emergency transportation |
| A0429 | Ambulance service, basic life support, emergency transport (BLS-emergency) | Emergency transportation |
| A0433 | Advanced life support, level 2 (ALS 2) | Emergency transportation |
| A0021 | Ambulance service, outside state per mile, transport (Medicaid only) | Mileage |
| A0380 | BLS mileage (per mile) | Mileage |
| A0390 | ALS mileage (per mile) | Mileage |
| A0425 | Ground mileage, per statute mile | Mileage |
| A0888 | Noncovered ambulance mileage, per mile (e.g., for miles traveled beyond closest appropriate facility) | Mileage |
| A0382 | BLS routine disposable supplies | Supplies |
| A0384 | BLS specialized service disposable supplies; defibrillation (used by ALS ambulances and BLS ambulances in jurisdictions where defibrillation is permitted in BLS ambulances) | Supplies |
| A0392 | ALS specialized service disposable supplies; defibrillation (to be used only in jurisdictions where defibrillation cannot be performed in BLS ambulances) | Supplies |
| A0394 | ALS specialized service disposable supplies; IV drug therapy | Supplies |

| | | |
|---|---|---|
| A0396 | ALS specialized service disposable supplies; esophageal intubation | Supplies |
| A0398 | ALS routine disposable supplies | Supplies |
| A0422 | Ambulance (ALS or BLS) oxygen and oxygen supplies, life-sustaining situation | Supplies |

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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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Jeffrey Rollman, MPH, prepared the background and limited analysis on disparities. Casey Hammer, FSA, MAAA, of Milliman, provided actuarial analysis. Garen Corbett, MS, of CHBRP staff prepared the Policy Context and synthesized the individual sections into a single report. A subcommittee of CHBRP's National Advisory Council (see previous page of this report) and a member(s) of the CHBRP Faculty Task Force, Nadereh Pourat, PhD, of the University of California, Los Angeles, as well as CHBRP's Associate Director, John Lewis, MPA reviewed the analysis for its accuracy, completeness, clarity, and responsiveness to the Legislature's request.

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

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