GAPB Public Meeting 3 – Day 2 (Morning Session)

Good morning and welcome to Day 2 of the Ground Ambulance and Patient Billing Advisory Committee public meeting. My name is Terra Sanderson, and I will be serving as the facilitator for today's meeting. Today's session is being recorded. By your attendance here today, you are giving consent to the use and distribution of your name, likeliness, and voice during this webinar. Before we dive into the discussion today, there are a few logistics that may be helpful for participation in today's session. Your meeting controls are in the toolbar at the bottom of your screen. If you need to connect your audio, follow the audio prompts that appear when you join Zoom. We recommend using the Call Me or Computer Audio options to ensure your name is synced with your audio. If you select Call Me, enter your phone number, including the area code. If you have an extension, you can enter your phone number, followed by a hyphen, and then your extension. We hope everyone has a great experience today. At this time, I will turn it over to Asbel Montes to provide us with a recap of Day 1.

Good morning, everyone, and welcome to Day 2, to our committee members as well. I thought we had some really great productive dialogue yesterday. As a matter of course for our committee members and the public that is listening as well, there will be no public comment today in the oral component as we did yesterday, but at the end of this, you also will receive some information following this where you can provide additional public comment as well. Right now, the public comment is to the committee members. I know there might have been some confusion yesterday with people continuing to raise their hands to speak, but public comment will be in a written form at this time. We have about six more recommendations to go through. There was a few committee members asked yesterday to relook at recommendation number 3, as well as recommendation number 8, options A and B for consolidation. So we will look at that following the recommendations that we will make today to discuss those options and the consolidation for the record as well. And so today, we will get more into finishing up the disclosures side of things and then move into the recommendations surrounding the prevention of surprise billing. So we'll get right to it. I'll stop here and see if any of the committee members have any questions or anything that they would like to discuss before we start into recommendation number 9. Okay, hearing none, we will move through just as a matter of course for the public as well with the agenda. We will break about following one of the recommendations here, maybe once or twice. We will have at least a 10-minute break. We will stay on track to do our midday break at noon Eastern time. We'll break for an hour and then we will come back and finalize up whatever recommendations we have been unable to get to up until. We plan to go all the way to 5:30 Eastern time, should that be needed, but depending upon how we get to the rest of these recommendations will determine the timing when we adjourn our meeting today. All right, so let's move to recommendation number 9. Recommendation number 9, and then we'll get some context around that and then we'll open it back up again to discussion and we will follow the same format that we did yesterday and that is to open for discussion, take the vote and the no votes will also have the ability to provide additional comment as well. So, recommendation number 9 basically indicates Congress requires the Secretary of Health and Human Services to amend the relevant conditions of participation to require healthcare providers to share patient insurance information with a ground ambulance emergency medical services provider or supplier that treated a neutral patient upon request by the ground ambulance emergency medical services provider or supplier. So, what is this recommendation about for context? We heard through public comment. We also heard through some of our presenters that gave us information that sometimes a ground ambulance provider may be interacting oftentimes when a patient calls 911 or an equivalent or vice versa. Sometimes the information is not as available to different providers across the nation or in different regions. In some regions, it's accessible. There might be a health information exchange or an HIE that's available to them and in some areas of the community, there is not. And does HIPAA actually cover and require them to do that? We did hear from a presenter from the Office of Civil Rights that talked about HIPAA and provided further context around that, that it is permissible, but it is not something that is a requirement. What are the conditions of participations for the hospital industry? We are asking or seeking an amendment from the Secretary of Health and Human Services to make this a requirement that they provide this information to a ground ambulance provider or supplier in order to continue to protect the patient so they

do not receive a bill, as we talked about in another recommendation, to make sure that any insurance information that was available was able to be billed by that provider before a patient became engaged in the process where they may not understand that. So that's a little bit of the context around what this recommendation is about. It's more around a disclosure consumer protection that allows to ensure that a patient doesn't erroneously receive a bill or receive a bill where technically they may have had insurance that was available at the receiving or sending hospital. So, I'll open it up to discussion about this recommendation. I see Patricia's hand raised.

Yeah, just like this is such an obvious thing that we would hope was already happening, that if we're in an emergency and we've handed off all of our insurance information as patients to the hospital that's now going to be treating us, it would be great if the hospital and the ambulance company were actually working together to share that information and get it in the hands of the ambulance company so they can start the billing process and keep us out of it. So, thinking about patients maybe still even in the hospital within the first few days after their 911 call, this would be a really important thing to just super clarify, make sure that hospitals understand they should give the information to the ambulances. And we're setting up a system with other recommendations to make sure that happens quickly so that patients never get that bill without the benefit of insurance information in that bill. Thanks.

Thanks, Patricia. Great commentary. Anybody else have anything before we take the vote? All right. Not seeing any hand's raised, Terra, if you'll call the vote.

Okay. Loren Adler?

Yes.

Shawn Baird?

Yes.

Adam Beck?

Yes.

Regina Crawford?

Yes.

Rhonda Holden?

Yes.

Patricia Kelmar?

Yes.

Ali Khawar? Peter Lawrence?

Yes.

Rogelyn McLean? Rog, are you on mute?

Apologies, double muted. Abstain. Thank you.

Okay. Asbel Montes?

Yes.

Ayobami Ogunsola?

Yes.

Suzanne Prentiss?

Yes.

Ritu Sahni?

Yes.

Edward Van Horne?

Yes.

Carol Weiser?

Abstain.

Gam Wijetunge?

Yes.

Gam, I think you broke up there.

Yes.

Okay. And Gary Wingrove.

Yes.

Okay, so Recommendation number 9 is finalized and I think Gam is confirming yes in the chat with he's having some audio difficulties. So, let's move to recommendation number 10. And so, this is the final or one of our finals around consumer protections and disclosures. And this is actually discussing some of the minimum elements that would need to be in a patient's bill. Right now, some of this might seem obvious. But what we did learn through discussions with billing offices and others that presented or through public comment is that oftentimes in some situations, not everything is included on a statement that a patient might be getting a bill relative to certain things. And so there is a recommendation that we standardize this and provide a bill to consumers with minimum elements in a bill when they do receive a bill. And so basically, the recommendation is that ground ambulance emergency medical services should provide a bill to consumers with minimum elements for a standardized bill. This would, one, all bills must include the following elements. A, clarify whether or not the bill reflects a final determination by the patient's insurance. B, provide information about how a patient can dispute the charges and the coverage determination. C, provide information that they should not receive a balance bill. Oops, if you'll go back. You're ahead of me. And if they do, how they can report that illegal bill to be sure it does not appear as an amount owed or be sent to collections. Next slide. And then two communications from ground ambulance emergency medical services to the patient before obtaining the patient's insurance information or completing a reasonable attempt to obtain said information must make clear that it is not a bill. Required language could be, this is not a bill. We are attempting to determine your insurance information. Further context. And then I'll allow Loren or Patricia. This came out of their subcommittee

work that they did as well in the first half of our meetings. But this further context was we do know that there are several states that already have something similar on the books. Not all states are doing something similar to, but to create more standardized would really help the consumer understand the communications that are coming from them. It was also discussed that on the insurance side around the explanation of benefits, there are elements that they require as well. And AHIP and others provided further context around some of that. That would be governed around certain elements. And so you're seeing it in the form of an element versus an actual standard bill that everybody gets that could be replicated without a new administrative burden. So, Patricia, I'm not going to call you on the spot again, but I do know this came out of your committee and I think further context from you to the public would be helpful. And then we'll open for discussion.

Sure. Thank you. Yeah, this was really important. And I think, you know, as I've talked to a few times so far in these public meetings, patient billing is very confusing. And it's really hard to understand what's a bill, what's not a bill, particularly if you're still recovering or maybe you're still in the hospital or you're on some type of medication that's making you groggy. Bills are confusing for the best of us. So, this is an attempt to really at the point where you have to start making the decision of how you're going to pay for your bills, you're given all the information that you need right there on the bill or on the communication. So in the case of a bill, you're actually going to understand whether or not insurance determination has been made on this claim. And so, you know whether it's a final bill or not. You'll know that you have balance billing protections, that you have surprise billing protections and how to assert those rights if you do end up getting a balance bill. So those are some of the protections just in the bill. And then the second point here on this slide here, two of two, what we're getting at there is if for some reason the hospital and the ambulance did not get the patient insurance information, the ambulance is allowed to reach out to the patient to determine if they have insurance, but it will be in a clear manner. It won't be in the context of a bill. It'll be in the context of a communication of we're trying to resolve your bill and make sure we know what you owe. So this is an indication to reach out quickly to the ambulance company to provide insurance information if you have it.

All right. So, we'll open up for any discussion regarding this recommendation and the recommendation that to Congress that there be some type of standardized billing elements for a patient bill from the ground ambulance industry. All right. Not seeing any hands, we will call for -- oh, Ted.

Yeah, I just want to also clarify, it's not just about paper anymore as we've been talking about it. There's communications that happen now once people are better receiving bills electronically via email. So, it's not just about paper, which obviously takes time. So that was a big piece of this. So, the messaging that happens is consistent across all ways in which patients are notified about us attempting and providers attempting to get information from them or when it is actually a bill. That's it. Thanks.

Thanks, Ted. Any other further discussion around this particular recommendation? All right. Not seeing any hands, Terra, we'll call the vote.

Okay. Loren Adler.

Yes.

Shawn Baird.

Yes.

Adam Beck.

Yes.

Regina Crawford.

Yes.

Rhonda Holden.

Yes.

Patricia Kelmar.

Yes.

Ali Khawar.

Peter Lawrence.

Yes.

Rogelyn McLean.

Abstain.

Asbel Montes.

Yes.

Ayobami Ogunsola.

Yes.

Suzanne Prentiss.

Yes.

Ritu Sahni.

Yes.

Edward Van Horne.

Yes.

Carol Weiser.

Abstain.

Gam Wijetunge.

I see that. Very good.

Okay. It looks like Gam has posted his response in the chat. And then Gary Wingrove.

Yes.

Okay.

All right. So now we're going to start to get into some of the recommendations around the prevention of surprise medical bills. And so, within the discussion, and you'll begin to see in basically recommendation number 12 is where we start to get into some of how the methodologies are formulated around preventing a balance bill to where the patient cannot be sent a balance bill for covered services. And so, excuse me, around one of those was relative to local state regulated rates. You've heard a lot about that. You've heard a lot of discussion around that through the different public hearings. And so, recommendation number 11. Excuse me, folks. Well, recommendation number 11 was really around the state local regulated rates. And you heard a lot of stuff talked about regarding guardrails around this. So basically, something's not capricious and arbitrary that is set at the local level or at the state level, but that there are some specific guardrails around this. So, when we begin to talk about recommendations 12B and 14, you will see things that are going to reference recommendations that have already been done. And there were two, mainly two. And that first one was the maximum out of pocket that we discussed earlier in recommendation number eight. And there were three options to that recommendation. There was a request by two committee members yesterday based upon the way the vote went on option A and B of the three-part option on the maximum out of pocket that we will revisit at the very end of our recommendations today to see if there's further recommendation to consolidate those two into one, as there appeared to be the preference of one over the others in those options. Then there is a second one that's going to be referenced when you see recommendation 12B and 14 that has several different options to get at the same recommendation. And so, the first is around the guardrails. And so, I'm going to first read what the actual recommendation is. We'll open it for discussion, and then we'll move to the two options surrounding this guardrail. The first is recommended is established minimum guardrails for state and local regulated rates for ground ambulance emergency medical services and non-emergency ground ambulance medical services to ensure reasonable regulated rates and a recommendation 12B and 14. And those recommendations that we will vote on later will be surrounding the concepts around ground ambulance emergency medical services, and then you'll see in recommendation 14 around grant non-emergency ground ambulance medical services. And so I will open the floor to discussion, and I see Suzanne, you have your hand raised.

I do. Good morning, everyone and thank you as well. I just want to set -- I don't know if it's a setting. Put my comments on the record now and provide the context for the relationship between the federal government, state, and local government. As some of you may or may not know, I am a state elected official but I have also served as a local elected official, a mayor, and I've run a municipal ambulance service. So throughout the meetings that we've had in, you know, over this time that we've been together and in particular the last few weeks, we've really honed in on this discussion about what the local state and local officials, what their role is in this what the transparency is in this, and the danger of taking trying to take over the process from the federal level to at the state and local level. You know, we heard in public comment yesterday and I'm just doing this very globally now, it'll be consistent with my votes, public comment yesterday, we heard about commandeering and there is, you know, anti-commandeering there. This would could represent commandeering by the federal government of state and local process and there are at least four Supreme Court decisions that I can find that uphold the role and preserve the role of state and local government. So, this is thinking about those that are doing the job. It's all a highly transparent process, and it takes into account, especially we get into the first option, exactly what's going on locally. So, I wanted to set my votes, how I'm going to how I'm looking at this up right now and be clear and on the record again, having this experience, state elected, local elected, running an ambulance service municipally. Thank you.

Thanks, Suzanne, for that commentary. Any other -- I see Gary your hand is raised.

Yeah, Suzanne I was wondering if you -- that was very nice, thanks for the background. I was wondering if you had a preferential one between A and B. This is another one where I think there's a standout option. As a state elected official, I just appreciate your opinion on if there's one that's better than the other.

Asbel, may I speak to this?

Absolutely.

Right. You're kind of the mayor of this process. Gary, thank you for the question. I'm going to be supporting A, because it preserves -- and I spoke to this during our meetings, it preserves and looks at like what's the operational model that fits that community locally? What does it cost around that operational model? What is the current payer mix? And it also reflects that it's a highly transparent process, state, and local level in setting these rates. So, A is going to be my preference. Thank you.

And Asbel, I agree with her, and this is another one where I think we could pick one of the two options and not have two to discuss.

Well, unfortunately, there's a full committee that has differing opinions, so we will have two options and you'll have the ability to if you vote no or yes to provide where you're reflective of that. So, we are a committee, we are an advisory committee and there are lots of different opinions on this. And so, two options to this piece of it. Patricia, I see your hand is raised.

Thank you. Yeah, this has been a real struggle in, I think, in our committee to figure out what is the right balance between finding a way to set the out-of-network payments that give all of the stakeholders kind of an equal level of power to try to get to the right rate. And we'll be voting later, really, about the state and local. But I think I'd like to say a few things just in terms of the guardrails. I appreciate that we're thinking about guardrails if we are going to go down the path of allowing state and local governments to be setting rates individually, you know, in each community. Because it should be a public process. And I appreciate Suzanne's perspective in the work that she described in her own community how ambulance rates are set. I have heard from patients, though, that have felt quite closed out of the rate-setting system. And when they've encountered rates and tried to get an explanation for rates, they received no response from local government. So I think probably there are some communities that are super responsive and the public is engaged in local rate-setting, the public meaning consumers and patients. But I think, you know, we have 19,000 municipalities, 3,000 counties. That's a lot to kind of be monitoring as a consumer advocate or for individuals who care about this issue or working on behalf of patients to kind of monitor how rates are being set in all of these communities. And I think even if it's a public process and information is provided and it's debated in the town hall or the county government, the patients are the ones with the least amount of information, right? All we know is how we're being treated and what the end of the day the bill is. We can't really judge whether, you know, advanced life support should be reimbursed at $1,000 or $6,000 or $100. We don't have that kind of power, so the best we can do when we talk in a public forum would be to say, it seems high, which, you know, is not a very effective way of advocating on our behalf. And when the local government may not be as responsive to that, it just puts us at a disadvantage. So, I would just like to say that. The other thing I want to point out is the public in 11 option A, there's a public process that's all delineated. For option B, which is the option I'll be voting for, it doesn't have a public process delineated, which is frustrating to me. I don't know why we wouldn't also have the public process delineated in option B, but I can talk to that more when we get to that point. Thank you.

So, I think, too, the public's probably wanting to know what these options are. So if you're going to be further discussing what option you're going to be, it might be helpful, I think, for the public to start through the options A, and then into the B, and then start the discussion process there. So if there's anything relative -- I'm assuming, Gary, your hand was raised previous, or did you still have a comment?

Yeah, I forgot to lower it, but I'll have a comment when we get to the next one.

Okay. Shawn, is your comment related to this, or just something somebody was discussing, or is it more relevant to as we start to move through? Because the public may be confused about what we're talking about right now until they actually see the recommendations.

I think it would be fine if you show both recommendations, then I have some comments to follow up on all of the discussion, I think.

Absolutely. Terra, if we will move to the next slide. So, let's start with option A, and let's walk through exactly what this option does as it talks about the recommendation around guardrails relative to local and state regulated rates. So right now, the recommendation is, and you'll hear a lot of dialogue around this, and the next several recommendations, there's going to be a lot of dialogue. And we do have options for that because the committee had different ideas on how to get to that same recommendation as well. And so, this is going to be where the votes are going to be important to understand through the discussion process and what the no votes might be, and the reason why they might be voting no. So a state or local regulated rate for ground ambulance emergency and non-emergency ambulance medical services that are established outside of a state balance or a surprise billing statute will meet the guardrail requirement under recommendation 12B or recommendation 14. If it, one, meets one or more of the following requirements, takes into account ground ambulance emergency medical service provider supplier's operational model and cost, two, takes into account ground ambulance emergency medical services provider or supplier's pay or mixed revenue, three, is adopted through a public process, for example, like a city council meeting or public notice, four, includes a public process for the annual evaluation of ground ambulance emergency medical service rate if the process includes procedures that take into account public input, such as rulemaking. For example, it ties it to an annual update to a cost evaluation by a specific local entity. Five, the establishment of a reimbursement rate for rulemaking through a state legislative regulatory process or via local community public process. Six, is adopted following a public hearing where rates are evaluated and discussed. Seven is linked to another rate that is determined with public input at the state or local level. We'll move to the next slide. And number two, there is full transparency with the rates subject to public disclosure and reported to a state governing entity for accessible public viewing. And three, the tri-departments must maintain a publicly available database of state and locally set rates that are binding for any minimum required payment broken out by service and locality. States and localities must report the information required for such a database to the federal government. So, I'll stop there. I see hands are beginning to raise, and this is a part of what many were talking about. These are some of the guardrails of one of the options that are indicative in order for local or state rates to be used or whatever happens to the balance piece. This is some of the guardrails discussed. I'll first go to Shawn.

Thank you. A couple of comments on this, and it really goes back to what Sue started with, that this is a lot about what happens at the local level when an EMS system is designed. And it's a little different. The reason you see option A being different than option B and not having the most substantive difference there, that there's a cap on local rates set by the federal government that would be uniform to everyone, every community, everywhere in option B, and that doesn't exist in option A, is that emergency medical services and ambulance transport are often the only healthcare around for many, many, many miles. The vast majority of America is rural or even super rural or frontier by geography, and these local governments understand what it takes to provide care in those areas. Urban areas face similar challenges with their own dearth of services in some places that we have to address locally. If we had, as in option B, a cap, when systems need to change, because as we all know, I just did another news clipping search last week and found 27 articles between the first of the year and last week about ambulance services closing because they cannot afford to stay open, and that costs patient access. A lot of protecting patients is preserving access to care. There's protecting them from the balance bill, of course, and there's preserving their access to care, and we as a committee have to balance both of that, and we look to our state and local government, which regulates EMS to do that job. EMS is the only sector of healthcare where local communities have a public process to determine exactly what kind of care they're going to get and how much it's going to cost. No other part of healthcare has that there. So option B starts to erode that away instead of reinforcing it, so I will be supporting option A strongly to be able to make that list of ambulance services closing go away, because at the same time, during that same nine-month period that I did a search, a major insurer came out with an earnings call two weeks ago and was very proud that they refunded back to shareholders $11.5 billion. $11.5 billion returned to

shareholders during the first nine months of this year. Contrast that with the list of services closing and Americans losing access to critical care, and I think that we can afford to follow these local regulated rates without having to have a consumer pick up any additional premium or anything else, so I will be supporting option A.

Thank you, Shawn. Pete.

I really appreciate the input that's been provided, and Suzanne, having been a local elected official, there is no more representative form of democracy than the local level, the cities of the United States. And working for a city and having been with this city for over 34 years, I attend city council meetings sometimes twice a month. We have advisory committees. The local elected officials take rates for ambulance seriously. They ask questions. They receive input. And the public shows up. The public shows up at city council meetings to discuss all sorts of items, and rates are included. As has been identified, the rates are established by the local governments in order to support the services established by the local governments. The community determines what level of service they want provided, and the community identifies what is going to be the payment for it. The local government rate-setting process is transparent. The local government rate-setting process is a public process, and it is the only form of government, in my opinion, that is truly public-centered. I have attended city council meetings, county meetings, state legislative meetings, and federal meetings at Congress. There is no level of public input above the county level. You don't get to show up and provide all sorts of input without traveling long, long distances. We have public meetings. We have public hearings. They're all set. They can't start before 5:30 p.m. so we don't do it in the middle of the day so that people can't be there. Rates are established by locals to support local levels of service. And I know that there's going to be other people providing the input, but A is the way to go. B is a non-starter because it removes the ability of the locals to do what they're supposed to do, support their community. End of report.

Thanks, Pete. Loren?

Thank you. So, I think a few points just to add to this discussion. So first, I am very sympathetic to the appeal to relying on local rate-setting processes to set, right, be clear, right, this is now not just a rate-setting process. This is setting a requirement on your local employers on an amount that they have to pay, ground ambulance EMS services. But I really do understand the appeal, and I think as this debate moves forward past this committee and onward, I do think thinking of ways to kind of structure guardrails that maybe don't even include a cap is a useful way to consider this. But I do want to sort of clarify that right now, yes, I very much agree these rate-setting processes are incentivized to look very closely at actual costs and have to account for the fact that higher rates are more likely to meet from pushback from employers and insurers, and thus sort of there's less likely to be covered to begin with, and it tends to mean higher cost-sharing for patients, many of whom are your local residents. If the employer or insurer now is required to allow this full locally set rate, many of these sort of current cost-control levers disappear. Just fundamentally, they disappear. And really, the main cost-control incentive that remains is that higher rates do mean higher cost-sharing for patients. They also mean higher premiums for your local residents, but that is largely subsidized, or at least substantially subsidized by the federal government. But right now, that would mean higher cost-sharing, and I think my fear is once you set up these dynamic incentives, especially if we -- I really think real strongly about our recommendation from yesterday to be able to limit patient cost-sharing to the lesser of $100 or 10% of the allowed amount. I think that is fundamentally impossible from a sort of practical -- maybe not impossible, but very difficult if you are just sort of saying local governments, you get to tell employers exactly what you want to be paid. For the most part, it's the local government who is billing for the service to begin with. So you can just sort of tell local employers how much money to give you for the service. I do think it is important, right, this committee kind of had -- obviously, the statute kind of talks about the balance billing prevention and that focus. Obviously, a big part of what we discussed is how to fund EMS in this country, which I think is vitally important. All of the recommendations we are talking about, cap or no cap here, are adding a substantial amount of revenue to EMS. I think when we sort of move past this committee, this committee kind of didn't discuss Medicare. I think we should be having a more holistic debate

eventually when this moves to Congress, because if we're talking about trying to fund EMS, you know, increasing Medicare rates or Medicaid rates at the state level also seems like a very important piece of the puzzle, knowing that we are kind of putting that aside in this committee. But, again, just to sort of close on this, I do think there is importance to allowing the local rate-setting processes to continue. The sort of option B here is only to set what is a pretty generous cap on -- we haven't actually talked about an exact number, but it would be something that is higher than most ground ambulance agencies are getting paid today. So, it is a cap. Local governments would be free to set rates how they please under that cap. But by setting a limit, you sort of carve off some of the dynamic incentives. And fundamentally, when this moves to Congress, you're going to have a budgetary score from the Congressional Budget Office. They are going to look at something like this without a limit and go, oh, I see the incentives here. This is going to come with a very big budgetary cost number. And I fear that makes it very difficult to actually pass into legislation, which I think having the sort of ground ambulance balance billing protections for patients is the key feature of what we're trying to accomplish here. And then lastly, it's not really in this piece, but I do also worry about one of the recommendations here is to tell ERISA self-funded plans that they have to adhere to these locally set rates. That is a pretty big step above what we've done historically in this country, where we're going to let state and local governments tell self-funded plans how much to pay for a medical service. I think that is sort of another sort of bridge too far, in my opinion. I'll close on that, knowing I'm the minority on this committee. Thank you.

And thank you, Loren, for your input. And that's why it's important to have all stakeholder input here. And I think Loren alluded to some other options to this that is probably best for the public as well as the committee to understand. This is part one of a two-part process. We are a FACA committee that makes recommendations. And there's many on this committee as well that understand recommendations and policies sometimes don't merge when you're having Congress act. But we must remember what the charter is of this committee, and that is to make recommendations. What Congress does with those recommendations is another process. We should make the recommendations that we feel are in the best for achieving the objectives of our charter as well. So, the points are very well made by Loren as well. But as far as the committee goes, Congress will act on what Congress wants to act on based upon these recommendations. But you should put forth the best recommendations that include consumer protections, disclosures, as well as access to these services, which is a consumer protection. So Rhonda, I'll let you raise your hand. Or speak, not raise your hand.

Thank you, Asbel. You know, I agree with how option A is laid out as far as like a public process. And I feel like that's typically how rates are set, is with a very transparent and very public process, allowing consumers to have that kind of input. I think that a lot of times, you know, maybe a consumer doesn't participate until it actually impacts them. And then they realize, oh, you know, maybe I need to attend these meetings and express my opinion. I think my overall concern is the and statements that are on both of these options. I feel like that's going to really increase the regulatory burden just for the ambulance services themselves, but also the states and the federal government having to maintain these databases on rates. And so that that's a concern for me. And, you know, I may vote no on both of them because of that.

So, Rhonda, are you suggesting that based upon these ands, that possibly the committee might want to consider some type of funding, grant funding to states or localities to assist with these disclosures or the administrative burden assigned to these disclosures?

Yes.

There is the opportunity to make an amendment as well. So, I'll throw that out that that could possibly be as you work through this.

Thanks, Asbel, and a little bit to that point, too. You know, Rhonda, as we were hearing through many of the comments, you know, some states have actually already implemented these programs. We've got numerous states have actually gone through in the last year, year and a half, produced some of the

balance billing legislation, cover some of the ERISA plans or balance billing does that with the state's rules. But you've got states that have determined how to operate these types of emergency services because it's been decades and decades of that where some states and counties do have the infrastructure. So, to your point, some areas may need that and others may have already had it. But, you know, all EMS is local, as Shawn was saying before, and the local governments have designed the systems in those areas for what is best needed for those communities. How many ambulances in geographic area, what the response times are, dual paramedics, single paramedic. Each system is a little different on purpose because every community in the U.S. is a little different. And the 911 needs are a little different. And that's why I think as we've been working through this, you've seen a lot of that making sure that the local and state for the decades and decades and decades since Emergency 51 was put out on TV, where EMS really started coming from is what it's based for those local communities. And you've got in many communities across the U.S. full procurement processes where you've got full disclosure on rates, on costs, on structure, what is needed. Because when you call 911 in America, no matter what, you're getting an ambulance responding. If you have the ability to pay, if you don't, we're crossing geographic lines and municipalities. So, it's a full system approach and where local government really is the best. And in cases, counties have that oversight. In some cases, the states do, because really state EMS from regulatory bodies we know is kind of where that piece is being held and how it's delegated. So fully support option A on this. Thanks, Asbel.

Thanks, Ted. Pete, I see your hand's raised.

Yeah, I just, you know, a guardrail that I can speak to in California that's in place, because I know people are saying, you know, that local governments can just raise the rates as high as they want. In California, we cannot recover more than the cost of providing the service. Every single fee that we charge the public has to be reviewed by the city council, and we have to be able to validate that we're not collecting more than the cost of providing the service. We can't use EMS to fund libraries. We can't use EMS to fund street repairs or recreation centers. What we can do is cover the cost of the service so that other sections of the government can be handled by the other portions of the revenue. But we cannot take our revenue and use it to fund other portions that are not related to EMS. That is a guardrail in California. I can't speak to the other 49 states, but just bringing that up.

And I think that's important, what Pete is saying, that what happens in California might be different than what happens, for instance, in Florida or Alabama or any other state in the Northeast. And so, I think it's important to note why there is this propensity to look at guardrails, to ensure that the guardrails are appropriate and it maintains local and state oversight if it's addressed. If it is not addressed, then as you read through the recommendations that we'll put through, there's always going to be technically some type of federal stopgap if local and states do not have that guardrail in place, which some do, some do not. Loren, I'll let you raise your hand and then we'll go to Suzanne and Shawn.

Sorry, just a quick technical question for the point that Patricia raised as well. I think Patricia and I had been thinking that sort of the option B here effectively incorporated was sort of like option A plus option B. Is that possible to reflect some way, or at least vocally you want to reflect that that is sort of my view is the combo of the two is really the ideal here?

And you can reflect that when you get to whether you vote no or not. Right now we're voting on options, Loren. So that yet isn't there. And that would be an option C if you wanted to do a combo of the two. But that is not the recommendation that are set forth at this time. Suzanne.

Thank you, Asbel. So earlier when we first introduced 11 before we got into the options, I laid out my perspective on the interplay between the federal government, state and local. So, I'm not going to go back to that. I've already said it. But what I will touch on right now is why I'm supporting A is connected to that, but also reflects my thinking on some of the comments that Shawn Baird made. Emergency medical services is the nation's primary care safety net. So, you know, if people call, we go and they can call for whatever reason that they have. If we tie the hands of local officials and move away from the

processes that have been in place and the people that best understand how this impacts their community, I think this could be a disservice. I believe it's going to be a disservice to the nation's primary care safety net. So, I'll be supporting A. Thank you.

Thank you, Suzanne. Shawn.

Yes, thank you. Just a couple of kind of follow ups to some of the discussion that's been happening. I know, you know, Loren has discussed some of the theoretical pressure for local communities to increase rates in the absence of a cap. I think that there has been no evidence presented currently that there is any kind of price gouging going on of patients or consumers where today we work without any kind of cap. And there are insurers and other entities that do pay the full amount. We know from our previous presentations and data sets about what the typical balance bill is. And we've seen that looked at it by both public and private entities and other ways and found that even among those public entities who provide ambulance service and every single one of their rates is subject to some kind of public process and rate setting. Their balance bills are not -- they need to be addressed to protect the patient, but they're not in any way egregious. And we don't see any kind of inflation, even in those markets that are served by insurance companies that do pay virtually the whole amount right now. So, I think we are talking about a lot of speculation and not a lot of evidence on that front. When we look at one other comment, I think it might have been Loren that brought up ERISA plans. And I wanted to clarify that we had had a presentation on this. And our understanding, I believe, was that those states with balance billing laws in place, the NSA provided that those balance billing laws for other providers were in fact covered by the NSA. And then a final couple of points on just premium. The idea that there might be this runaway cost, again, there's no evidence for it. So, within option A, I think you get all those guardrails in place. Providers need to send that message to Congress that localities can and do take this responsibility seriously. And that is how we will preserve access to quality care for patients. And option B just doesn't give us that same ability.

Thank you, Shawn, for that comment. Looks like we do not have any more hands, but I did want to bring up Rhonda's component. And I know this did come up and possibly there needs to be an amendment to this and section as well, because this will also be in option B about this full transparency. And there was some concern regarding possibly the administrative burden of this unfunded mandate. And possibly we need to have a slight amendment to two and three that Congress would provide funding through some type of grant process. They're also going to have to fund -- this would be a congressional thing. I hate to go there. Whenever you force departments to do something, there is going to be a cost for them creating a federal database like this. And so, we probably want to recognize that within this and make a slight amendment that would say Congress should appropriate the appropriate funding for the disclosure and the reporting aspects to something like that. And we'll allow the individuals writing the final report as our contractor to put that semblance around. So, I'm going to suggest we put that amendment to this recommendation for A as well as add it to B, because this same language is in B as well when you vote on it. So, if there is any opposition to putting something like that, please raise your hand. If not, for the record, we will add that into this recommendation. So that is what you will be voting on. And Terra, we will go to vote.

Okay. Loren Adler.

No.

Shawn Baird.

Yes.

Adam Beck.

No.

Regina Crawford.

Yes.

Rhonda Holden.

Yes.

Patricia Kelmar. Patricia, are you on mute? Put it in the chat. Patricia is voting no. Ali Khawar. Peter Lawrence.

Yes.

Rogelyn McLean.

Abstain.

Asbel Montes.

Yes.

Ayobami Ogunsola.

Yes.

Suzanne Prentiss.

Yes.

Ritu Sahni.

Yes.

Edward Van Horne.

Yes.

Carol Weiser.

Abstain.

Gam Wijetunge.

He put it in chat abstain.

Okay. And Gary Wingrove.

Yes.

Okay. And then I'll just give those that voted no the opportunity to speak to their vote. So we will start with Loren.

Thank you. I think I've spoken to my vote already with the acknowledgement that I do think the provisions in this are still useful as guardrails to the local process, but just in addition to option B. And then, you know, I do think to Shawn's point, I'll just sort of add something. I do think $1,000 balance bills are meaningful. I don't think that's nothing. You know, and that's a quarter of balance bills are roughly over $1,000. That is meaningful in terms of patient costs.

Okay. And Adam Beck.

Yeah, I would associate myself largely with Loren's comments from earlier. I think my primary concern with option A is the lack of any upper limit guardrail and really giving full power to the same entity that is providing the service and making the charge to also be able to dictate a rate. I'll get when we get to option B, which I think of these two is preferable, given that there's some restraint on, you know, on excessive charges or really just inflationary rates. But I would both would have concerns if this is being viewed as a recommendation to apply state or locally mandated rates to a ERISA group health plans, which I think would be a bridge too far and something that would not be good public policy to recommend to Congress. The other thing I think with this sort of process is that it would be wise to allow for -- and I think this is referenced elsewhere in some of our mandate recommendations that payer provider negotiations and contracts can continue to exist. And so I think really allowing for a private market solution that may end up being more favorable towards the consumer and end up creating in network agreements that are beneficial to both parties, that those should be allowed to continue. And I'm concerned that these recommendations don't account for that solution, which really would, I think, be preferable to defaulting to any sort of whether it's federal, state, or local government rate setting. So that's some of my rationale for voting no on this.

Okay, and Patricia, do you have any additional comments?

Just briefly, thank you, Loren, for a really well articulated argument of the concerns of the implication if we end up going with an out of network payment that requires the employers and plans to pay the locally set rate. The lack of cap in this option is what's most concerning to me. And I just want to underscore the extreme importance of getting roll up reporting to the states and then to the feds. I think that that will be the best way if this is the process that the Congress ends up choosing to monitor and keep track of rates. I've seen rates -- I appreciate that California has in place a cap, and that might be something that people want to consider as one of additional guardrails that the local ambulance rates can't do more than cover the costs. So that would be an important thing to consider maybe in future policy proposals. But just knowing in California, even right now, rates can vary by a thousand dollars from one neighborhood to the next, depending on the county which is governing your ambulance rates. So it's extreme differences and it could have a big impact on patient cost share and premiums eventually as well. So that's why I voted no. And I'll be voting yes on the next option.

Okay, thank you.

All right. So, it looks like we have the no's for the record, so we will move to option B. And before we get to option B, I know this has come up quite frequently about setting policy that mandates ERISA rates that currently fall under the NSA, anything like that. I'm going to ask for the legal team, maybe Rog, or I'm not sure if there's a member from DOL that can speak to that within the current NSA for the public record, if that is possible from one of the legal authorities, if that's possible on the call.

Rog, do you want to address that?

No, Carol, have at it, please.

All right. Asbel, let me try to restate your question so that I am sure that I understand it. I believe that you are asking whether under the No Surprises Act, ERISA self-funded plans are required to comply with

state balance billing laws and/or use an all payer model agreement. Have I correctly restated your question?

You have correctly restated that, Carol.

Okay. Under the No Surprises Act, states may opt into -- I'm sorry. Under the No Surprises Act, ERISA self-funded plans may not be subject to state insurance law. Those laws are preempted by ERISA. But there is an opportunity for self-insured plans if they wish to opt into state balance billing laws. So under the No Surprises Act, the general rule or the default rule is that the ERISA self-funded plans have their own negotiated contracts. And the recognized amount is the qualifying payment amount, which is the median of at least three contracted rates. There is a requirement that if there is, for example, a new service code, something like that, the plan did not cover that in 2019, then that the plan must look to something like fair health or another index. Index is not exactly the right word. So that's my understanding. I don't know whether Elizabeth Schumacher or Angela Molina from DOL is on and wishes to elaborate in any manner. But again, that's my understanding of how it applies for an ERISA self-funded plan. Now, an ERISA insured plan, just to be clear, is the insurance, the state insurance laws are recognized for an insured plan. Q2 And I'm not sure if anyone else from DOL is on, but the current the way the No Surprises Act is written might differ a little from what you're seeing through here. But at this point in time, based upon Carol, your knowledge and perspective on the committee is that the ERISA funded plans have the ability to opt in at the state level and understand that with the methodology around that qualifying payment amount. And we will go into a rabbit hole really quickly on what that is around and how that governing happenings, especially when you enter into an independent dispute resolution process and where there has been some alignment on that, and interpretation. There have been a lot of lawsuits that we have seen happen through that process. But our charge right now is relative to making recommendations, whether we think they will be policy changes that will be implemented or bad policy or what have you. This committee should make recommendations and then Congress will ultimately decide in part two. So, Carol, thanks for that context. I know that keeps coming up as a point of conversation, and I do appreciate that. So, let's move to option B. Option B is local set rates cannot be higher than the payment reimbursement options that will be referenced when you see recommendation 12A. And so, following this recommendation, there will be some payment reimbursement options that you will see given. And this recommendation is saying around the guardrails is that if there is a local set rate, it cannot be higher than the payment reimbursement option referenced in recommendation 12A. It also goes on to discuss the ands. And the and is that there is full transparency with the right subject to the public disclosures. And the TRI departments must maintain a publicly available database of these locally set rates. We went on the record on the other option a that we'll also put in there and amend it that there be some type of funding provided to Congress relative to that. Just remember, and I don't need to fast forward into recommendation 12A. It still preserves, even though there is this maximum rate, it still preserves the state balance billing, those that have already passed state balance billing rules on the fully insured plans and things like that that might reflect back to it. This is basically a provision that in the absence of that and in the absence of a state billing law or the lack of a local set rate, that this maximum reimbursement rate happens as well. So there is a guardrail. This is basically creating a ceiling on the rate with also continuing to disclose in full transparency any local rates that are set as well as the TRI departments maintaining this with the caveat of the recommendation that Congress will allow for funding of this mandate. So I will go to Gary first. I see his hand is raised.

Thanks, Asbel. I already talked about my opinions between A and B, so I'm not going to do that again. But I just wanted to state for the record, I remain disappointed that we have not thought about the other end yet. For the areas where we're talking about guardrails on the top, but we're not talking about guardrails on the bottom. And Shawn, thank you for being the one that's doing that search about the ambulance service closures. I didn't realize you were the person doing that. I should have given you credit and I would have if I had known. But I still think we've got an access issue that has not fully been explored and we've missed something we should have done, which is not establish the other side of this guardrail.

Thank you, Gary, for that commentary. Any other discussion around this particular recommendation? I know we've talked about that. Shawn.

Yeah, and I just, it comes back to some of the discussion I think about the appropriateness of an absolute cap versus deference to guardrails and local rate setting. And we've heard a number of members of the committee address the reasons why they felt like the cap was necessary. And in hearing those, what I heard was speculation on three items. Speculation on price gouging from local governments, speculation that premiums could or would increase to consumers, and speculation that it would be shifted to a higher cost share. And I would counter that with the reason I made the decision for option A and would vote no on option B is that I'm not working in speculation, I'm working in what we know as a set of facts. We know that there's no evidence that there's been any community rate setting that creates price gouging, even with the lack of a cap now. We know that insurers are returning record profits and sending that back to shareholders instead of using it to pay providers, which creates a balance bill. Our data that we looked at in this committee showed an average balance bill of $587. That's money that insurers should have spent to take care of their patients and preserve access to care, not return to shareholders. And it doesn't even come close to the total spend on ambulance service to cover that extra bit. And then we've had speculation on increased cost sharing, yet this committee just passed a recommendation yesterday capping cost sharing at no greater than $100. So, I feel like what we should be doing is setting the stage for Congress to understand how to appropriately act based on the known set of facts, not based upon what we think may or may not happen. So, thank you. That's why I'll not be able to support option B.

Thanks, Shawn. And Pete, I see your hand raised.

Yeah, just reiterating, EMS is a local system. EMS is a local system that is established by the local entities to provide service to the local citizens. And the local rates should be what is used to determine that system. I cannot support B because it really eliminates the local ability to establish the rates. So, I cannot support it.

And Loren -- I'm assuming, Shawn, your hand still raised from before. Loren.

Yeah, I mean, I think it's just worth keeping in mind. Right. We do have decades of evidence now, empirical evidence that when provider costs go up, premiums go up commensurately. Right? We have a ton of evidence from the hospital sector that when hospitals consolidate, hospital prices go up and premiums go up commensurately to attract those costs. Right. I think I agree very much with Shawn that insurers are not benevolent actors here. They are profit motivated as well. But for the sake for that reason, if you increase their claims costs, they're not just going to eat that. Right. They are going to increase premiums, especially given how subsidized premiums are. So, I should be clear, not a benevolence of insurer thing, but I do think we do have a lot of evidence on that front. And we do have a lot of evidence in healthcare that folks do respond to incentives. Like healthcare isn't its complete own world, but people respond to financial incentives and healthcare just as they do elsewhere. Obviously, they are also doing tons of good, but I don't think folks are immune from strong financial incentives.

And Patricia.

Thank you. So just to take a step back, a lot of what we're doing and in the recommendations over these two days is really righting some pretty significant wrongs kind of in general in the ambulance industry. By even getting to a point where we're requiring some type of minimum payment, we're giving the ambulance companies the ability to get more consistent payments through the different recommendations. I think we're righting some of those wrongs and we are going to get better rates for more rides than is existing today. And that will be a good thing. Patients do want good emergency services in their communities. What's happening right now is we have some actors who are paying way under. We have the rest of the bill going to the patients and depending on the community that they're in,

they're paying an awful lot or they're paying not a lot. So, I think we are moving in general to a more sustainable payment model through these recommendations. And these nuances are contentious. We are trying to find the balance. I take objection a little bit about the accusation of speculation without data, particularly around the cost sharing. First of all, on the cost sharing, we did have some data. We looked at what it seemed like patients were paying out-of-pocket right now. We talked about that in the course of the discussion and we came up with $100. That was a compromise. There were authors of --

[Inaudible]

We knew that based on the information we looked at. So, I want people in the public to know that that wasn't pure speculation. We looked at numbers. We talked about them. Secondly, on speculation for local rates, it is speculation because there's not a lot of data out there. So, our organizations spent some time digging around just in California. And we saw rates in the local communities for basic life support about -- let's see, the lowest one I found in just random five counties, $1,500. And the highest was $2,800. So significant variation. I don't know. Is it based on cost? I can't tell. I have no ability to do that. But those are the variations that we're seeing. So, it's not surprising that we're a little nervous to give full-on permission for local and community rate-setting organizations to tell our insurers, to tell our local employers how much they have to pay. That's all I have to say.

Perfect. Thanks, Patricia. And the one comment I want to make before we actually make this discussion as well, because I think there's been a lot of really great information that you hear and discuss from all parties. I do think that we're talking here a lot around accountability and transparency. And where is that information? I think Patricia made some really good arguments here that when you dig around, it's hard to find out. So, it makes sense to me, option one and two, creating some type of transparency arm to that. And then where's that accountability, but also preserving the right for local communities to choose and make that choice. And when local communities choose, it's also the patients and the consumers that are involved. Whether they become involved or not, that's a different story. I mean, you can put the information out there, but you can't force people to become involved in something. And so I think this is where you begin to see the philosophical differences amongst the committee to begin to look at solutions-based. In my work specifically around the reimbursement side of things, looking at this piece of it, I think guardrails are appropriate because we know that there are some communities that it is capricious and arbitrary how they come up with rates. And so there needs to be some definition of how you do that, that it should be more than the cost. And how is that publicly disclosed? How do you look at the cost factors? And this is another reason why we defined cost and what are those elements that should be looked at. And so, when you look at those different types of things, you either have to see the ability to say in those jurisdictions where they are following these minimal guidelines under the state's purview, it has to allow for that. In the event that they do not, then there needs to be a stopgap measure, and you'll start to see that through the recommendations as well. So, it's not just carte blanche, but it is basically saying if local or state communities are going to be involved in this process, then the process has to have some limitations around it. To Pete's point, in Orange County, they have that, but there could be counties where that is not happening and there's not local localities happening, but states may be doing something around that, as we heard from several of our presenters discuss that on a statewide level, maybe not so much on a county level. But a statewide level. And then there are some states that don't do it at all. And so then the feds do have to come in and put together some type of stopgap until you put some incentivization around that. So, I will be voting, of course, no on this, because I believe that you should allow for a full state transparency as we work through this on a guardrail. And then the methodologies as we work through the recommendations on 12 and 14 are going to be pretty enlightening on where you kind of stand and working through some of those nuances. So, at a minimum, you need a guardrail, and then you can talk through, is there another option where the feds come into as well, but it's not a limiting guardrail of a local set rate. Ritu, I see your hand raised, and then we will go to vote on this recommendation.

Yeah, thanks, Asbel. You know, I'm just the simple country doctor, and this is all money stuff. I don't know. I just put out, I just do -- you know. But from a medical perspective, I think my role in this

committee has always been to focus on the patient. Not that anybody else hasn't, but to focus on the medicine that we provide, because this is not, even though CMS legally considers this a ride, this is healthcare. And the care we provide improves patient outcome, and I have lots of data that shows that. I can tell you that in my own region, we have multiple rates, because we have different practices of medicine in our different communities. And the cost of providing care in an area with less available primary care is a lot different than the cost of providing the same quality of EMS care in a community where the community is much more dialed in, if you will. And so, from a medical direction perspective, all politics are local, all healthcare is local, and I will be voting no on B, because from my perspective as a local EMS medical director, this allows for us to have the best possible outcomes for our patients.

Thanks, Ritu. Not seeing any other hands, we will go to vote, and then after this vote, we'll allow the no's to provide final commentary, and then we will go to break. Go ahead, Terra, with calling the vote.

Okay, Loren Adler?

Yes.

Shawn Baird?

No.

Adam Beck?

Yes.

Regina Crawford?

No.

Rhonda Holden?

No.

Patricia Kelmar?

Yes.

Ali Khawar? Peter Lawrence?

No.

Rogelyn McLean?

Abstain.

Asbel Montes?

No.

Ayobami Ogunsola?

Yes.

Suzanne Prentiss?

No.

Ritu Sahni?

No.

Edward Van Horne?

No.

Carol Weiser?

Abstain.

Gam Wijetunge, and it looks like he has put abstain in the chat. And Gary Wingrove?

No.

Okay, so now we will give the opportunity for those that voted no to state any additional comments they have, and we will start with Shawn.

Thank you. I certainly won't repeat all of the robust discussion that we just had, but I do think that my no vote really comes back to the principle that protecting transparency and allowing our consumers and patients the opportunity for the most direct access in the quality of care and rate setting happens at the local level, and that is where they can engage. And if there's a default federal rate that's set by Congress, that really basically strips some of that opportunity because that becomes the de facto rate, and there's far less direct access to participate in Congress than there is at City Hall. And the other comment I would make is that I believe Ritu really summed up what we're trying to do here, which is make sure our patients get the best care possible, and that is why I voted no.

Okay, Regina?

I'm not going to rehash what's already been discussed, but it all starts and begins at the local level. So I support. I do think Shawn and Ritu summed it up quite well. Enough said.

Okay, and Rhonda?

Just as said by Shawn and others before me.

Okay, Peter?

Everything said prior, just reiterating local system, local control, local rates.

Asbel?

The only thing that I'm going to add there is I only agree with this recommendation in the absence of a local rate setting methodology. So, if there is not a local rate setting methodology, then it would be appropriate for something like this to happen. But once the locals set that or the states do something similar, then to me this becomes, and they follow the guardrails appropriately, then this should not be an impediment to that happening.

Okay, and Suzanne?

Thank you. I've made my objections and my affirmations clear throughout the process. I want to thank Shawn for his comments just now on B, and also Ritu for always bringing us back to the patients that we serve and the medical, clinical part of this process that we need to preserve and help sustain as we're thinking about the work we do here. Thank you.

Okay, and Ritu?

Thank you. I think I explained my vote. The one thing I do want to add, though, is I think this theme is going to percolate through the rest of the day. That being said, as I reflect on this, we've reached like 98% consensus. And when you really look at what comes out between these two options and what we discussed before, it's almost on the margins. And so, I just don't want to lose -- it may have sounded a little contentious, or at least there was great discussion from a lot of people that I really respect. But I think at the end of the day, you're really talking about just some small differences of opinion in some small areas. That overwhelming consensus of this group was very positive and pretty similar.

Okay, and Edward?

Yeah, Ritu, you said it well again. This is all our focus about the patient and getting the patient out of the middle. I think the multiple recommendations we're working on I think has that general consensus. We recognize the nuance there is that EMS is local. Every time you call 911, regardless of where you are, an ambulance has to respond regardless of your ability to pay. And the local systems, the local rates, the local transparency builds that model so that it makes it work as appropriately as is needed to save those lives regardless. And that's what makes it so different than a hospital or a physician or a different type of healthcare that you can choose and who and where to go. You don't get that with 911. So I would say thank you.

Okay, and Gary?

Yeah, I would just add that there is no greater consumer protection than having an ambulance to respond. Just like we know there's variation in cost in California counties, I'd be interested to know if the wages vary greatly in every state. But we also know there are ambulance services closing and we don't have a minimum guardrail. And I'm less concerned about a public process that a community or a county might have than I am about the known ambulance closures that have happened and we haven't addressed those.

Okay, thank you.

Okay, so we will go to break and we will return here at 11:10 Eastern Time.

Welcome back. We will now resume the discussion with recommendation number 12.

Well, let me get to my mute button. All right. So, we will probably make it through recommendation 12, there are two options to this, before we take a lunch break, depending upon where we are going on our midday break. For some of you, it might be your breakfast break. But I wanted to kind of walk through and we're going to start getting into, again, the prevention of surprise billing. This is a recommendation around -- and this is where the definitions are going to become key and very important on the recommendations that we made on the adoption of definitions yesterday. And so this first recommendation is prohibiting balance billing and guaranteeing a reasonable payment for ground ambulance emergency medical services. Under the definition for ground emergency ambulance emergency medical services, and when you read the emergency inter-facility transport, this recommendation, as we start talking through the two different options around the methodologies surrounding how the payment will be defined will include those transports as we talked about yesterday, where they are at inter-facility transport that originates at a facility where the services are not available to transfer somewhere else. So that will be included in there based on the definitions. I'm just making a

key point there, because this is where the adoption of those definitions become important as we continue to work through some of these recommendations. So, this recommendation 12, and I'll open for discussion. If you're going to be talking about one of the different options, we're going to be asking you to kind of keep your comments till we get to that option. First before, but this is just on the general premise of discussion around this particular recommendation. So, this prohibit balance billing and guarantee reasonable payment for ground ambulance emergency medical services. So, any discussion about this particular, just the topic of this recommendation. Loren.

I just probably wanted to say, I thought this was -- I think, one of the nice things to this committee is that there was pretty broad consensus early on that this was a pretty key goal and pretty, I think, unanimous, but at least very broad agreement that prohibiting balance billing for ground ambulance CMS was an important goal here. And I think that is, you know, I think, why the committee was chartered. And I'm glad to see glad to see that during our deliberations.

That's a very important point and context to make, and thank you for that, Loren. Because there was broad support by all committee representatives relative to making sure that we prohibit balance billing. Any other discussion before we get into the first option? There are two options to get to this actual recommendation. So, to the point that someone made prior to the break as well, there's general consensus, but there's lots of different solutions how to get to the same result, and that's what you're seeing play out in the committees. So, it's not contentious. It's just a part of the consensus building process. Okay, not seeing any more hands, I'll move to the first option of this recommendation. And so there are four parts to this option. So, you can succinctly read them. I'm gonna go through each one of these before we open the floor to discussion. So, option A, part one of that is the establishment of an out-of-network reimbursement is a national set rate by the Congress and secretaries. So, the first thing we're talking about is your out-of-network reimbursement rate is a national set rate by the Congress and secretaries. So, the group health plan or a health insurance issuer offering group or individual health insurance coverage, group health plan or health insurance issuer must pay the following amount minus the cost-sharing amount for ground ambulance emergency services provided to a participant, beneficiary, or enrollee. Basically, it's establishing a national set rate. Go to your next slide. Part two of that is gonna describe the payment reimbursement options. So, one will for fully insured plans and other plans already regulated by state law, the rate is the amount specified in a state balance billing law or in a state with an all-payer model agreement, the amount defined in that agreement. What that means is if a state has already passed a law, regulating the fully insured plans that they already regulate and can regulate, remember ERISA is not covered under that, that law will stay into place and whatever is set is that rate. Two, if there is no state balance billing law or a group or individual health insurance coverage is not regulated by state law, then the amount moves to if Medicare covers the service, a congressional set percentage of Medicare. If Medicare does not cover the service, for example, like an ambulance response, no transport that was voted on earlier, a fixed amount set by the Congress or a percentage of a benchmark determined by the Congress. So what this recommendation depending on the payment reimbursement options is keeping whatever state law that was passed regarding balance billing for fully insured plans or other plans, it keeps that in place. And then for all other insureds, basically what the committee's charged with, it is a set rate that will be determined if Medicare covers it. It's a determination of a percentage of that Medicare benchmark. And then if Medicare doesn't cover the service, then Congress will set a fixed amount for the service or a percentage of some benchmark that is determined by Congress. So, the next slide. Then we get into the timing of the payment. You'll see this, we had to address prompt pay and direct pay as well. So, you will get into kind of the timing of the payment. And so basically within 30 days of the receipt of a bill as currently defined within the No Surprises Act. And remember when we adopted definitions, we did adopt the definition of a bill. And so that'll govern that bill. And then two, patient share can be billed after the group health plan or health insurance issue pays or denies the claim. And then three, the group health plan or health insurer must make prompt payment directly to a ground ambulance emergency medical services provider or supplier. Remember, we did define prompt payment. And then four, if it is determined that a planner issuer has failed to make payments in accordance with the prompts and direct payment requirements, the secretaries of the appropriate department shall impose a per annum simple interest rate of some defined percentage.

Note that many states use 18% or more for this percentage. And then also the secretary shall also be authorized to impose civil monetary penalties for each violation with a cap of multiple violations. Next slide. And then we address here the maximum patient cost sharing as was indicated in the recommendation number eight. That's where we ended yesterday. And that's where we have three options to recommendation number A, but we will be discussing recommendation number A because there was a few that aligned specifically around number B of that recommendation that we will talk about at the end of our recommendation list today as well. So that comprises what recommendation 12 option A is about. So I'll open the floor to discussion. Wow. Okay. Okay, Pete, I see your hand raised.

Yeah, and thank you, Asbel. And to Loren's statement earlier, a lot of time was spent early on and everybody coalesced that we do need to resolve and get the patients out of the middle. And it's, you know, Loren and Patricia have been wonderful consumer advocates and I appreciate their input and their willingness to look at info and have good discussions and the whole group has. This eliminates though the local control, and the local rates need to be included. I cannot support something knowing how many guardrails are in place in my community and the participation of the public. I can't support 12A here, because it's not giving me the ability for locals to control EMS. EMS is a local system. It's supporting local communities and it needs to be rates established. And there needs to be a role of the local community in that rate structure. So I cannot support out 12A, I will be on 12B.

Shawn?

Thank you. And my comments would largely be around the discussion that we had on the previous recommendation to establish the guardrails. So I don't think I need to really revisit all of that. But I do want to point out that option A really takes away what is a tiering of the levels of accountability for rate setting and moves pretty directly to a federal rate, a single national rate. Or yes, the state balance billing law rate is in there but it's missing the middle steps of state and local regulated rate process as well as an opportunity specifically delineated for direct negotiation between providers and insurers in the absence of a state and local regulated rate or a state balance billing law. So I think when we get to option B, which I'll be speaking in favor of, because of that tiered system, federal all the way down to the most local, then not having this single national rate, it kind of eliminates all the incentives to reach an appropriate rate for a region given their level of service. That's what I see as fundamentally a problem with option A.

All right. Adam.

Yeah, and I can further elaborate this in what I think will be a no vote on this recommendation. I want to clarify some things because I'm concerned about the amount of different points that have been lumped in together in recommendation 12A. Because I think it is extraordinarily important that the patient be taken out of the middle, that balance billing be prohibited, that patients be limited to a discernible and smaller percentage of cost sharing rather than owing the balance bill from the ground ambulance provider. But we've lumped a lot of different provisions together in recommendation 12A. And I think the one that is most concerning to me, while a percentage of Medicare has what appears to be a federal benchmark, I think could end up being a very appropriate and administratively feasible required payment amount. There's also a provision in this recommendation that would mandate coverage of private payers for services that are not covered by Medicare. And that's concerning that we would be mandating coverage for something that Medicare has determined is not appropriate for coverage. And now that onus is going to be put on private payers, which I think it's important to remember, by and large are employers who are paying directly for healthcare, not these large for-profit insurance companies where we're making up numbers about various, I guess, stock buybacks. And so really putting that burden on an employer as an unprecedented coverage mandate for something that is not a covered service under Medicare, I think really makes this a recommendation that unfortunately I can't support because I think there are a lot of other elements here that would be sound policy recommendations. But it's also important to remember that this is being paired with -- my understanding is this is being paired with a later recommendation that would establish both this required minimum payment subject to these

penalties for not paying within 30 days, despite the fact that there's no evidence that that has been an issue with the initial payment under the No Surprises Act. But it would pair that with an independent dispute resolution process so that you have, in essence, a mandated federal benchmark that then can be supplemented for these ground ambulance companies, many of whom are private actors, many of whom are very attractive to private equity companies that have come in and bought up ground ambulance services, decreased quality and increased costs. And I think that they would view the windfall from this mandated initial payment along with the opportunity then to pursue additional revenue through the independent dispute resolution process like we've seen with the private equity owned emergency services providers that have really overutilized the No Surprises Act IDR process. I think that joining all of that together in one recommendation makes this flawed and I unfortunately can't support it as a result. But the bottom line is that the baseline recommendation of recommendation 12 that was on the first slide, that balance billing should be prohibited and that a reasonable payment should be guaranteed to the provider, to the supplier, that fundamentally is something that I would agree with and if that were the recommendation could vote yes.

Thanks, great context, and clarity where you are, Adam, as well. Loren.

Thank you. So I just wanted to clarify as I'll be voting yes on this option, I wanted to clarify, I think, a few points of understanding on this, what the proposal actually does. So one, I think it's important to clarify here that states would maintain their ability to allow local input for state regulated plans where this differs from the future recommendations as it's not creating what I think would be an unprecedented mandate on self-funded plans to pay for healthcare based on what a state or local government tells them to do. Right, so the states for fully insured plans, those state regulated plans, they still could account for local input, right? To the sort of California law that just passed or the Texas law that passed, right? Those would continue to bind for those plans, right? In all of these, if you contract, you can always contract for something different than the rate to Shawn's point. So there still would be the option to contract here. And then just to Adam's point to make sure here, right? I know we are voting later on this sort of independent dispute resolution, yes or no option. To be very clear, my intent is to vote no on that side of the recommendation. So to be clear, my support of this proposal is not contingent on there also being an IDR process.

Thanks, Loren. And Patricia.

Yes, thank you. I mean, it just pleases me to no end. The first slide of recommendation 12, protecting patients from balance billing. Excellent consensus on that. Thank you to the whole group here. And secondly, you know, ensuring a reasonable payment. So you know, that is where the differences of opinion come. But just to reiterate what Loren said is, we are not saying that states and local communities have no ability to play a role. If you can go back to, maybe it's slide one of four in option A, or let's say in the next one, I guess, please, number two. The first payment reimbursement here is whatever the state law is. And I know, Asbel, when you were reading it, you inserted the word already regulated by state law, but I'm hoping you're not intending that. I'm hoping it could be that states could go ahead.

Correct.

Okay, great. Yeah, so we're not saying if you're not in now, you never get to have a state balance billing law. And that's where I think, if there's going to be local rate setting, and if that's really important to a state, they will step up, they will set up a system where the locals can set it, or they have some kind of guardrails, whatever it may be. So I feel like local rate setting is still certainly an option. And any state that feels that this is really important to them has every ability to go ahead and do that under this option. But we do need to have something more consistent, particularly if the states aren't going to be stepping forward with a local option. So this is super important. It would get rid of all the discrepancies and whether one state is more lobbied than another state for higher rates. It would bring us to a reasonable amount that we could quickly change if things are looking bad. If we made a mistake, we would see that

soon enough, and we'd be able to remedy it across the country. So I think that Congress would be smart in making sure that they wouldn't set that rate too low, that we wouldn't have ambulance services. That's nobody's intention here. And also, I do want to point out, we do have a recommendation about rural and super rural. So, I think that that is really important to understand that there might be areas and there might be an overlay on this that does something else for those areas where we're having less access for ambulances. And that's still an opportunity both for the states to do or under this broader recommendation. And like Loren, I wouldn't be voting for an IDR to be attached to this process, but I will be voting yes on option A.

Loren, I see your hand is raised.

Sorry, I just wanted to piggyback and clarify one more point. Patricia kind of made the same point as well here. And I guess kind of to a point that Ritu raised earlier that I don't know that the disagreement is actually that far apart here. And that, I don't view this as meant to be like, this is super stingy. We're not gonna -- right? I take well the evidence that there is underfunding of EMS often in this country. And I do think there is value in this being a percentage of Medicare that is higher than today's rates. So, I do think this is something where there is a net influx of money into the ground ambulance EMS service, at least as I'm envisioning it, given that we've sort of obviously kind of obscured what the actual number is here. But I did want to clarify that I do envision this being, sort of, right, there is some premium increase here. And I do think some level of that is justified. And I'm not sure sort of the overall generosity here is necessarily all that different here. I think some of this is just sort of a question of kind of guardrails.

Okay, and then I see Ritu, your hand's raised.

Yeah, there was just one other point I wanted to make. For those who are watching this, I think one of the things that may jump out is this idea that we would still have in-network and out-of-network plans for a situation where nobody gets to choose who comes. And we did have a lot of vigorous discussion as a group as to whether or not we should just say there's no such thing as in-network and out-of-network. And what we heard from a lot of different sources from various -- sides is a bad word -- but from various points of view is that contracting for certain services could lead to better efficiencies and also create more impetus for trying new things. And so, we didn't want to be so prohibitive that would make that difficult. But I do want to put on the record that we had a long discussion about whether or not to remove in-network and out-of-network language from ground ambulance 911 calls.

And Ted, I see your hand's raised.

Yeah, thanks. And to the point about what Ritu is speaking to is the ability for companies, private equity, private ambulance, third services, hospitals to be able to negotiate with the payers to get the right rate. I think we had a lot of testimony that that's been very difficult, generally impossible on the 911 side to actually get a real negotiated rate. And that's why to have some of these guardrails that I'm gonna support up for 12B versus 12A, I think all organizations are looking to be able to have that kind of conversation. And it's in some of the language for 12B specifically because organizations want that. And I think we've seen that increase at least from a lot of the groups that are working through the IDR process where now you're starting to see those negotiations actually happen at a better rate than what was happening before. And the IDR process being able to actually go in there and have those conversations. And you see the awards that are happening on the IDR side across on the air ambulance space because you can see that the rates and the appropriate pieces that the providers actually have been having to do because the costs have been inflating, the cost to operate it and the cost most importantly to cover service and geographic areas. And from the response standpoint, being able to handle every single call when requested. And there's a readiness fee in EMS that's there. And that is unfortunate, but it is part of it. It's baked into the cost of the overall operating system. So you have to have that readiness fee which does cause some of those costs to be higher than it would be if you were getting paid on every single transport or every single patient that comes into an ER. You don't have that

ability in EMS. You have to be ready for every single call with ever the request is and wherever it is. So thank you.

Any other discussion before we get to the vote on option A? Not seeing any, Terra, we'll call for a vote.

Okay, Loren Adler?

Yes.

Shawn Baird?

No.

Adam Beck?

No.

Regina Crawford?

No.

Rhonda Holden?

No.

Patricia Kelmar?

Yes.

Ali Khawar? Peter Lawrence?

No.

Rogelyn McLean?

Abstain.

Asbel Montes?

No.

Ayobami Ogunsola? Dr. Ayo, are you on mute?

I'm sorry, yes, I'm sorry.

Okay. Suzanne Prentiss?

No.

Ritu Sahni?

No.

Edward Van Horne?

No.

Carol Weiser?

Abstain.

And we have Gam Wijetunge that has posted his vote in the chat, and he has voted to abstain. And Gary Wingrove?

No.

Okay, so now we will give those that voted no the opportunity to speak on their vote and we will start with Shawn.

Thank you. My no vote was based on option A, not preserving the full tier of state balance billing down to state and local regulated rate down to negotiations with insurers and then finally as a last resort, a federal rate.

Okay, and then we have Adam.

Yeah, my no vote, as I indicated earlier, I think would be cured if it weren't for a recommendation, I believe it's A2b that requires coverage and payment for non-Medicare covered services. So but for that item, I think this would be a reasonable recommendation.

Okay, and Regina?

Yes, my vote no is because I did not think -- option one did not allow the steps for the locals to negotiate those rates and I think that is imperative. Although we started negotiating rates, at this point, we still have a long way to go, especially with ground ambulance. So, I could not support that. I think option B is a better option. Thank you.

Okay, Rhonda?

The same, it's taking away the ability of the locals to negotiate rates and then also the mutually agreed upon reimbursement rates between an ambulance service and an insurance provider.

Okay, Peter?

12B provides much more appropriate rate setting processes from the state to the local, to the negotiations, to then the federal, and that's the reason why I voted no on 12A.

Okay, Asbel?

I'm a no vote, specifically for some of the reasons that everyone is giving here as well. This option didn't go far enough to make sure we preserved the local rights relative to the cost in different areas around those appropriate guardrails that we spent a lot of time discussing. And for that reason, I'm a no.

Okay, Suzanne?

Thank you. So, I'm a no vote for reasons that I have stated on our last recommendation and bringing them through here. I am working in all corners to protect state and local, well, the sovereignty at the state level and what's already recognized. So, although I appreciate all the comments that have been

made, both for and against, I think that option B is the -- I'm going to be voting for B because it's preferable and consistent with what I have voted on already. Thank you.

Ritu?

Nothing to add. I agree with statements already made.

Okay, Edward?

Yeah, thank you. I voted no, specifically as stated to preserve the ability to have the tiered response of tiered coverage from states to locals, to negotiations, and then a federal fallback if needed, which is 12B.

And Gary?

Nothing to add.

Okay, thank you.

Okay. So, we have made it through option A. We are going to go into option B. And we will discuss in option B, you've heard it referenced already. So let's walk through what this reimbursement methodology is to the general consensus that we did receive in this recommendation to the point that we are prohibiting surprise billing and creating a reasonable rate for ground ambulance emergency medical services. So, the first piece of this is an out-of-network reimbursement. An out-of-network rate is a minimum required payment rate methodology established by the Congress and secretaries. And so, we're first gonna establish a minimum required payment. The group health plan or health insurance issuer offering group or individual health insurance coverage, group health plan or health insurance issuer must pay the following amount, minus the cost sharing amount for ground ambulance services provided by the recipient, beneficiary, or enrollee. Next slide, Terra. And so, what is the minimum required payment? The minimum required payment is a tiered approach. So tier one is first gonna look at the amount specified in a state balance billing law or in a state with an all-payer model agreement, the amount defined in that agreement. Tier two, if there is no state balance billing law, the state or local regulated rate, when the process for determining that rate has sufficient guardrails, as we discussed in the guardrail component. Number three, if there is neither a state balance billing law nor a state or local regulated rate, the mutually agreed reimbursement rate amount between the group health plan or health insurance issuer for such plan or coverage and the ground ambulance emergency medical services provider or supplier. That, in general, is telling you if they have got an agreement that they have worked through, whether it's a single case agreement or a contract in that work where you've mutually agreed upon a rate, that rate applies. Tier four, if neither of the three above qualify, then if none of the above exists, then the amount is, for a Medicare covered service, it's the congressional set percentage of Medicare. If Medicare doesn't cover the service, then it's either a fixed amount set by the Congress or a percentage of a benchmark determined by the Congress. So, this is your tiered approach of how that minimum required payment will work. Next slide. So, then we go into the timing of the payment, very similar to option A, pay within 30 days of receipt of a bill as currently defined in the NSA. Goes back to the definitions of a bill that we adopted yesterday. Number two, patient share can be billed after the group health plan or health insurance issuer pays or denies the claim. Three, the group health plan or health insurance issuer makes prompt payment, which we defined yesterday, directly to ground ambulance emergency medical services provider or supplier. And then four, if it is determined that a plan or issuer has failed to make payment in accordance with the prompt and direct payment requirements, the secretaries of the appropriate department shall impose a per annum simple interest rate of some defined percentage. And then the secretary shall be authorized to impose civil monetary penalties for each violation with a cap for multiple violations. Next slide. And then we actually have a discussion of the maximum patient cost sharing as indicated in recommendation number eight. That was what we looked at yesterday, very similar to option A. And we will have a discussion based upon a few committee

members asking to revisit recommendation 8B. And then we'll go to the last slide, which then gives you what we had lengthy discussion on earlier today around the recommendations concerning the minimum guardrails for states and local regulated rates for ground ambulance emergency medical services as indicated in recommendation 11 that we've already voted on. So, I will now open the floor for discussion and I see, Shawn, that you have your hand raised.

Thanks, Asbel. I jumped up to raise my hand because I am actually very excited to be able to vote in favor of a recommendation that will in fact fulfill the mission of prohibiting balance billing and guaranteeing a reasonable payment for ground ambulance and EMS. That has been what we have been trying to get to for these many months. And I know for many people who are on the call, they've been working on it for a lot longer than the committee process has even been going on. And so as an ambulance provider, as a paramedic who's been working in the field for sadly a little more than 30 years, I'll date myself, I think this is a tremendous opportunity for us to really move something forward that will be meaningful for every part of the system. That is because this option, option B, paired with the guardrails that were in a previous recommendation and passed, paired with cost sharing limitations that I know you just mentioned we'll be looking at again, but will really protect the patient from anything egregious, and paired with the disclosures that are so important so that consumers of healthcare and EMS and ambulance understand exactly what the process is and what's fair and not fair, legal and not legal, all of that, that that whole combination is going to allow us to fulfill that mission of eliminating balance billing and preserving access to high quality emergency care. So, I will be in favor of option B.

Perfect. And Terra or Matt, if you'll go back to -- perfect, that way. Any more discussion around this? Anybody have any discussion that they would like around this option? I see Suzanne and then Carol's hand raised. So, we'll start with you, Suzanne.

Thank you, Asbel. And I'm looking for clarity. So, I support option B. I just want to make sure that this doesn't interfere with any of the contracts that have already been negotiated for agencies that are in network.

So, this is only addressing if you are out of network.

Okay, thank you.

Carol.

Just a technical point with respect to the interest charge. If that is intended to be the sole repercussion, then that would have to be made clear. If the typical pattern is followed of this being a provision that's included in the Public Health Service Act, the Public Health Service Act does have specified consequences, civil monetary penalties, and it would have to be made clear whether the interest charge is in addition or instead of those civil monetary penalties.

Carol, thanks for bringing that. If you will go to, I think that is mentioned in slide three of five. To address that point, I think it's the intent to ensure that there is a civil monetary penalty not to be an addition to anything else there. So, for a technical point of clarification, when we're writing the final report, we'll want to make sure that intent is very clear in the final report. Thank you for bringing that to the attention, Carol. Anybody else have -- I saw somebody had raised -- Suzanne.

Thank you, Asbel, for just working me through this. Just going back on contracts. Can you --

Go back to one of five. I'm sorry if we go to slide one of five.

Okay.

Your out-of-network rate is a minimum required, so it's out-of-network rate. If you have a contract where you're in-network, this would not apply. This only applies to the out-of-network rate.

Okay, thank you, I just --

And this committee has not made a recommendation to say that all EMS, there is no such thing as in- or out-of-network, that ultimately, while it was discussed, it was never put into a final recommendation about that.

Thank you.

This is only governing out-of-network rates. Any other discussion around these options? This option B, around any elements of this option? Patricia.

Asbel, I think, could you go to the next slide? And just for the benefit of folks listening in, can you explain the kind of situation that number three is? Because I know when we were first discussing this, it was a little confusing to me whether this was an in-network contracted rate. So, can you just talk about number three to explain it to folks on the phone?

So as an out-of-network provider, not to be confused with being in-network under an agreement, you sometimes could have what they would call these single-case agreements, or maybe you've negotiated a specific rate for a transport, whether it is a ground emergency medical services, or it was a part of what we defined as an emergency inter-facility training, you agreed upon a mutually agreed reimbursement rate. That rate would be upheld versus moving to tier four. So, if you've got some type of reimbursement rate as an out-of-network provider, there are some throughout the nation that may not have a formal in-network agreement, but they have agreed to some rate structure with some other type of third party that agrees to a rate, that rate would supersede the tier number four. Loren, I see your hand raised.

Sure. So yeah, I mean, I think just to sort of for discussion purposes on this, I think my main concern, so this recommendation, despite the language looking very different, is very similar to the last recommendation for what it's worth. The real core difference is that this proposal would also regulate what would tell self-funded employer plans that they have to follow the local or state set rates. I think it is to me, it's really that provision to me that is why I'll be voting no on this. Otherwise, I think a version of this proposal that didn't sort of kind of do a new regulation on ERISA plans here with proper guardrails, I think would be a perfectly reasonable option.

Thanks, Loren. Great commentary. Pete.

Just following up on something Patricia was saying about, you know, how number three here would work. Obviously, if you've already got a rate with the individual insurance carrier, then that rate applies. In local government, there are times that when we establish rates, the rate basically says select special events. You know, we have somebody come to a contest. The rate system says the mutually agreed upon costs or the following rates. And you can do the same thing with your ambulance. If you wanted the ability to negotiate, you could say in your rate system, the rates will be as follows, a mutually agreed upon rate or the following amount. And that is the way that you can establish this, that, you know, people say that there's no way we could get to three, but it's entirely possible and it's done when you build your resolution to say, you know, mutually agreed upon because we want the ability to negotiate on certain rates or this is the set amount. And it's done, as I said, for special events within my city all the time.

Any other commentary related to this option B? All right, seeing none, Terra, we'll take the vote.

Okay, Loren Adler?

No.

Shawn Baird?

Yes.

Adam Beck?

No.

Regina Crawford?

Yes.

Rhonda Holden?

Yes.

Patricia Kelmar?

No.

Ali Khawar? Peter Lawrence?

Yes.

Rogelyn McLean?

Abstain.

Asbel Montes?

Yes.

Ayobami Ogunsola?

No.

Suzanne Prentiss?

Yes.

Ritu Sahni?

Yes.

Edward Van Horne?

Yes.

Carol Weiser? Carol, are you on mute?

Sorry, I was having difficulty getting off mute. Abstain.

Okay. Gam Wijetunge? And it looks like Gam has put abstain in the chat. And Gary Wingrove?

Yes.

Okay, so now we will go back to those that voted no and give them the opportunity to comment. And we'll start with Loren.

I think I've said everything during the discussion portion.

Okay. And Adam?

Largely same principle as before, the coverage mandate for non-Medicare covered services, but then also this one does go a step further by mandating ERISA plans be governed by a state or local process, so that was also a deal breaker in this recommendation.

Okay. And Patricia?

Yeah, so I preferred option A, which is why I voted for that. And, you know, obviously in this option B, the important elements that I obviously, well, not obviously, that I do support are the timing payments, the guardrails, and the maximum cost share. So, I don't have any problems with that. It's just the payment mechanism. I just feel like it's going to be really confusing from the consumer perspective to understand which rate is applying, whether or not they're being overcharged, whether they're insurer or from the employer perspective who are paying these rates, you know, what's going on. So I think it's just much more confusing than option A and has the potential to have some issues with the local rate setting that I mentioned in the earlier conversation. That's why I voted no.

Okay. And Dr. Ayo?

Yes. My preference for option A is the fact that it provides a layer of checks, which I like, which I also think may be appropriate. And then option, my no-go to option B is because the methodology seems a little bit -- it should have been a little bit of complication here. So that is why I try to balance both. And my preference for option A is, I suggest, is more superior. And that's why I voted no for B. Thank you.

Okay. Thank you.

We will be back at 1 o'clock Eastern time. And we will move into the prohibitions on the non-emergency ground ambulance side. It'll sound very similar to what you've already heard, but we'll go through the same type of dialogue. And so, we will be reconvening one hour from now, back at 1 o'clock Eastern time.