IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
NORTHERN DIVISION

MISSISSIPPI ASSOCIATION OF HEALTH PLANS, INC.	**PLAINTIFF**
V.	**CAUSE NO. 3:24-cv-379-HTW-LGI**
MIKE CHANEY, IN HIS OFFICIAL CAPACITY AS COMMISSIONER OF INSURANCE OF MISSISSIPPI	**DEFENDANT**

MISSISSIPPI ASSOCIATION OF HEALTH PLANS'
REPLY IN SUPPORT OF ITS MOTION FOR PRELIMINARY INJUNCTION

The Fifth Circuit has long recognized that "the purpose of a preliminary injunction is to preserve the status quo"—that is, "to prevent irreparable injury so as to preserve the court's ability to render a meaningful decision on the merits". *Canal Auth. of State of Fla. v. Callaway*, 489 F.2d 567, 576 (5th Cir. 1974). MAHP's suit raises serious constitutional concerns with House Bill 1489, which the Commissioner casts aside with charged innuendo about the industry participants he regulates. Absent immediate judicial intervention enjoining the enforcement of the Bill, MAHP's members and insured Mississippians will suffer significant and nonrecoverable costs. Issuing the injunction while MAHP's claims are expeditiously resolved on the merits, by contrast, harms no one. Thus, in this case—where constitutional rights are on the line, where MAHP's facial challenges to the Bill can be readily resolved, and where MAHP has established a likelihood of prevailing on the merits—a preliminary injunction is warranted.

I. MAHP HAS STANDING TO BRING ITS CLAIMS, WHICH ARE RIPE FOR REVIEW, AND IS SUBSTANTIALLY LIKELY TO SUCCEED ON THE MERITS OF THIS CONSTITUTIONAL CHALLENGE.

The Commissioner's response mostly parrots the arguments asserted in his motion to dismiss, arguing MAHP lacks standing to assert its claims and that MAHP's claims are unripe.

Doc. 20 at 8–9. MAHP's *Memorandum Brief in Support of its Response in Opposition to the Commissioner's Motion to Dismiss*, Doc. 22, which is incorporated herein by reference, clearly shows it has standing and its constitutional challenges to House Bill 1489 are ripe for adjudication. The Commissioner's claim that MAHP "cannot establish a substantial likelihood of success on its Contract Clause claim" because it has not shown "a substantial impairment to its members' contracts" is also unavailing. Doc. 20 at 9–15. MAHP has thoroughly explained the nature and extent of the Reimbursement Mandate's impairment on existing policies and contracts of health insurance between MAHP's members and their subscribers. *See* Doc. 1 at ¶¶21–30; Doc. 10 at 8–12; Docs. 17, 17-1 at ¶¶3–18, and 17-2 at ¶¶3–16; Doc. 22 at 10–12, 27–30. MAHP relies upon those previous explanations, which are incorporated herein by reference. Moreover, the fact MAHP's members are in a regulated industry does not condemn them to anticipate any possible legislative mandate. *See Chrysler Corp. v. Kolosso Auto Sales, Inc.*, 148 F.3d 892, 895 (7th Cir. 1998) (citing *Allied Structural Steel Co. v. Spannaus*, 438 U.S. 234, 250, 98 S.Ct. 2716, 57 L.Ed.2d 727 (1978)) ("The fact that some incidents of a commercial activity are heavily regulated does not put the regulated firm on notice that an entirely different scheme of regulation will be imposed. The form and particularly the consequences of such a scheme would be so difficult to foresee that it would be unrealistic to think that the firm had been compensated for the risk of bearing those consequences when it negotiated the original contract.").

The Commissioner argues MAHP must show the Bill's enactment was "arbitrary and irrational", Doc. 20 at 10, a test MAHP has demonstrated the Reimbursement Mandate fails because legislation giving a special interest *carte blanche* to charge whatever it wants and compelling others to pay can be neither objective nor rational.[1] Doc. 17-1 at ¶16; Doc. 17-2 at

[1] Notably, the Arkansas statute the Commissioner points to as an example caps ambulance reimbursement rates at the **lesser of** the state's Workers' Compensation fee schedule or ambulance companies' billed charges in the

¶14. The Declarations submitted by MAHP clearly demonstrate significant impairment to its members' existing contracts, showing out-of-network ambulance billed charges are higher than plan allowables, and are as high as 19 times the CMS reimbursement rate.[2] Doc. 17-1 at ¶¶12–13; Doc. 17-2 at ¶13. Though the Commissioner seeks to minimize this impairment with his position that insurance companies may apply a commercial reasonableness standard to deny unreasonable billed charges, Doc. 20 at 13, the Bill does not state that, and he has not yet issued regulations or an MID Bulletin so clarifying. Given the unprecedented mandate and its substantial impairment on terms clearly stated in the Declarations, a review of all members' plan documents or ambulance bills received to date is unnecessary.

Further contrary to the Commissioner's argument, Doc. 20 at 15, MAHP has shown the Reimbursement Mandate, which provides a windfall to out-of-network ambulance companies, serves no legitimate public purpose or interest. *See* Doc. 1 at ¶29; Doc. 10 at 12–13. And while the Commissioner cites cases suggesting the Legislature is entitled deference in determining whether a public purpose exists, the Supreme Court has been clear that "[d]espite the customary deference courts give to state laws directed to social and economic problems, '[l]egislation adjusting the rights and responsibilities of contracting parties must be upon reasonable conditions and of a character appropriate to the public purpose justifying its adoption.'" *Spannaus*, 438 U.S. at 244. The inescapable reality is that ambulance companies stand to profit significantly from the

absence of government contract discounts; they do not require insurers to pay the **"greater of**" up to whatever ambulance companies decide to bill, as does House Bill 1489. *See* Ex. "1", Ark. Code Ann. § 23-99-1802(a)(2). West Virginia has no similar requirement.

[2] The Commissioner contends MAHP's members can remedy these cost increases by simply increasing Mississippians' insurance premiums, co-pays, and other insurance-related costs. Doc. 20 at 29 ("This temporary economic hit . . . can be remedied by MAHP's health insurance members when their policies come up for renewal."); *id*. at 29 n.19 ("MAHP['s] members would be able to recover any costs . . . by raising premiums or subjecting their insureds to some other cost sharing mechanism."). This suggestion for health insurance companies to increase premium costs in later years to cover unanticipated costs in 2024 reinforces an injury-in-fact exists.

Reimbursement Mandate, on the backs of everyone else including insured Mississippians. The Commissioner cannot call this arrangement "reasonable." Doc. 20 at 6.

The Commissioner's reliance on "legislative history accompanying H.B. 1489" to demonstrate a public purpose, Doc. 20 at 16, is misplaced, because the bulk of what he identifies does not relate to the version of House Bill 1489 signed into law. The Commissioner provides links to two videos depicting March 13, 2024, floor presentations of House Bill 1489 and House Bill 1629 (which contained the Reimbursement Mandate's language before it was inserted into House Bill 1489) on the floor of the Mississippi House of Representatives. *Id*. But when these speeches were made, the Reimbursement Mandate was starkly different than the version that was signed into law, as it *did not* provide for unlimited reimbursement to ambulance companies; it provided for the greater of (1) an amount set by a local government's contract or ordinance; or (2) 325% of Medicare. *See* Ex. 2 at 4.[3] The final form of the Bill presented on the Senate Floor on April 10, 2024, which the Commissioner champions as having 100% support, replaced the version that had been considered and approved by the Senate Insurance Committee, and for the first time required reimbursement of the "**greater of**" 325% of Medicare or the ambulance company's "billed charges" – in other words, up to whatever amount an out-of-network ambulance company decides to charge. *See* Ex. 2 at 14–15. The Commissioner does not cite to a single legislative floor speech discussing the legislature's intent regarding the "greater of" Reimbursement Mandate in the final version of the Bill. Thus, the legislative history the Commissioner presents does not reflect a carefully thought-out public policy reason to give ambulance companies such power or financial windfall.

[3] Exhibit 2 includes three versions of House Bill 1489: the version passed by the House of Representatives on March 13, 2024, Ex. 2 at 1–5; the version unveiled for the first time and passed by the Senate on April 10, 2024, Ex. 2 at 6–10; and the final, enacted version, Ex. 2 at 11–15.

The Commissioner also submits a declaration by State Health Officer, Dr. Daniel P. Edney, M.D. Doc. 20 at 16–17; Doc. 19-3. The overwhelming majority of Dr. Edney's declaration, however, is irrelevant and demonstrates no purported legislative intent. In his declaration, Dr. Edney acknowledges he provided limited information to the legislature, attached to his Declaration as Exhibit A; thus the legislature did not have his August 15, 2024, Declaration or the justifications he now states for the Bill. Doc. 19-3 at 5–6. Because the limited information in his Exhibit A is the only information the Legislature could have considered when drafting and/or voting on the Bill, in evaluating a purported public purpose the Court should consider only *that* document, which provides no evidence of a "public purpose" for impairing MAHP's members' contracts with their subscribers or for granting a windfall for out-of-network ambulance companies.

Similarly, the Commissioner recycles his argument that the Coverage Mandate is not vague by stating his view of the legislation and contending MAHP is not likely to succeed on its vagueness claim. Doc. 20 at 17–25. In furtherance of judicial economy, MAHP relies on its previous briefing identifying the specific provisions of the Coverage Mandate that are unconstitutionally vague, explaining why those provisions are vague, and illuminating the impact of those vague terms on MAHP's members' business operations. *See* Doc. 1 at ¶¶31–41; Doc. 10 at 13–20; Docs. 17, 17-1 at ¶¶19-27, and 17-2 at ¶¶17–25; Doc. 22 at 7–10, 31–35. Notably, the Commissioner cites purportedly similar language in statutes enacted in Arkansas and West Virginia, arguing since those state's statues were not challenged for vagueness, the Bill cannot possibly be vague. Doc. 20 at 20, 23 n.8. Despite some similarities, the differences in the Arkansas and West Virginia statutes are significant.[4] Both state's coverage requirements tied to "treat,"

[4] The Commissioner also attaches guidelines of Arkansas BlueCross BlueShield's letterhead, which would have been drafted following more clearly defined terms in Arkansas' statute. Notably, that entity is wholly independent from MAHP member Blue Cross and Blue Shield of Mississippi, A Mutual Insurance Company.

"triage," "encounters" and transports to "alternative destinations" explicitly require the ambulance service to "coordinate" the patient's care through telemedicine "with a physician for a medical-based complaint or with a behavioral health specialist for a behavioral-based complaint." *See* Exhibit "1"; W. Va. Code Ann. § 16-4C-26[5]; Ark. Code Ann. § 23-79-2703(1). There, a physician or "mental health specialist" determines the appropriate level of care and to where a patient should be transported in an emergency sufficient to justify ambulance services. Under House Bill 1489, this decision seemingly is left to ambulance personnel (or the enrollee), yet neither the Commissioner nor Dr. Edney's declaration contend those individuals are either trained or licensed to make such medical determinations. The absence of physician oversight requirements exacerbates the vagueness of the Bill's coverage mandate, as it removes physician orders as a potential benchmark for evaluating whether billed services are emergency in nature, which the Commissioner states is the only context in which the coverage mandate applies. Doc. 13 at 27. Moreover, neither Arkansas nor West Virginia compel coverage for an ambulance service provider to "assess" a patient, so they lend no clarity to the vagueness of that term. Ex. 1; Ark. Code Ann. § 23-79-2703; W. Va. Code Ann. § 16-4C-26. Lastly, West Virginia does not require coverage for "encounters," and Arkansas incorporated clear guideposts for determining what a covered "encounter" includes by limiting coverage to instances where the patient refuses treatment and where the ambulance service is coordinating care with a physician. *Id*. In the end, these statutes, by their additional clarity, serve only to highlight the vagueness of House Bill 1489.

II. MAHP HAS SUFFICIENTLY DEMONSTRATED IRREPARABLE HARM WARRANTING INJUNCTIVE RELIEF.

The Commissioner argues the fact MAHP sought injunctive relief less than three months after the Bill was signed into law "alone militates against any finding of irreparable harm . . . ."

[5] The Commissioner attaches only the definitions tied to West Virginia's version of the Coverage Mandate.

Doc. 20 at 25. The Commissioner cites three cases in which the plaintiffs sought injunctive relief after waiting at least nine months, Doc. 20 at 26, significantly longer than here. MAHP filed its Complaint before the effective date of House Bill 1489, less than two months after it was signed into law, Doc. 1, and filed its motion for preliminary injunction less than twenty days later. Doc. 9. District courts in the Fifth Circuit generally question timeliness only if the request for injunctive relief is "delayed for five months or more." *Gemstone Foods, LLC v. Pitts*, No. 3:23-CV-2968-KHJ-MTP, 2024 WL 1466799, at *2 (S.D. Miss. Apr. 4, 2024) (quoting *Ronaldo Designer Jewelry, Inc. v. Cox*, 1:17-CV-2, 2017 WL 3879095, at *10 (N.D. Miss. Sep. 5, 2017) (collecting cases)). Given the difficulty in attempting to implement the Bill's requirements due to its vagaries, this timeframe is entirely reasonable.

Finally, the Commissioner's contention that the financial losses that will be sustained by MAHP's member cannot constitute irreparable harm, Doc. 20 at 28, is undermined by Fifth Circuit precedent, as such losses would be unrecoverable, Doc. 10 at 23, 24, and 26. *See, e.g., Nat'l Rifle Ass'n of Am., Inc. v. Bureau of Alcohol, Tobacco, Firearms & Explosives*, No. 3:23-CV-1471-L, 2024 WL 1349307, at *9 (N.D. Tex. Mar. 29, 2024) (quoting *Rest. L. Ctr. v. United States Dep't of Lab.*, 66 F.4th 593, 597 (5th Cir. 2023) (finding that in the Fifth Circuit, "the nonrecoverable costs of complying with a putatively invalid regulation typically constitute irreparable harm."); *Louisiana v. Biden*, 55 F.4th 1017, 1034 (5th Cir. 2022) (citing *Texas v. EPA*, 829 F.3d 405, 433 (5th Cir. 2016)) ("[C]omplying with a regulation later held invalid almost always produces the irreparable harm of nonrecoverable compliance costs.").

III. THE PUBLIC INTEREST FAVORS INJUNCTIVE RELIEF.

Aside from the significant and unrecoverable cost increases that House Bill 1489 imposes on MAHP's members and Mississippians insured by private health insurance, and aside from the

imminent risk of regulatory enforcement by the Commissioner against MAHP's members, enjoining the Commissioner's implementation and enforcement of House Bill 1489 will advance the public interest because it will prevent MAHP's members and insured Mississippians from enduring further constitutional violations at the hands of the Commissioner. *Ingebretsen v. Jackson Pub. Sch. Dist.*, 864 F. Supp. 1473, 1491 (S.D. Miss. 1994), *aff'd sub nom. Ingebretsen on Behalf of Ingebretsen v. Jackson Pub. Sch. Dist.*, 88 F.3d 274 (5th Cir. 1996) ("The court finds that the public interest will not be disserved by the issuance of an injunction aimed at preventing the enforcement of a potentially unconstitutional statute."). Maintaining the status quo until this Court can rule on the merits harms no one and prevents significant injury to MAHP's members and their insureds.

IV. CONCLUSION

For the foregoing reasons, Plaintiff Mississippi Association of Health Plans requests the Court to enter an Order granting the Plaintiff's Motion for Preliminary Injunction and further requests such other relief as the Court deems just and proper.

Dated: August 22, 2024.

Respectfully Submitted,

MISSISSIPPI ASSOCIATION OF HEALTH PLANS, INC

By: */s/ James A. McCullough, II*
James A. McCullough, II
One of Its Attorneys

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CERTIFICATE OF SERVICE

I hereby certify that on this day, a true and accurate copy of the foregoing was electronically transmitted to the Clerk of the Court using the ECF System for filing, which delivered notice of same to all counsel of record.

Dated: August 22, 2024.

/s/ James A. McCullough, II
James A. McCullough, II

West's Annotated Code of West Virginia
Chapter 16. Public Health
Article 4c. Emergency Medical Services Act

W. Va. Code, § 16-4C-26

EXHIBIT 1

§ 16-4C-26. Triage, treat, and transport to alternative destination

Effective: June 6, 2024
Currentness

(a) An emergency medical services agency may triage and transport a patient to an alternative destination in this state or treat in place if the emergency medical services agency is coordinating the care of the patient through medical command or telehealth services with a physician for a medical-based complaint or with a behavioral health specialist for a behavioral-based complaint. Emergency medical services agencies shall execute a memorandum of understanding with alternative treatment destinations as permitted by the protocols to transport patients.

(b) On or before October 1, 2024, the director shall establish protocols for emergency medical services agencies to triage, treat, and transport to alternative destinations.

Credits
Acts 2024, c. 214, eff. June 6, 2024.

W. Va. Code, § 16-4C-26, WV ST § 16-4C-26
Current with legislation of the 2024 Regular Session and First Extraordinary Session.

End of Document

West's Arkansas Code Annotated
Title 23. Public Utilities and Regulated Industries (Refs & Annos)
Subtitle 3. Insurance (Chapters 60 to 109) (Refs & Annos)
Chapter 99. Health Care Providers (Refs & Annos)
Subchapter 18. Minimum Allowable Reimbursement for Ground Ambulance Services (Refs & Annos)

A.C.A. § 23-99-1802

§ 23-99-1802. Minimum allowable reimbursement for ground ambulance services

Effective: August 1, 2023
Currentness

(a)(1) The minimum allowable reimbursement rate under any health benefit plan issued by a healthcare insurer to a participating ground ambulance service provider or an out-of-network ground ambulance service provider shall be at the rates approved or contracted between an ambulance service provider and a local government entity as provided for in § 14-266-105.

(2) In the absence of rates set as provided under subdivision (a)(1) of this section, the minimum allowable rate of reimbursement under a health benefit plan issued by a healthcare insurer shall be the lesser of:

(A) The rate established by the Workers' Compensation Commission under its medical fee schedule for ambulance services; or

(B) The provider's billed charges.

(b) A payment made under this section shall be considered payment in full for the covered services provided, except for any copayment, coinsurance, deductible, and other cost-sharing feature amounts required to be paid by the enrollee.

(c)(1) A healthcare insurer shall remit payment within thirty (30) days for ambulance services directly to the ground ambulance service provider.

(2) A healthcare insurer shall not send payment to an enrollee.

Credits
Acts of 2023, Act 597, § 1, eff. Aug. 1, 2023.

A.C.A. § 23-99-1802, AR ST § 23-99-1802
The constitution and statutes are current through the 2024 Fiscal Session and 2024 Second Extraordinary Session of the 94th Arkansas General Assembly. Some statute sections may be more current; see credits for details. Also included are changes made by the Arkansas Code Revision Commission received through June 30, 2024.

End of Document

West's Arkansas Code Annotated
Title 23. Public Utilities and Regulated Industries (Refs & Annos)
Subtitle 3. Insurance (Chapters 60 to 109) (Refs & Annos)
Chapter 79. Insurance Policies Generally
Subchapter 27. Arkansas Triage, Treat, and Transport to Alternative Destination Act (Refs & Annos)

A.C.A. § 23-79-2703

§ 23-79-2703. Coverage for ambulance service to triage and transport enrollee to alternative destination or treat in place

Effective: August 1, 2023
Currentness

(a) On and after January 1, 2024, a healthcare insurer that offers, issues, or renews a health benefit plan in this state shall provide coverage for:

(1) An ambulance service to:

(A) Treat an enrollee in place if the ambulance service is coordinating the care of the enrollee through telemedicine with a physician for a medical-based complaint or with a behavioral health specialist for a behavioral-based complaint; or

(B) Triage or triage and transport an enrollee to an alternative destination if the ambulance service is coordinating the care of the enrollee through telemedicine with a physician for a medical-based complaint or with a behavioral health specialist for a behavioral-based complaint; or

(2) An encounter between an ambulance service and enrollee that results in no transport of the enrollee if:

(A) The enrollee declines to be transported against medical advice; and

(B) The ambulance service is coordinating the care of the enrollee through telemedicine with a physician for a medical-based complaint or with a behavioral health specialist for a behavioral-based complaint.

(b) The coverage under this section:

(1) Only includes ambulance service transportation to the treatment location;

(2) Is subject to the initiation of ambulance service treatment as a result of a 911 call that is documented in the records of the ambulance service;

(3) Is subject to health benefit plan deductibles or copayment requirements;

(4) Does not diminish or limit benefits otherwise allowable under a health benefit plan, even if the billing claims for medical or behavioral health services overlap in time that is billed by the ambulance service also providing care; and

(5) Is subject to any health benefit plan provisions that apply to other services covered by the health benefit plan.

(c) The reimbursement rate for an ambulance service whose operators triage, treat, and transport an enrollee to an alternative destination, or triage, treat, and do not transport an enrollee if the enrollee declines to be transported against medical advice, if the ambulance service is coordinating the care of the enrollee through telemedicine with a physician for a medical-based complaint or with a behavioral health specialist for a behavioral-based complaint under this section shall be at least at the rate:

(1) Contracted with a local government entity where the alternative destination is located; or

(2) Established by the Workers' Compensation Commission under its schedule for emergency Advanced Life Support Level 1.

Credits

Acts of 2023, Act 480, § 2, eff. Aug. 1, 2023.

A.C.A. § 23-79-2703, AR ST § 23-79-2703

The constitution and statutes are current through the 2024 Fiscal Session and 2024 Second Extraordinary Session of the 94th Arkansas General Assembly. Some statute sections may be more current; see credits for details. Also included are changes made by the Arkansas Code Revision Commission received through June 30, 2024.

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MISSISSIPPI LEGISLATURE REGULAR SESSION 2024

By: Representatives Hobgood-Wilkes, Barton, Arnold, Hines, Mickens, Carpenter

To: Insurance

COMMITTEE SUBSTITUTE
FOR
HOUSE BILL NO. 1489

AN ACT TO BE KNOWN AS THE MISSISSIPPI TRIAGE, TREAT AND TRANSPORT TO ALTERNATIVE DESTINATION ACT; TO PROVIDE THAT HEALTH BENEFIT PLANS SHALL PROVIDE COVERAGE FOR AN AMBULANCE SERVICE TO TREAT OR ASSESS AN ENROLLEE IN PLACE, OR TRIAGE OR TRIAGE AND TRANSPORT AN ENROLLEE TO AN ALTERATIVE DESTINATION, OR AN ENCOUNTER BETWEEN AN AMBULANCE SERVICE AND ENROLLEE THAT RESULTS WITHOUT TRANSPORT OF THE ENROLLEE UNDER THE PLAN; TO PROVIDE THAT THE COVERAGE REQUIRED UNDER THIS SECTION IS SUBJECT TO THE INITIATION OF AMBULANCE SERVICE TREATMENT AS A RESULT OF A 911 CALL THAT IS DOCUMENTED IN THE RECORDS OF THE AMBULANCE SERVICE AND SUBJECT TO DEDUCTIBLES OR CO-PAYMENT REQUIREMENTS OF THE PLAN, AND DOES NOT DIMINISH OR LIMIT BENEFITS OTHERWISE ALLOWABLE UNDER THE PLAN; TO PROVIDE THAT THE REIMBURSEMENT RATE FOR AN AMBULANCE SERVICE PROVIDER WHOSE OPERATORS ASSESS, TRIAGE, TREAT OR TRANSPORT AN ENROLLEE TO AN ALTERNATIVE DESTINATION SHALL BE NOT LESS THAN THE ADVANCED LIFE SUPPORT RATE WITH MILEAGE TO THE SCENE; TO PROVIDE THAT THE MINIMUM ALLOWABLE REIMBURSEMENT RATE UNDER ANY HEALTH BENEFIT PLAN TO A PARTICIPATING AMBULANCE SERVICE PROVIDER OR AN OUT-OF-NETWORK AMBULANCE SERVICE PROVIDER SHALL BE THE GREATER OF THE RATES CONTRACTED BETWEEN AN AMBULANCE SERVICE PROVIDER AND A COUNTY, MUNICIPALITY OR SPECIAL PURPOSE DISTRICT OR AUTHORITY, OR OTHERWISE APPROVED OR ESTABLISHED BY ORDINANCE OR REGULATION ENACTED BY ANY SUCH COUNTY, MUNICIPALITY OR SPECIAL PURPOSE DISTRICT OR AUTHORITY, OR THREE HUNDRED TWENTY-FIVE PERCENT OF THE REIMBURSEMENT ALLOWED BY MEDICARE FOR SERVICES ORIGINATING IN RURAL AREAS; TO PROVIDE THAT IF AN AMBULANCE SERVICE PROVIDER'S BILLED CHARGES ARE LESS THAN THE MINIMUM ALLOWABLE REIMBURSEMENT RATE PROVIDED FOR IN THIS ACT, THEN SUCH MINIMUM ALLOWABLE REIMBURSEMENT RATE SHALL BE THE PROVIDER'S BILLED CHARGES; AND FOR RELATED PURPOSES.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MISSISSIPPI:

SECTION 1. (1) This section shall be known and may be cited as the "Mississippi Triage, Treat and Transport to Alternative Destination Act".

(2) **Definitions.** As used in this section, the following terms shall be defined as provided in this subsection:

(a) "911 call" means a communication made on behalf of an enrollee indicating that the enrollee may need emergency medical services;

(b) (i) "Alternative destination" means a lower-acuity facility that provides medical services, including, without limitation:

1. A federally qualified health center;

2. An urgent care center;

3. A physician's office or medical clinic, as chosen by the patient; and

4. A behavioral or mental health care facility, including, without limitation, a crisis stabilization unit and a diversion center.

(ii) "Alternative destination" does not include a:

1. Critical access hospital;

2. Dialysis center;

3. Hospital;

4. Private residence; or

5. Skilled nursing facility.

(c) "Ambulance service provider" means a person or entity that provides ambulance transportation and emergency medical services to a patient for which a permit is required under Section 41-59-9;

(d) "Enrollee" means an individual who is covered by any health benefit plan; and

(e) "Health benefit plan" means any such policy as defined by Section 83-63-3.

(3) Coverage for ambulance service to assess, triage and transport enrollee to alterative destination or treat in place. On and after July 1, 2024, any health benefit plan shall provide coverage for:

(a) An ambulance service to:

(i) Treat or assess an enrollee in place; or

(ii) Triage or triage and transport an enrollee to an alterative destination; or

(b) An encounter between an ambulance service and enrollee that results without transport of the enrollee.

(4) The coverage required under this section:

(a) Is subject to the initiation of ambulance service treatment as a result of a 911 call that is documented in the records of the ambulance service;

(b) Is subject to deductibles or co-payment requirements of the health benefit plan;

(c) Does not diminish or limit benefits otherwise allowable under a health benefit plan, even if the billing claims for medical or behavioral health services overlap in time that is billed by the ambulance service provider that is also providing care; and

(d) Is subject to any provisions of the health benefit plan that apply to other services covered by the health benefit plan.

(5) The reimbursement rate for an ambulance service provider whose operators assess, triage, treat or transport an enrollee to an alternative destination shall be not less than the advanced life support rate with mileage to the scene.

SECTION 2. (1) (a) The minimum allowable reimbursement rate under any health benefit plan as defined by Section 83-9-1 to a participating ambulance service provider or an out-of-network ambulance service provider shall be the greater of:

(i) The rates contracted between an ambulance service provider and a county, municipality or special purpose district or authority, or otherwise approved or established by ordinance or regulation enacted by any such county, municipality or special purpose district or authority; or

(ii) Three hundred twenty-five percent (325%) of the reimbursement allowed by Medicare for services originating in rural areas.

For the purposes of this section, the term "ambulance service provider" means a person or entity that provides ambulance transportation and emergency medical services to a patient for which a permit is required under Section 41-59-9.

(b) If an ambulance service provider's billed charges are less than the reimbursement rate provided in this subsection (1), the minimum allowable reimbursement rate under any health benefit plan to the participating ambulance service provider or an out-of-network ambulance service provider shall be the provider's billed charges.

(2) A payment made under this section shall be considered payment in full for the covered services provided, except for any co-payment, coinsurance, deductible, and other cost-sharing feature amounts required to be paid by the enrollee.

SECTION 3. Sections 1 and 2 of this act shall be codified as new sections in Chapter 9, Title 83, Mississippi Code of 1972.

SECTION 4. This act shall take effect and be in force from and after July 1, 2024.

Adopted
SUBSTITUTE NO 1 FOR COMMITTEE AMENDMENT NO 1 PROPOSED TO

House Bill No. 1489

BY: Senator(s) McLendon

Amend by striking all after the enacting clause and inserting in lieu thereof the following:

SECTION 1. (1) This section shall be known and may be cited as the "Mississippi Triage, Treat and Transport to Alternative Destination Act."

(2) **Definitions.** As used in this section, the following terms shall be defined as provided in this subsection:

(a) "911 call" means a communication made on behalf of an enrollee indicating that the enrollee may need emergency medical services;

(b) (i) "Alternative destination" means a lower-acuity facility that provides medical services, including, without

limitation:

1. A federally qualified health center;

2. An urgent care center;

3. A physician's office or medical clinic, as chosen by the patient; and

4. A behavioral or mental health care facility, including, without limitation, a crisis stabilization unit and a diversion center.

(ii) "Alternative destination" does not include a:

1. Critical access hospital;

2. Dialysis center;

3. Hospital;

4. Private residence; or

5. Skilled nursing facility.

(c) "Ambulance service provider" means a person or entity that provides ambulance transportation and emergency medical services to a patient for which a permit is required under Section 41-59-9;

(d) "Enrollee" means an individual who is covered by any health benefit plan; and

(e) "Health benefit plan" means any such policy as defined by Section 83-63-3.

(3) Coverage for ambulance service to assess, triage and transport an enrollee to an alterative destination or treat in

place. On and after July 1, 2024, any health benefit plan shall provide coverage for:

(a) An ambulance service to:

(i) Treat or assess an enrollee in place; or

(ii) Triage or triage and transport an enrollee to an alterative destination; or

(b) An encounter between an ambulance service and enrollee that results without transport of the enrollee.

(4) The coverage required under this section:

(a) Is subject to the initiation of ambulance service treatment as a result of a 911 call that is documented in the records of the ambulance service;

(b) Is subject to deductibles or co-payment requirements of the health benefit plan;

(c) Does not diminish or limit benefits otherwise allowable under a health benefit plan, even if the billing claims for medical or behavioral health services overlap in time that is billed by the ambulance service provider that is also providing care; and

(d) Is subject to any provisions of the health benefit plan that apply to other services covered by the health benefit plan.

(5) The reimbursement rate for an ambulance service provider whose operators assess, triage, treat or transport an enrollee to an alternative destination shall be not less than the minimum

allowable reimbursement for advanced life support rate with mileage to the scene.

SECTION 2. (1) (a) The minimum allowable reimbursement rate under any policy of accident and sickness insurance as defined by Section 83-9-1 to an out-of-network ambulance service provider for all covered services shall be the rates contracted between an ambulance service provider and a county, municipality or special purpose district or authority, or otherwise approved or established by ordinance or regulation enacted by any such county, municipality or special purpose district or authority in which the covered healthcare services originated.

(b) In the absence of rates provided in subsection (a), the minimum allowable reimbursement rate to an out-of-network ambulance service provider shall be the greater of:

(i) Three hundred twenty-five percent (325%) of the reimbursement allowed by Medicare for the respective services originating in the respective geographic area; or

(ii) The ambulance service provider's billed charges.

(2) A payment made under this section shall be considered payment in full for the covered services provided, except for any copayment, coinsurance, deductible and other cost-sharing feature amounts required to be paid by the enrollee.

(3) For purposes of this section, the term "ambulance service provider" means a person or entity that provides ambulance

transportation and emergency medical services to a patient for which a permit is required under Section 41-59-9.

(4) This section shall stand repealed on June 30, 2028.

SECTION 3. Sections 1 and 2 of this act shall be codified as new sections in Title 83, Chapter 9, Mississippi Code of 1972.

SECTION 4. This act shall take effect and be in force from and after July 1, 2024.

Further, amend by striking the title in its entirety and inserting in lieu thereof the following:

AN ACT TO BE KNOWN AS THE MISSISSIPPI TRIAGE, TREAT AND TRANSPORT TO ALTERNATIVE DESTINATION ACT; TO PROVIDE THAT HEALTH BENEFIT PLANS SHALL PROVIDE COVERAGE FOR AN AMBULANCE SERVICE TO TREAT OR ASSESS AN ENROLLEE IN PLACE, OR TRIAGE OR TRIAGE AND TRANSPORT AN ENROLLEE TO AN ALTERATIVE DESTINATION, OR AN ENCOUNTER BETWEEN AN AMBULANCE SERVICE AND ENROLLEE THAT RESULTS WITHOUT TRANSPORT OF THE ENROLLEE UNDER THE PLAN; TO PROVIDE THAT THE COVERAGE REQUIRED UNDER THIS SECTION IS SUBJECT TO THE INITIATION OF AMBULANCE SERVICE TREATMENT AS A RESULT OF A 911 CALL THAT IS DOCUMENTED IN THE RECORDS OF THE AMBULANCE SERVICE AND SUBJECT TO DEDUCTIBLES OR CO-PAYMENT REQUIREMENTS OF THE PLAN, AND DOES NOT DIMINISH OR LIMIT BENEFITS OTHERWISE ALLOWABLE UNDER THE PLAN; TO PROVIDE THAT THE REIMBURSEMENT RATE FOR AN AMBULANCE SERVICE PROVIDER WHOSE OPERATORS ASSESS, TRIAGE, TREAT OR TRANSPORT AN ENROLLEE TO AN ALTERNATIVE DESTINATION SHALL BE NOT LESS THAN THE MINIMUM ALLOWABLE REIMBURSEMENT FOR ADVANCED LIFE SUPPORT RATE WITH MILEAGE TO THE SCENE; TO PROVIDE THAT THE MINIMUM ALLOWABLE REIMBURSEMENT RATE UNDER ANY POLICY OF ACCIDENT AND SICKNESS INSURANCE TO AN OUT-OF-NETWORK AMBULANCE SERVICE PROVIDER SHALL BE RATES CONTRACTED BETWEEN AN AMBULANCE SERVICE PROVIDER AND A COUNTY, MUNICIPALITY OR SPECIAL PURPOSE DISTRICT OR AUTHORITY, OR OTHERWISE APPROVED OR ESTABLISHED BY ORDINANCE OR REGULATION ENACTED BY ANY SUCH COUNTY, MUNICIPALITY OR SPECIAL PURPOSE DISTRICT OR AUTHORITY; TO PROVIDE THAT IN THE ABSENCE OF SUCH RATES, THE MINIMUM ALLOWABLE REIMBURSEMENT RATE SHALL BE THE GREATER OF THREE HUNDRED TWENTY-FIVE PERCENT OF THE REIMBURSEMENT ALLOWED BY MEDICARE FOR SERVICES ORIGINATING IN RURAL AREAS OR THE AMBULANCE SERVICE PROVIDER'S BILLED CHARGES; TO PROVIDE A DATE OF REPEAL ON SUCH PROVISIONS; AND FOR RELATED PURPOSES.

MISSISSIPPI LEGISLATURE REGULAR SESSION 2024

By: Representatives Hobgood-Wilkes, Barton, Arnold, Hines, Mickens, Carpenter

To: Insurance

HOUSE BILL NO. 1489
(As Sent to Governor)

AN ACT TO BE KNOWN AS THE MISSISSIPPI TRIAGE, TREAT AND TRANSPORT TO ALTERNATIVE DESTINATION ACT; TO PROVIDE THAT HEALTH BENEFIT PLANS SHALL PROVIDE COVERAGE FOR AN AMBULANCE SERVICE TO TREAT OR ASSESS AN ENROLLEE IN PLACE, OR TRIAGE OR TRIAGE AND TRANSPORT AN ENROLLEE TO AN ALTERATIVE DESTINATION, OR AN ENCOUNTER BETWEEN AN AMBULANCE SERVICE AND ENROLLEE THAT RESULTS WITHOUT TRANSPORT OF THE ENROLLEE UNDER THE PLAN; TO PROVIDE THAT THE COVERAGE REQUIRED UNDER THIS SECTION IS SUBJECT TO THE INITIATION OF AMBULANCE SERVICE TREATMENT AS A RESULT OF A 911 CALL THAT IS DOCUMENTED IN THE RECORDS OF THE AMBULANCE SERVICE AND SUBJECT TO DEDUCTIBLES OR CO-PAYMENT REQUIREMENTS OF THE PLAN, AND DOES NOT DIMINISH OR LIMIT BENEFITS OTHERWISE ALLOWABLE UNDER THE PLAN; TO PROVIDE THAT THE REIMBURSEMENT RATE FOR AN AMBULANCE SERVICE PROVIDER WHOSE OPERATORS ASSESS, TRIAGE, TREAT OR TRANSPORT AN ENROLLEE TO AN ALTERNATIVE DESTINATION SHALL BE NOT LESS THAN THE MINIMUM ALLOWABLE REIMBURSEMENT FOR ADVANCED LIFE SUPPORT RATE WITH MILEAGE TO THE SCENE; TO PROVIDE THAT THE MINIMUM ALLOWABLE REIMBURSEMENT RATE UNDER ANY POLICY OF ACCIDENT AND SICKNESS INSURANCE TO AN OUT-OF-NETWORK AMBULANCE SERVICE PROVIDER SHALL BE RATES CONTRACTED BETWEEN AN AMBULANCE SERVICE PROVIDER AND A COUNTY, MUNICIPALITY OR SPECIAL PURPOSE DISTRICT OR AUTHORITY, OR OTHERWISE APPROVED OR ESTABLISHED BY ORDINANCE OR REGULATION ENACTED BY ANY SUCH COUNTY, MUNICIPALITY OR SPECIAL PURPOSE DISTRICT OR AUTHORITY; TO PROVIDE THAT IN THE ABSENCE OF SUCH RATES, THE MINIMUM ALLOWABLE REIMBURSEMENT RATE SHALL BE THE GREATER OF THREE HUNDRED TWENTY-FIVE PERCENT OF THE REIMBURSEMENT ALLOWED BY MEDICARE FOR SERVICES ORIGINATING IN RURAL AREAS OR THE AMBULANCE SERVICE PROVIDER'S BILLED CHARGES; TO PROVIDE A DATE OF REPEAL ON SUCH PROVISIONS; AND FOR RELATED PURPOSES.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MISSISSIPPI:

SECTION 1. (1) This section shall be known and may be cited as the "Mississippi Triage, Treat and Transport to Alternative Destination Act."

(2) **Definitions.** As used in this section, the following terms shall be defined as provided in this subsection:

(a) "911 call" means a communication made on behalf of an enrollee indicating that the enrollee may need emergency medical services;

(b) (i) "Alternative destination" means a lower-acuity facility that provides medical services, including, without limitation:

1. A federally qualified health center;

2. An urgent care center;

3. A physician's office or medical clinic, as chosen by the patient; and

4. A behavioral or mental health care facility, including, without limitation, a crisis stabilization unit and a diversion center.

(ii) "Alternative destination" does not include a:

1. Critical access hospital;

2. Dialysis center;

3. Hospital;

4. Private residence; or

5. Skilled nursing facility.

(c) "Ambulance service provider" means a person or entity that provides ambulance transportation and emergency medical services to a patient for which a permit is required under Section 41-59-9;

(d) "Enrollee" means an individual who is covered by any health benefit plan; and

(e) "Health benefit plan" means any such policy as defined by Section 83-63-3.

(3) Coverage for ambulance service to assess, triage and transport an enrollee to an alterative destination or treat in place. On and after July 1, 2024, any health benefit plan shall provide coverage for:

(a) An ambulance service to:

(i) Treat or assess an enrollee in place; or

(ii) Triage or triage and transport an enrollee to an alterative destination; or

(b) An encounter between an ambulance service and enrollee that results without transport of the enrollee.

(4) The coverage required under this section:

(a) Is subject to the initiation of ambulance service treatment as a result of a 911 call that is documented in the records of the ambulance service;

(b) Is subject to deductibles or co-payment requirements of the health benefit plan;

(c) Does not diminish or limit benefits otherwise allowable under a health benefit plan, even if the billing claims for medical or behavioral health services overlap in time that is billed by the ambulance service provider that is also providing care; and

(d) Is subject to any provisions of the health benefit plan that apply to other services covered by the health benefit plan.

(5) The reimbursement rate for an ambulance service provider whose operators assess, triage, treat or transport an enrollee to an alternative destination shall be not less than the minimum allowable reimbursement for advanced life support rate with mileage to the scene.

(6) This section shall apply to all contracts described in this section that are entered into or renewed on or after July 1, 2024.

SECTION 2. (1) (a) The minimum allowable reimbursement rate under any policy of accident and sickness insurance as defined by Section 83-9-1 to an out-of-network ambulance service provider for all covered services shall be the rates contracted between an ambulance service provider and a county, municipality or special purpose district or authority, or otherwise approved or established by ordinance or regulation enacted by any such county, municipality or special purpose district or authority in which the covered healthcare services originated.

(b) In the absence of rates provided in subsection (a), the minimum allowable reimbursement rate to an out-of-network ambulance service provider shall be the greater of:

(i) Three hundred twenty-five percent (325%) of the reimbursement allowed by Medicare for the respective services originating in the respective geographic area; or

(ii) The ambulance service provider's billed charges.

(2) A payment made under this section shall be considered payment in full for the covered services provided, except for any copayment, coinsurance, deductible and other cost-sharing feature amounts required to be paid by the enrollee.

(3) For purposes of this section, the term "ambulance service provider" means a person or entity that provides ambulance transportation and emergency medical services to a patient for which a permit is required under Section 41-59-9.

(4) This section shall stand repealed on June 30, 2028.

SECTION 3. Sections 1 and 2 of this act shall be codified as new sections in Title 83, Chapter 9, Mississippi Code of 1972.

SECTION 4. This act shall take effect and be in force from and after July 1, 2024.

Mississippi Legislature
2024 Regular Session

House Bill 1489

House Calendar | Senate Calendar | Main Menu
Amendments | Conference Reports | Additional Information

Bill Text for All Versions Explanation

Approved by the Governor
As Passed the House
Committee Substitute
As Introduced

Description: Ambulance services; provide for payment for treatment in place and provide for minimum reimbursement rate in health insurance policies.

Fiscal Note: No fiscal note conducted

Background Information:
Disposition: Law
Deadline: General Bill/Constitutional Amendment
Revenue: No
Vote type required: Majority
Effective date: July 1, 2024
Chapter Number: 468

History of Actions:

1	02/19 (H)	Referred To Insurance
2	03/05 (H)	Title Suff Do Pass Comm Sub
3	03/13 (H)	Committee Substitute Adopted
4	03/13 (H)	Passed {Vote}
5	03/14 (H)	Transmitted To Senate
6	03/21 (S)	Referred To Insurance
7	03/28 (S)	Title Suff Do Pass As Amended
8	04/10 (S)	Amended
9	04/10 (S)	Passed As Amended {Vote}
10	04/10 (S)	Motion to Reconsider Entered
11	04/11 (S)	Reconsidered
12	04/11 (S)	Amended
13	04/11 (S)	Passed As Amended {Vote}
14	04/12 (S)	Returned For Concurrence
15	04/16 (H)	Decline to Concur/Invite Conf
16	04/16 (H)	Conferees Named Turner,Arnold,Carpenter
17	04/17 (S)	Conferees Named Michel,McLendon,Whaley
18	04/18 (S)	Conference Report Filed
19	04/18 (H)	Conference Report Filed
20	04/19 (S)	Conference Report Adopted {Vote}
21	04/24 (H)	Conference Report Adopted {Vote}
22	04/26 (H)	Enrolled Bill Signed
23	04/26 (S)	Enrolled Bill Signed
24	05/02	Approved by Governor

Amendments:

[S] Committee Amendment No 1 ***Replaced by Substitute***

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[S] Amendment No 1 to Substitute No 1 for Committee Amendment No 1 ***Lost*** Voice Vote

[S] Amendment No 2 to Substitute No 1 for Committee Amendment No 1 ***Adopted*** Voice Vote

[S] Substitute No 1 for Committee Amendment No 1 ***Adopted*** Voice Vote

Amendment Report for House Bill No. 1489

Conference Reports:

Conference Report

----- Additional Information -----

House Committee: Insurance
Senate Committee: Insurance

Principal Author: Hobgood-Wilkes
Additional Authors: Barton, Arnold, Hines, Mickens, Carpenter

Title: AN ACT TO BE KNOWN AS THE MISSISSIPPI TRIAGE, TREAT AND TRANSPORT TO ALTERNATIVE DESTINATION ACT; TO PROVIDE THAT HEALTH BENEFIT PLANS SHALL PROVIDE COVERAGE FOR AN AMBULANCE SERVICE TO TREAT OR ASSESS AN ENROLLEE IN PLACE, OR TRIAGE OR TRIAGE AND TRANSPORT AN ENROLLEE TO AN ALTERATIVE DESTINATION, OR AN ENCOUNTER BETWEEN AN AMBULANCE SERVICE AND ENROLLEE THAT RESULTS WITHOUT TRANSPORT OF THE ENROLLEE UNDER THE PLAN; TO PROVIDE THAT THE COVERAGE REQUIRED UNDER THIS SECTION IS SUBJECT TO THE INITIATION OF AMBULANCE SERVICE TREATMENT AS A RESULT OF A 911 CALL THAT IS DOCUMENTED IN THE RECORDS OF THE AMBULANCE SERVICE AND SUBJECT TO DEDUCTIBLES OR CO-PAYMENT REQUIREMENTS OF THE PLAN, AND DOES NOT DIMINISH OR LIMIT BENEFITS OTHERWISE ALLOWABLE UNDER THE PLAN; TO PROVIDE THAT THE REIMBURSEMENT RATE FOR AN AMBULANCE SERVICE PROVIDER WHOSE OPERATORS ASSESS, TRIAGE, TREAT OR TRANSPORT AN ENROLLEE TO AN ALTERNATIVE DESTINATION SHALL BE NOT LESS THAN THE MINIMUM ALLOWABLE REIMBURSEMENT FOR ADVANCED LIFE SUPPORT RATE WITH MILEAGE TO THE SCENE; TO PROVIDE THAT THE MINIMUM ALLOWABLE REIMBURSEMENT RATE UNDER ANY POLICY OF ACCIDENT AND SICKNESS INSURANCE TO AN OUT-OF-NETWORK AMBULANCE SERVICE PROVIDER SHALL BE RATES CONTRACTED BETWEEN AN AMBULANCE SERVICE PROVIDER AND A COUNTY, MUNICIPALITY OR SPECIAL PURPOSE DISTRICT OR AUTHORITY, OR OTHERWISE APPROVED OR ESTABLISHED BY ORDINANCE OR REGULATION ENACTED BY ANY SUCH COUNTY, MUNICIPALITY OR SPECIAL PURPOSE DISTRICT OR AUTHORITY; TO PROVIDE THAT IN THE ABSENCE OF SUCH RATES, THE MINIMUM ALLOWABLE REIMBURSEMENT RATE SHALL BE THE GREATER OF THREE HUNDRED TWENTY-FIVE PERCENT OF THE REIMBURSEMENT ALLOWED BY MEDICARE FOR SERVICES ORIGINATING IN RURAL AREAS OR THE AMBULANCE SERVICE PROVIDER'S BILLED CHARGES; TO PROVIDE A DATE OF REPEAL ON SUCH PROVISIONS; AND FOR RELATED PURPOSES.

Information pertaining to this measure was last updated on 06/18/24 at 09:18
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