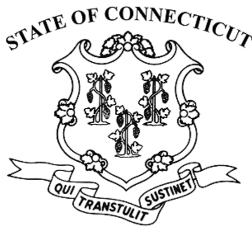

Senate

General Assembly

File No. 17

February Session, 2024

Substitute Senate Bill No. 179

Senate, March 13, 2024

The Committee on Public Health reported through SEN. ANWAR of the 3rd Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING RATES FOR AMBULANCE AND PARAMEDIC SERVICES.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Subdivision (9) of section 19a-177 of the 2024 supplement
2 to the general statutes is repealed and the following is substituted in lieu
3 thereof (*Effective July 1, 2024*):

4 (9) (A) Establish rates for the conveyance and treatment of patients
5 by licensed ambulance services and invalid coaches and establish
6 emergency service rates for certified ambulance services and paramedic
7 intercept services, provided (i) the present rates established for such
8 services and vehicles shall remain in effect until such time as the
9 commissioner establishes a new rate schedule as provided in this
10 subdivision, and (ii) any rate increase not in excess of the Medical Care
11 Services Consumer Price Index, as published by the Bureau of Labor
12 Statistics of the United States Department of Labor, for the prior year,
13 filed in accordance with subparagraph (B)(iii) of this subdivision shall
14 be deemed approved by the commissioner. For purposes of this

15 subdivision, licensed ambulance services and paramedic intercept
16 services shall not include emergency air transport services or mobile
17 integrated health care programs.

18 (B) Adopt regulations, in accordance with the provisions of chapter
19 54, establishing methods for setting rates and conditions for charging
20 such rates. Such regulations shall include, but need not be limited to,
21 provisions requiring that: [on and after July 1, 2000:] (i) Requests for rate
22 increases [may] shall be filed no more frequently than once a year,
23 except, [that,] in any case where an agency's rate schedule [of maximum
24 allowable rates] falls below that of the Medicare allowable rates for that
25 agency, the commissioner shall immediately amend such schedule so
26 that the rates are at or above the Medicare allowable rates; (ii) only
27 licensed ambulance services, certified ambulance services and
28 paramedic intercept services that apply for a rate increase in excess of
29 the Medical Care Services Consumer Price Index, as published by the
30 Bureau of Labor Statistics of the United States Department of Labor, for
31 the prior year, and do not accept the [maximum allowable rates] rate
32 schedule contained in any voluntary state-wide rate schedule
33 established by the commissioner for the rate application year shall be
34 required to file detailed financial information with the commissioner,
35 provided any hearing that the commissioner may hold concerning such
36 application shall be conducted as a contested case in accordance with
37 chapter 54; (iii) licensed ambulance services, certified ambulance
38 services and paramedic intercept services that do not apply for a rate
39 increase in any year in excess of the Medical Care Services Consumer
40 Price Index, as published by the Bureau of Labor Statistics of the United
41 States Department of Labor, for the prior year, or that accept the
42 [maximum allowable rates] rate schedule contained in any voluntary
43 state-wide rate schedule established by the commissioner for the rate
44 application year shall, not later than the last business day in August of
45 such year, file with the commissioner a statement of emergency and
46 nonemergency call volume, and, in the case of a licensed ambulance
47 service, certified ambulance service or paramedic intercept service that
48 is not applying for a rate increase, a written declaration by such licensed
49 ambulance service, certified ambulance service or paramedic intercept

50 service that no change in its currently approved **[**maximum allowable
51 rates**]** <u>rate schedule</u> will occur for the rate application year; and (iv)
52 detailed financial and operational information filed by licensed
53 ambulance services, certified ambulance services and paramedic
54 intercept services to support a request for a rate increase in excess of the
55 Medical Care Services Consumer Price Index, as published by the
56 Bureau of Labor Statistics of the United States Department of Labor, for
57 the prior year, shall cover the time period pertaining to the most recently
58 completed fiscal year and the rate application year of the licensed
59 ambulance service, certified ambulance service or paramedic intercept
60 service. <u>Not later than November first, annually, the commissioner shall</u>
61 <u>issue the licensed ambulance service, certified ambulance service and</u>
62 <u>paramedic intercept service rate schedule for each such agency that</u>
63 <u>applies for a rate increase pursuant to clause (ii) of this subparagraph.</u>
64 <u>Not later than October first, annually, the commissioner shall issue the</u>
65 <u>rate schedule for each such agency that accepts the ambulance service</u>
66 <u>or paramedic intercept service rate schedule pursuant to clause (iii) of</u>
67 <u>this subparagraph.</u>

68 (C) Establish rates for licensed ambulance services, certified
69 ambulance services or paramedic intercept services for the following
70 services and conditions: (i) "Advanced life support assessment" and
71 "specialty care transports", which terms have the meanings provided in
72 42 CFR 414.605; and (ii) mileage, which may include mileage for an
73 ambulance transport when the point of origin and final destination for
74 a transport is within the boundaries of the same municipality. The rates
75 established by the commissioner for each such service or condition shall
76 be equal to (I) the ambulance service's base rate plus its established
77 advanced life support/paramedic surcharge when advanced life
78 support assessment services are performed; (II) two hundred twenty-
79 five per cent of the ambulance service's established base rate for
80 specialty care transports; and (III) "loaded mileage", as the term is
81 defined in 42 CFR 414.605, multiplied by the ambulance service's
82 established rate for mileage. Such rates shall remain in effect until such
83 time as the commissioner establishes a new rate schedule as provided
84 in this subdivision.

85 (D) Establish rates for the treatment and release of patients by a
86 licensed or certified emergency medical services organization or a
87 provider who does not transport such patients to an emergency
88 department and who is operating within the scope of such
89 organization's or provider's practice and following protocols approved
90 by the sponsor hospital. The rates established pursuant to this
91 subparagraph shall not apply to the treatment provided to patients
92 through mobile integrated health care programs;

93 Sec. 2. Section 38a-498 of the general statutes is repealed and the
94 following is substituted in lieu thereof (*Effective January 1, 2025*):

95 (a) Each individual health insurance policy providing coverage of the
96 type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section
97 38a-469 delivered, issued for delivery, renewed, amended or continued
98 in this state shall provide coverage for medically necessary conveyance
99 and treatment and emergency medical services by licensed and certified
100 ambulance services and paramedic intercept services for persons
101 covered by the policy pursuant to the rate schedule issued by the
102 Commissioner of Public Health pursuant to subdivision (9) of section
103 19a-177, as amended by this act. The hospital policy shall be primary if
104 a person is covered under more than one policy. The policy shall, as a
105 minimum requirement, cover such services whenever any person
106 covered by the contract is transported when medically necessary by
107 ambulance to a hospital. Such benefits shall be subject to any policy
108 provision which applies to other services covered by such policies.
109 Notwithstanding any other provision of this section, such policies shall
110 not be required to provide benefits in excess of the [maximum
111 allowable] rate schedule established by the Department of Public Health
112 in accordance with section 19a-177, as amended by this act.

113 (b) (1) Each such individual health insurance policy shall provide that
114 any payment by such company, corporation or center for emergency
115 ambulance services or paramedic intercept services under coverage
116 required by this section shall be paid directly to the ambulance or
117 paramedic intercept service provider rendering such service if such

118 provider has complied with the provisions of this subsection and has
119 not received payment for such service from any other source.

120 (2) Any ambulance or paramedic intercept service provider
121 submitting a bill for direct payment pursuant to this section shall stamp
122 the following statement on the face of each bill: "NOTICE: This bill
123 subject to mandatory assignment pursuant to Connecticut general
124 statutes".

125 (3) This subsection shall not apply to any transaction between an
126 ambulance or paramedic intercept service provider and an insurance
127 company, hospital service corporation, medical service corporation,
128 health care center or other entity if the parties have entered into a
129 contract providing for direct payment.

130 Sec. 3. Section 38a-525 of the general statutes is repealed and the
131 following is substituted in lieu thereof (*Effective January 1, 2025*):

132 (a) Each group health insurance policy providing coverage of the type
133 specified in subdivisions (1), (2), (4), (6), (11) and (12) of section 38a-469
134 delivered, issued for delivery, renewed, amended or continued in this
135 state shall provide coverage for medically necessary conveyance and
136 treatment and emergency medical services by licensed and certified
137 ambulance services and paramedic intercept services for persons
138 covered by the policy pursuant to the rate schedule issued by the
139 Commissioner of Public Health pursuant to subdivision (9) of section
140 19a-177, as amended by this act. The hospital policy shall be primary if
141 a person is covered under more than one policy. The policy shall, as a
142 minimum requirement, cover such services whenever any person
143 covered by the contract is transported when medically necessary by
144 ambulance to a hospital. Such benefits shall be subject to any policy
145 provision which applies to other services covered by such policies.
146 Notwithstanding any other provision of this section, such policies shall
147 not be required to provide benefits in excess of the **[**maximum
148 allowable**]** rate schedule established by the Department of Public Health
149 in accordance with section 19a-177, as amended by this act.

150 (b) (1) Each such group health insurance policy shall provide that any
151 payment by such company, corporation or center for emergency
152 ambulance services under coverage required by this section shall be
153 paid directly to the ambulance or paramedic intercept service provider
154 rendering such service if such provider has complied with the
155 provisions of this subsection and has not received payment for such
156 service from any other source.

157 (2) Any ambulance or paramedic intercept service provider
158 submitting a bill for direct payment pursuant to this section shall stamp
159 the following statement on the face of each bill: "NOTICE: This bill
160 subject to mandatory assignment pursuant to Connecticut general
161 statutes".

162 (3) This subsection shall not apply to any transaction between an
163 ambulance or paramedic intercept service provider and an insurance
164 company, hospital service corporation, medical service corporation,
165 health care center or other entity if the parties have entered into a
166 contract providing for direct payment.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2024*	19a-177(9)
Sec. 2	*January 1, 2025*	38a-498
Sec. 3	*January 1, 2025*	38a-525

Statement of Legislative Commissioners:
In Section 2(b)(3), "ambulance provider or paramedic intercept service provider" was changed to "ambulance or paramedic intercept service provider", for consistency with Section 2(b)(1) and (b)(2) and Section 3(b).

PH *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 25 $	FY 26 $
State Comptroller - Fringe Benefits[1]	GF - Cost	Potential	Potential
Resources of the General Fund; Social Services, Dept.	GF - Cost	Potential	Potential

Note: GF=General Fund

Municipal Impact:

Municipalities	Effect	FY 25 $	FY 26 $
Various Municipalities	Cost	Potential	Potential
Various Municipalities	Savings	Potential	Potential

Explanation

The bill results in potential costs to the state and municipalities and potential savings for certain municipalities beginning in FY 25.

The bill requires health carriers to cover medically necessary ambulance services in line with the rate schedule that the Department of Public Health (DPH) already sets for these services. Under current practice, carriers often negotiate lower rates than the "maximum allowable rates" published by DPH. The bill's provision may result in higher costs for health carriers (including the state employees and some municipal plans) and savings to towns.

Additionally, the bill appears to expand the existing mandate for medically necessary ambulance services to include paramedic intercept

[1]The fringe benefit costs for most state employees are budgeted centrally in accounts administered by the Comptroller. The estimated active employee fringe benefit cost associated with most personnel changes is 41.25% of payroll in FY 25.

services, for which providers can seek direct reimbursement under the bill.[2] This component of the bill may result in costs to the plans and associated with the Exchange.

To the extent the bill also mandates coverage for certain treatment at the scene when there is no ambulance transport, the bill results in potentially significant costs for the state employee plan, fully insured municipalities, and associated with exchange enrollees, as that is not currently a mandated or typically provided coverage.

Potential Costs to the Office of the State Comptroller – Fringe Benefits and Municipalities

The bill results in a potential cost to the State Comptroller – Fringe Benefits account associated with new mandated coverage of paramedic intercept services, and potentially different reimbursement rates under the plan. The state employee health plan uses reimbursement rates for emergency medical services (EMS) up to DPH's current maximum allowable rate. The cost to the plan will depend on the difference between current reimbursement rates for EMS and the rates utilized under the bill, as well as the number of EMS claims.

Certain municipalities with either self or fully insured health plans or participation in the Partnership plan will see a potential cost to the extent the plans do not currently fully reimburse the maximum allowable rates for EMS, including the potentially mandated coverage of treatment without medical conveyance, subject to the Commissioner's rate schedule. Due to federal law, municipalities with self-insured health plans are exempt from state health insurance benefit mandates, so potential costs are contingent on the plan electing to adopt the mandate.

[2] Paramedic intercept services are advanced life support (ALS) services provided by a paramedic from a separate organization to a patient being transported by an ambulance service. At the ambulance services' request, an outside paramedic meets the ambulance via a separate vehicle and rides inside to provide services for more serious cases.

Potential Costs Related to Exchange Enrollees

The bill could result in a cost to the state to defray additional premium costs for enrollees purchasing health insurance on the state's exchange, to the extent the requirement for "paramedic intercept services" is determined to increase premiums and constitute a new state benefit mandate.

Typically under current law, the provider of the ambulance transport service bills the insurance company for a higher level of care made possible by the paramedic intercept service and then reimburses the provider of paramedic intercept services at an agreed upon rate. It is not clear to what extent the bill will result in coverage for services not already being partially covered through such combined billing arrangements. The plain average of DPH's 2024 rate schedule for paramedic intercept services is $1,088, for basic life support (BLS) is $945, and for advanced life support (ALS) is $1,611.[3]

The bill could also result in additional costs to defray premiums for exchange enrollees to the extent there is an additional new mandate for treatment without conveyance that is determined to require defrayal.

Under the Affordable Care Act (ACA), states are allowed to mandate benefits in excess of the essential health benefits but must pay for the excess coverage. Federal regulations require the state to defray the cost of additional benefits related to specific care, treatment or services mandated by state action after December 31, 2011 (except to comply with federal requirements) for all plans sold on the exchange.[4] There are currently 130,141 enrollees in qualified health plans on the exchange, including 29,687 in Covered Connecticut.

To the extent the bill is determined to include one or two new state benefit mandates that require defrayal, there would be a cost to the state

[3] DPH Office of Emergency Medical Services, 2022-2024 Allowable Rates by EMS Organizations

[4] 45 CFR 155.170

beginning January 1, 2025.[5] Full year costs would begin in FY 26 and continue annually.

Defrayal costs for Covered Connecticut enrollees would be incurred by the Department of Social Services (DSS), to the extent the bill raises premiums for those enrollees. The bill could also increase Covered Connecticut costs to the extent it increases the negotiated reimbursement rates for already covered ambulance services, however, that impact would be limited due to the way federal subsidies for those enrollees would increase as well.

It is not clear how or when the ACA defrayal rules will be enforced for non-Covered Connecticut enrollees. Recently proposed federal regulations, if finalized, would provide a means for the state to integrate existing state benefit mandates in essential health benefit categories into Connecticut's benchmark plan, which could alleviate some federal premium defrayal requirements in the out years.[6]

Potential Municipal Savings

The bill could result in a savings to various municipalities beginning in FY 25 to the extent insurance providers reimburse ambulance companies at a higher rate and extend the coverage to include paramedic intercept services.

Funding structure for ambulance services varies widely by municipality. Municipalities that provide their own paid ambulance service will likely see the largest impact as a greater portion of operating expenses may be covered by the insurance providers. Municipalities that do not provide any expenditures for ambulance services will have no impact.

Insurance providers currently negotiate a reimbursement percentage for ambulance services based on the maximum allowable rate set by

[5]After determining if the mandate is subject to defrayal, states must reimburse the carriers or the insureds for the excess coverage. The premium costs are to be quantified by each insurer on the exchange and reported to the state.
[6] 88 FR 82510

DPH. Removing the maximum allowable language may allow ambulance services to negotiate based on a higher rate or receive the full DPH rate.

For example, an insurance company that currently reimburses an ambulance provider at 80% of the average statewide rate set by DPH might instead be required to reimburse at 100% of that rate. For a service such as basic life support (BLS), the ambulance provider would see an increase of approximately $190 for each instance when they provide BLS.[7] This revenue increase for ambulance services may result in a corresponding savings to municipalities.

Municipalities may also see a corresponding savings to the extent insurance providers reimburse ambulance companies for paramedic intercept services.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation, the DPH EMS rate schedule, carrier negotiated rates, the number of QHP enrollees on the exchange, federal regulations concerning defrayal, and the methods municipalities use to provide and fund ambulance services.

Sources: *Department of Public Health 2022 Office of Emergency Medical Services Annual Report*
Department of Public Health https://portal.ct.gov/DPH/Emergency-Medical-Services/EMS/Office-of-Emergency-Medical-Services-Homepage
Office of Health Strategy All Payer Claims Database

[7] Basic life support (BLS) is defined by the Connecticut Department of Public Health's Office of Emergency Medical Services as transportation by ground ambulance vehicle where the vehicle is staffed by an individual who is qualified as an EMT-basic.

OLR Bill Analysis
sSB 179

AN ACT CONCERNING RATES FOR AMBULANCE AND PARAMEDIC SERVICES.

SUMMARY

Existing law generally requires certain health insurance policies to cover medically necessary ambulance services. This bill expands this coverage requirement by (1) requiring health carriers to provide this coverage in line with the rate schedule that the Department of Public Health (DPH) sets for these services and (2) extending this coverage requirement to include paramedic intercept services.

By law, DPH must establish emergency medical services (EMS) rates and adopt regulations on rate-setting methods. Corresponding to the insurance changes, the bill eliminates provisions referring to required regulations on the "maximum allowable rates" for EMS services, and instead refers to the "rate schedule" set by DPH.

Additionally, the bill sets an annual (1) October 1 deadline for DPH to issue the EMS rate schedule for ambulance and paramedic intercept service agencies that accept the DPH-set rate and (2) November 1 deadline for DPH to issue rates for these agencies that apply for a rate increase in excess of the inflationary increase and do not accept the rate schedule. By law, these agencies have the option to either accept DPH's established rate with an inflationary increase or request a higher rate (in which case, they must file detailed financial information).

EFFECTIVE DATE: July 1, 2024, except that the insurance provisions are effective January 1, 2025.

INSURANCE COVERAGE

Under current law, certain health insurance policies must cover medically necessary ambulance services. The bill requires coverage of medically necessary conveyance and treatment and emergency medical services by ambulance and paramedic intercept services, according to DPH's rate schedule. Similar to current law, the bill specifies that carriers are not required to provide coverage exceeding DPH's rate schedule. (By law, "paramedic intercept services" are paramedic treatment services provided by an entity that does not provide the ground ambulance transport.)

The bill also requires that for paramedic intercept services, as under existing law for ambulance services, (1) the policy must generally provide for direct payment to the provider and (2) if the provider submits a bill for direct payment, the bill must indicate that it is subject to mandatory assignment.

As under current law, the bill applies to individual or group policies delivered, issued, amended, renewed, or continued that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; (4) accident-only coverage, (5) limited benefit coverage (individual plans only); and (6) hospital or medical services, including HMOs. (Because of the federal Employee Retirement Income Security Act (ERISA), state insurance mandates do not apply to self-insured benefit plans.)

COMMITTEE ACTION

Public Health Committee

Joint Favorable Substitute
Yea 35 Nay 2 (03/04/2024)