

Pennsylvania EMS Testimony

Protecting Pennsylvania Strengthening Fire and Emergency Medical Services

Gary Watters | October 14, 2026

House Republican Policy Committee | Murrysville, Pennsylvania

Chairman Rowe, Representative Cooper, and members of the committee, thank you for the opportunity to speak today and for your attention to the future of emergency medical services.

I am Gary Watters, Executive Director and EMS Chief of AMED, and President of the Ambulance Association of Pennsylvania.

I appreciate Representative Cooper's leadership on House Bill 1152. Our members face inadequate reimbursement and insurance checks sent to patients that never reach the agency that provided the care.

When someone calls 911, they expect a trained, competent crew to arrive quickly. Making that possible requires staffing, vehicles, equipment, medications, training, and facilities every hour of every day, regardless of call volume.

Much of EMS reimbursement is tied to transporting a patient. But the cost of keeping a crew ready exists before the call comes in and continues afterward. Those costs vary with community expectations, geography, call volume, transport times, and the level of coverage needed.

Pennsylvania's Department of Health reports more than 2.2 million EMS calls annually. In announcing HB 1152, Representative Cooper reported that 47 ambulance companies closed in 2023 and 2024.

When an agency closes, its calls do not disappear. Neighboring services must cover more territory, often with resources already stretched thin. That can leave another community without an immediately available ambulance while its crew responds elsewhere.

We cannot continue relying on neighboring agencies to absorb these losses indefinitely.

I am asking you to act in three areas.

First, move forward with meaningful insurance reimbursement reform.

AAP supports the core protections in HB 1152 as introduced: direct payment to EMS agencies within 45 days, reimbursement at 350 percent of the applicable Medicare ambulance rate for dispatched 911 services, and protection against balance billing beyond required insurance cost sharing.

Patients having a medical emergency cannot shop for an ambulance. They should not be caught between the responding EMS agency and their health plan.

AAP spent \$10,000 to obtain and analyze insurer payment data that health plans refused to provide, helping inform this discussion. Our concern now is that the proposed immediate relief will be replaced with another lengthy and uncertain process.

We support studying the cost of readiness and how it should be funded. However, that work must proceed alongside insurance reimbursement relief. EMS agencies cannot build a stable future with insurance reimbursement uncertainty and conditions outside their control.

Second, establish dependable funding for readiness.

Equipment grants and training assistance are valuable, and we appreciate those investments. But agencies also need dependable, recurring revenue to keep crews available when someone dials 911. An ambulance purchased with a grant still needs people to staff it tomorrow.

State and local leaders must establish clear responsibility for maintaining coverage and a sustainable way to pay for it. Regional cooperation can help, but those plans must account for added costs, travel distances, simultaneous emergencies, and the neighboring agencies' capacity.

Third, make workforce funding accessible to EMS.

Local workforce development boards are not funding EMS. The AAP developed a statewide EMT apprenticeship program through the Department of Labor and Industry, but because local workforce development boards do not prioritize EMS, we have not been able to move any employees through it.

We need EMS to receive meaningful priority in workforce funding, including support for apprentice wages and tuition. EMS agencies need help covering the cost of employing and training someone while that person becomes qualified to serve.

Recruitment programs will accomplish less than we hope if agencies cannot afford to employ people while they train.

Title 35 charges the Department of Health with regulating EMS and developing and improving the system. In our experience, it places too much emphasis on regulatory enforcement and too little on improving EMS service delivery, supporting better patient care, and building a sustainable statewide EMS system.

Please preserve the immediate reimbursement and patient protections in HB 1152, fund the readiness our communities expect, and make workforce funding accessible to EMS.

The measure of success is whether an ambulance staffed by a highly trained crew is available when a Pennsylvanian needs it.

Thank you. I welcome your questions.

Supporting References

These references accompany the written submission and are not part of the oral remarks.

Statewide call volume and existing support

Pennsylvania Department of Health, April 20, 2026. Reports more than 2.2 million EMS calls annually and describes equipment investments and tuition assistance. The additional \$6 million discussed in that release was a budget proposal.

<https://www.pa.gov/agencies/health/newsroom/-6-million-investment-for-ems-professionals-in-2026-2027-propose>

Agency closures

Representative Jill Cooper, April 9, 2025. Reports 47 ambulance companies closed in 2023–2024 and describes the resulting burden on neighboring services. This is a historical figure.

<https://www.pahousegop.com/News/36006/Latest-News/Cooper-Bill-Addresses-Emergency-Services-Crisis>

Reimbursement and patient protections

HB 1152, Printer's Number 1272, as introduced. Specifies direct reimbursement within 45 days at 350 percent of the applicable Medicare ambulance rate for dispatched 911 services and prohibits collection beyond required patient cost sharing.

<https://www.palegis.us/legislation/bills/text/HTM/2025/0/HB1152/PN1272>

Proposed amendment and AAP position

The A04224 trial engrossment reviewed by AAP proposes an EMS Stabilization Board, reimbursement tiers ranging from 100 to 350 percent of Medicare, conditions involving regionalization, and expiration of the board section after four years. These are proposed provisions. The testimony expresses AAP's opposition to delaying immediate relief and its preference for a durable solution.

AAP payment data analysis

AAP invested \$10,000 to obtain and analyze insurer payment data available under federal Consolidated Appropriations Act transparency requirements. This work informed AAP's legislative advocacy for reimbursement reform.

Direct payment under existing law

Act 84 of 2015 offers a conditional opt-in direct-payment arrangement for nonnetwork emergency EMS claims. Agencies must register annually and notify insurers with claims. When an insurer pays its network rate, collection beyond required patient cost sharing is prohibited. It does not establish the 350 percent Medicare reimbursement rate proposed in HB 1152. The concern about undisclosed rates reflects AAP's experience; no statewide participation count is asserted.

<https://www.legis.state.pa.us/WU01/LI/LI/US/HTM/2015/0/0084..HTM>

EMT apprenticeship development

Partner4Work's September 27, 2024 board briefing documents collaboration with AAP to develop an EMT apprenticeship. The testimony's description of local funding barriers reflects Gary Watters's account of AAP's experience.

<https://www.partner4work.org/uploads/partner4work-briefing-book-for-september-27-2024.pdf>