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Hon. Xavier Becerra
Attorney General
1300 I Street, 17th Floor
Sacramento, California 95814

INITIATIVE COORDINATOR
ATTORNEY GENERAL'S OFFICE

Attention: Ms. Ashley Johansson
Initiative Coordinator

Dear Attorney General Becerra:

Pursuant to Elections Code Section 9005, we have reviewed the proposed statutory initiative (A.G. File 17-0043, Amendment No. 1) related to emergency medical personnel.

BACKGROUND

Emergency Medical Services in California

Counties Administer Local Emergency Medical Services (EMS). In California, counties are responsible for developing and coordinating local EMS systems through EMS agencies. These agencies help organize emergency 911 call response, emergency ambulance service, and local trauma hospitals to ensure that effective emergency medical care is available throughout the county. There are 26 county EMS agencies and seven multicounty EMS agencies. (Multicounty agencies coordinate emergency medical services in the state's more rural areas.) In order for agencies to coordinate these systems, state law authorizes local EMS agencies to charge annual fees to entities included in its EMS—for instance, trauma hospital designation fees, ambulance provider fees, and emergency medical personnel license fees. Some local EMS agencies also receive county general fund budget resources to support operations.

Local EMS Agencies Set Exclusive Operating Areas (EOAs) for Ambulance Services. In order to better coordinate emergency medical care, counties often divide their geographical area into zones, known as EOAs, in which a single ambulance provider has primary responsibility for providing emergency medical transportation. For instance, the Riverside County EMS Agency has divided the county into 12 EOAs and designated primary emergency transportation responsibility in each of those areas to a local provider of ambulance services. In most areas of the state, the local EMS agency signs multiyear contract agreements with ambulance providers to establish services for each EOA under its jurisdiction. Local EMS agencies select among several ambulance providers through a competitive bidding process. Typically, the winning contractor pays a fee to the local EMS agency for the right to serve that EOA. Exclusive rights to respond to 911 calls in that area allow the provider to generate revenue by collecting reimbursements from patients' insurers for the ambulance trips it provides. (We discuss this in more detail below.) In exchange, the ambulance provider must

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meet certain service requirements, such as responding to 911 calls within a specific amount of time (typically between 8 minutes and 12 minutes).

Emergency Medical Care and Transportation

Ambulances Provide “911” Emergency Medical Care and Transportation. When an accident, injury, or illness occurs and a 911 call request is made for emergency medical assistance, an ambulance crew is dispatched to the emergency scene. (A local fire department vehicle is also dispatched in most circumstances.) Ambulance emergency medical technicians (EMTs) and paramedics, alongside fire department personnel, then provide medical treatment to stabilize the patient. Once the patient is stable, an ambulance crew transports the patient to the hospital while the on-board EMTs or paramedics provide continued medical care until the patient is admitted. Ambulances also provide nonemergency transportation between health facilities when a patient needs treatment or testing.

Most Ambulance Transportation Provided by Private Companies. Privately owned and operated ambulance crews respond to about 75 percent of emergency 911 calls in California. In the other 25 percent of cases, the local fire department or municipality operates its own ambulance service and transports patients to hospitals themselves.

Insurance Providers Pay for Ambulance Trips. State law requires ambulance providers to transport patients regardless of the patient’s insurance coverage or ability to pay. In most cases, however, ambulance companies are paid for ambulance trips by the patient’s insurer. In general, more than one-half of all ambulance trips are for patients with Medicare or Medi-Cal, 20 percent for patients with private insurance, and the remaining roughly 20 percent for patients with no insurance coverage. Medicare and Medi-Cal set the reimbursement amount for ambulance trips at a fixed level, even if the cost for the ambulance provider to transport the patient is above that fixed amount. In these cases, an ambulance provider would lose money transporting that particular patient. (Ambulance providers typically receive little or no payment when transporting patients with no insurance coverage.) Ambulance providers make up for these losses by billing patients with private insurance more than the average cost to transport patients. Specifically, the average cost of an ambulance trip in California is about \$600, whereas Medi-Cal and Medicare typically reimburse \$150 and \$450, respectively. To compensate for these losses, ambulance providers bill private insurers \$1,300 on average per trip, more than double the costs of the typical ambulance trip.

Insurance Reimbursement Rates Do Not Automatically Adjust for Changes to Industry Costs. As discussed above, Medi-Cal and Medicare reimbursement rates do not automatically change as industry costs change. Instead, ongoing rates are set in law and not necessarily revisited every time the cost of providing a service changes. This means that ambulance providers cannot immediately offset new costs—for example, that result from higher labor costs or additional requirements—by shifting those costs to Medi-Cal or Medicare. (In the long term, however, reimbursement rates could adjust to reflect higher or lower costs in the ambulance provider industry.) In addition, private insurers are already billed, on average, more than double the average cost of an ambulance trip and it is not clear that ambulance providers could offset new costs that affect the industry by recovering more from insurers.

Changes to Ambulance Industry Costs Typically Reflected in Local EMS Contract Bids. Private ambulance providers submit contract bids (for exclusive rights to operate in the EOA) that allow them to remain profitable after taking into account how much insurers pay for ambulance trips

in the area. Because ambulance providers cannot immediately offset new costs by shifting them to insurers, higher (or lower) costs faced by ambulance providers are typically accounted for in contract bids submitted to the local EMS agency. Faced with higher costs, for example, an ambulance provider might propose less comprehensive ambulance services or a smaller annual ambulance provider fee paid to the local EMS agency. As a result, when ambulance provider costs increase, local EMS agencies must accept some combination of lower fees or less comprehensive ambulance services.

Ambulance Providers Minimize Costs by Strategically Positioning Ambulance Crews. Unlike fire department crews, who await emergency calls while stationed at their permanent department location, ambulance crews are positioned throughout a city or region depending on the volume and location of 911 calls typically received in that area and the response times agreed upon in the contracts. After an emergency call arrives and the nearest ambulance crew responds, each of the other crews in the area repositions to again provide an optimal geographic coverage for the next emergency call. This practice—known as “posting”—allows the ambulance provider to meet the response time requirements stipulated in its contract while using fewer ambulance crews than would be needed if they were stationed at permanent locations, resulting in lower overall costs.

EMTs and Paramedics

California’s Ambulance EMTs and Paramedics. In California, approximately 17,000 EMTs and paramedics (not counting EMT-certified firefighters) operate 3,600 ambulances. EMTs provide first-aid and basic medical care, whereas paramedics are trained to provide critical medical care. (EMTs and paramedics are treated similarly for purposes of this initiative.) Ambulances are staffed by two crew members—either two EMTs, an EMT and a paramedic, or two paramedics—who typically work 12-hour shifts.

Some EMTs and Paramedics Receive Mental Health Services. Emergency response personnel—such as police officers, firefighters, EMTs, and paramedics—often witness or experience traumatic events while working. Traumatic experiences may include the death of a colleague, serious work-related injury, natural disaster, terrorism incident, or emergency events involving children. Partly as a result of these types of events, emergency response personnel experience higher rates of post-traumatic stress disorder, depression, and suicide than the general public. To address this, many ambulance employers offer professional counseling to emergency medical personnel that have experienced a traumatic event. They also may provide mental health and wellness education and long-term mental health service plans for these personnel.

Some EMTs and Paramedics Receive Training to Respond to Disasters and Active Shooters. State and local EMS entities, in coordination with private ambulance providers, oversee training protocols for emergency medical personnel that help prepare them to respond to natural disasters, situations involving active gunfire, and acts of terrorism. These special circumstances require complex emergency medical responses—including field triage, extraction of injured patients from dangerous areas, and tactical safety protocols—not typically included as part of standard EMT or paramedic training.

Labor Law in California

State Labor Code Includes Laws Employers Must Follow. The California Labor Code consists of laws that employers must follow with respect to wages, hours, breaks, and working conditions. For

example, the Labor Code specifies the state minimum wage, when employees must receive overtime pay, when meal and rest breaks must be provided, and what steps employers must take to ensure a safe and healthy workplace.

Employers Must Provide Most Employees With Meal and Rest Breaks. The Labor Code includes laws that dictate when employers must provide their employees meal and rest breaks. Although there are some exceptions for salaried employees and employees in specific industries, most employers must provide an unpaid thirty minute meal break during each work shift and a paid ten minute rest break every four hours. (Work shifts longer than ten hours must include two meal breaks.)

Meal and Rest Breaks Taken by EMTs and Paramedics. Under current industry *practice*, EMTs and paramedics remain “on call” throughout their work shift in case a 911 call is made and they are the nearest ambulance. This means that scheduled meal and rest breaks are often interrupted by emergency calls or by a request to reposition to a new posting location (in the event that a different ambulance crew responds to a call and the remaining crews must reposition). In addition to interrupted meal and rest breaks, most ambulance providers require that ambulance crews are driving within 60 seconds after they receive an emergency call. This requirement helps the ambulance provider meet the response time requirements in their contracts but also affects how EMTs and paramedics use their break time. In practice, crews must remain in or near the ambulance throughout their shifts, including during meal and rest breaks.

Although meal and rest breaks are often interrupted and must be taken within close proximity to the ambulance, most ambulance crew shifts include periods of inactivity. The portion of each ambulance’s time spent inactive during a shift depends on several factors, including the geographical size and population of the area (urban areas tend to have fewer long periods of inactivity), the number of ambulance crews in the area, as well as the volume and type of emergency calls received during the shift. As a result, ambulance crews have periods of inactivity during their shifts during which meal and rest breaks might be taken, even though the crew must remain near the ambulance or their break may be interrupted or irregularly spaced (for instance, taken during the first or last hour of a shift).

Recent Court Decision Likely Requires “Off-Duty” Breaks for EMTs and Paramedics. In 2016, the California Supreme Court ruled that the employer practice of requiring on-call rest breaks does not comply with state labor law. Instead, employers must provide rest breaks that are off-duty and uninterrupted (even in the event of an emergency). The decision, *Augustus v. ABM Security Services*, applies to private security guards whose employers required that they keep their radios on during rest breaks. The Supreme Court found that the current practice of keeping guards on-call violated state law and accordingly awarded the company’s security guards associated penalties and damages. Given that the industry practice of on-call breaks among EMTs and paramedics is similar to that of private security guards, it appears probable that the decision made in *Augustus* will also apply to EMTs and paramedics.

To comply with state law as interpreted in *Augustus*, ambulance crews would have to go off-duty during their meal and rest breaks. As a result, ambulance providers would have to operate more ambulances in each area, relative to current industry practice, to provide sufficient coverage in that area without jeopardizing their ability to meet response time requirements. Ambulance provider staff estimate that, relative to current practice, 25 percent more ambulance crews will be needed to meet the requirements of *Augustus* (if no changes were made to response time requirements).

PROPOSAL

This measure makes various changes to state laws that affect private-sector EMTs and paramedics. The measure would not apply to public agencies (or their employees) that operate ambulance services. We describe the measure's provisions in detail below.

Requires On-Call Meal and Rest Breaks for EMTs and Paramedics. This measure requires EMTs and paramedics to be on call throughout their shifts. In effect, the measure continues the longstanding industry practice of requiring EMTs and paramedics to remain on call during breaks. In addition, it requires crews' meal breaks not occur in the first or last hours of their shift and that multiple meal breaks are scheduled at least two hours apart. The measure requires ambulance providers to operate enough ambulances in an area in order to meet these requirements.

Seeks to Limit Legal Costs for Past Practice of On-Call Meal and Rest Breaks. The *Augustus* decision suggests that the longstanding practice of requiring EMTs and paramedics to remain on-call during their breaks is in violation of state law. As a result, private ambulance providers may now be legally responsible for penalties and other damages associated with meal and rest break violations. Several lawsuits that allege these types of break violations have been brought against private ambulance providers and remain outstanding at this time. The measure, in addition to requiring on-call meal and rest breaks going forward, seeks to apply that standard in pending litigation. In this way, the measure seeks to limit legal liability that ambulance providers face based on past industry practice.

Requires Employer-Paid Training and Mental Health Services. The measure requires ambulance providers to offer EMTs and paramedics (1) annual natural disaster, active shooter, and violence prevention training; (2) mental health and wellness education; (3) mental health counseling; and (4) access to long-term mental health services.

FISCAL EFFECTS

The fiscal effects of this measure would depend on how state courts interpret its provisions and other legal issues. The measure's fiscal effects would depend specifically on (1) whether the *Augustus* decision (which requires that breaks be off-duty) applies to emergency medical personnel in the same way that it applies to private security guards and (2) whether the courts validate the measure's provision that seeks to limit any pending legal liability related to on-call breaks. In addition to legal uncertainties, the measure's fiscal effects also depend on the responses of ambulance providers and local governments to the measure.

Below, we discuss the measure's major fiscal effects based on the following assumptions: (1) the *Augustus* decision will apply to EMTs and paramedics in the absence of this measure, and (2) the measure successfully limits pending legal costs.

Much Lower Private Ambulance Provider Costs Than Costs of Complying With Augustus. Operating more ambulances in order to provide off-duty breaks, as required by *Augustus*, represents a substantial new cost to providers—potentially in excess of \$100 million annually. Under the measure's requirement that EMTs and paramedics remain on-call during breaks, however, providers would not face these new costs. In this way, the measure has the effect of providing large savings to providers. Offsetting these savings to some degree, the measure requires ambulance providers to ensure more accommodating schedules for on-call meal breaks, which in many cases will require

providers to operate somewhat more ambulances in an area. This would result in some new costs. On net, we believe the measure's meal and rest break provisions would result in savings in the high tens of millions of dollars annually to ambulance providers.

Some New Costs to Ambulance Providers to Provide Training and Mental Health Services. Private ambulance providers that do not currently offer training and mental health services at the levels required under this measure would pay new costs for providing those benefits. Employers would also be required to pay EMTs and paramedics their regular hourly wage while employees attend trainings or counseling. These provisions would likely result in new costs in the low tens of millions of dollars annually to ambulance providers.

Lower Net Overall Costs to Private Ambulance Providers. The measure's requirement that EMTs and paramedics remain on-call throughout their shifts would result in large savings to private ambulance providers relative to the costs of providing off-duty breaks under *Augustus*. These savings would be offset somewhat by new costs associated with providing training and mental health services. On net, we believe the measure would result in savings in the tens of millions of dollars annually to ambulance providers.

Lower Net Local Government Costs Due to Lower Net Ambulance Costs. As discussed above, we assume that short-term increases or decreases in industry costs are primarily accounted for in contract bids submitted to EMS agencies for ambulance services. We therefore expect the measure to result in net savings to local governments in the tens of millions of dollars annually that result from lower ambulance provider net costs reflected in agency contracts with these providers.

Summary of Fiscal Effects. This measure would have the following major fiscal effect:

- Local government net savings likely in the tens of millions of dollars annually due to lower emergency ambulance contract costs.

Sincerely,



for Mac Taylor
Legislative Analyst



for Michael Cohen
Director of Finance