Emergency

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Executive summary

WHEN A MEDICAL EMERGENCY STRIKES, the most important thing is to get help fast. And about 1 in 10 times, insured Americans get to the emergency room by ambulance.¹ In fact, ground ambulances transport approximately 3 million privately insured people to emergency rooms annually.²

The problem is that patients generally don’t choose their ambulance service. They (or someone else) call 9-1-1, and the dispatcher sends out a responder. Then, the patient is obligated to pay the bill.

In December 2020, Congress passed the No Surprises Act (NSA) to protect patients from many types of out-of-network balance bills.³ The law prohibited surprise billing for emergency room services, air ambulances and most out-of-network care at in-network facilities. It did not include protections from surprise billing by ground ambulances. Yet, Congress acknowledged important work was left undone, by including provisions in the NSA to establish the Advisory Committee on Ground Ambulance and Patient Billing.⁴ The committee is charged with reviewing options for protecting consumers from surprise ground ambulance billing.

Studies show about half of emergency ambulance patients with insurance are at risk of receiving a surprise medical bill which is an out-of-network charge for those transportation services.⁵ Those balance bills carry a median out-of-pocket charge of $450⁶ but in some states, the average is more than $1000.⁷

Balance billing occurs when patients are charged the difference between the in-network and out-of-network rate. This common billing practice throughout the health care industry is even more prevalent for ambulances.

Ambulances have the highest out-of-network billing rate in the country, adding up to around $129 million spent by insured patients on ambulance surprise bills every year.⁸ In at least seven states, more than two-thirds of emergency ground transports could result in a balance bill.⁹

Ten states have enacted laws to protect patients against out-of-network bills from ambulance companies.¹⁰ However these state laws are limited to protecting only patients who are insured by a state-regulated health plan. That means that 60% of Americans who get their insurance coverage through a self-funded plan offered by their employer are left unprotected because these types of plans are exempt from state laws.¹¹ Insured patients need a federal solution, modeled after these state laws, to ensure protection across all 50 states.

This report highlights the need for nationwide ground ambulance surprise billing protections. It provides an overview of the ground ambulance business models and how states have addressed the problem of ambulance balance billing. In addition, it recommends what data the government should accumulate and what policy solutions the government should consider based on that data.
Introduction:
Half of ambulance rides by insured patients result in a surprise bill

YOU CAN READ HEADLINES ABOUT THE outrageous bills that patients receive after being transported to an emergency room. These “ambulance surprise bills” put tremendous financial stress on families already dealing with a medical emergency; despite having insurance, millions of patients find themselves paying hundreds of dollars out-of-pocket for these out-of-network charges from ground ambulances.12

“Surprise bills” are what people commonly call balance bills – the charges a patient receives from out-of-network providers after their health plan pays part of the cost. Surprise billing is a ubiquitous business practice in the ground ambulance industry.

Three million privately insured patients use emergency ground transportation every year and half receive a balanced bill for those services.13 One reason for the high prevalence of surprise billing is that many ambulances do not contract with health insurance plans14 and the patients, therefore, are deemed out-of-network. Health plans will pay some part of the bill, but the ambulance is permitted to seek payment directly from the patient for any unpaid amount. Ambulance surprise bills can be financially devastating, costing consumers a median charge of $450 more than the typical in-network price, and up to $1,000 per trip.15 Almost half of U.S. adults hesitate to seek out care because they worry about these unexpected bills.16

Similar surprise billing problems existed in other sectors of the health care industry until January 2022, when the No Surprises Act went into effect. This federal law prohibited surprise billing for emergency room services, air ambulances and most out-of-network care at in-network facilities. The law did not address the billing practices of ground ambulances and instead called for the creation of an Advisory Committee on Ground Ambulance and Patient Billing.17 This committee is charged with conducting appropriate analysis and issuing recommendations to protect consumers from ambulance surprise bills.

The purpose of this report is to document the prevalence of surprise billing as a common business feature of emergency ground transportation and its impact on both patient costs and the health system in general. By examining the history of emergency medical transportation in the United States, the report will underscore the complexity of the ambulance industry and the business models that have led to more surprise billing. Additionally, this report examines how some states have addressed the problem, seeking to reduce costs to patients who need emergency ambulance transportation and to save money in the health system as a whole. The report ends with recommendations for how to solve the ground ambulance surprise billing problem across the nation.
The roots of surprise billing in ground ambulances

Our modern ambulance system stems from a 1966 government study that exposed a lack of rapid response by trained individuals who could save lives in an emergency, if they had properly equipped ambulances. After the report raised national attention about the problem, in the 1970s, the federal government invested in regional and community emergency response transportation systems. But in 1981, funding for emergency medical services was merged into general health block grants. This bureaucratic shift meant states had discretion on how to fund health programs, including emergency medical response services, essentially putting an end to the earmarked federal funding of the 1970s. Depending on political pressures and the health of state budgets, emergency transportation funding fluctuated in the years to follow. As a result, some communities shut down their community-based emergency services entirely and left the door open for private ambulance companies to come into the market. Other communities responded by seeking to lower their costs by relying on volunteers and replacing diminished public funding by billing patients and their health insurance plans to pay for their operations.

Since the 1980s, the ambulance industry has become an interesting mix of ownership models. In 2020, private businesses provided 30% of ambulance rides, government entities besides fire departments gave 25% of that form of emergency transportation and fire departments provided 37%. Privately owned ambulance companies are a growing share of ambulance service providers. This business model generates revenue either by contracting with local municipalities to provide ambulance services or operating on a fee-for-service basis, charging health plans or patients directly.

Today, private equity firms own two of the three largest emergency ambulance and air medical transport services, shifting the market toward greater emphasis on profit-making for emergency transportation services. A New York Times investigation into private equity investment in ambulances showed the impact that this ownership has on its billing behavior. At least one large ambulance provider ramped up its debt collection practices and filed hundreds of lawsuits against patients after it was acquired by a private equity firm. The investigation showed most publicly funded providers take a less aggressive stance or some don’t sue at all.

As a result of the decreased federal subsidies for community emergency services combined with the increased prevalence of privately owned, for-profit ambulance services, patient billing, with the potential for surprise billing, has become a standard practice.
How pervasive surprise billing impacts patients

The ground ambulance system is complex, with diverse ownership and business models. But many models consistently use surprise billing, which negatively impacts patient finances.

For most emergency situations, 9-1-1 dispatchers choose the ambulance provider based on its proximity to the scene and the severity of the patient’s injury. The problem of surprise billing arises because ground ambulances have the highest out-of-network billing rate of any medical specialty in the country.29

Because ambulances do not rely on patient choice or “shopping”, ground ambulance companies do not need to enter a network to gain access to patients.30 Their “guaranteed” patient flow eliminates the main incentive that other providers have to join an insurer’s network — gaining more patients.31

The net result is that because patients have little to no ability to choose their emergency transportation services, ambulance companies can charge what they want. Except in the few communities that offer free ambulance services, patients are responsible for the bills after services are rendered.

Government-funded insurance (Medicaid and Medicare) pays ambulances on a fee schedule. But for patients with private insurance, the companies bill the patient’s health

$129 million
Amount spent by patients for ambulance surprise bills annually
plan. Because there is no contracted rate of payment, the health plan pays only a share of the ambulance bill. Ambulance companies then send the remaining amount, the balance bill, to the patient. This bill is what is often called a surprise bill — the patient has no idea what they will be charged but they are financially responsible for it.

Many studies show surprise billing is prevalent across the United States. Findings include:

- 85.6% of encounters with ambulance services resulted in an out-of-network bill to the patient (national sample of privately insured patients between 2010-2016).[^32]
- 71% of ambulance rides involved potential surprise bills (study of one large national insurance plan using data from 2013 through 2017).[^33]
- 51% of ambulance rides included an out-of-network charge for which a patient may receive a surprise bill (study of people with large-employer coverage in 2019).[^34]

There can be a wide variance of surprise billing rates by region. In at least seven states, more than two-thirds of emergency ground transports could result in a balance bill.[^35] In three states, less than a quarter of ambulance rides included an out-of-network charge.[^36]

Surprise medical bills are not only common—they are expensive. A 2019 analysis found that the median cost to the patient for a surprise ground ambulance bill is $450, but can be much higher.[^37] Regional variation also exists in the average price of a surprise ground ambulance bill, ranging from $121 in Maryland to $1,209 in California.[^38] In three states — California, Massachusetts and Minnesota

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[^35]: "The emergency response bill says that there can be a wide variance of surprise billing rates by region. In at least seven states, more than two-thirds of emergency ground transports could result in a balance bill."
[^36]: "The emergency response bill says that in three states, less than a quarter of ambulance rides included an out-of-network charge."
[^37]: "The emergency response bill says that surprise medical bills are not only common—they are expensive. A 2019 analysis found that the median cost to the patient for a surprise ground ambulance bill is $450, but can be much higher."
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— the median surprise ground ambulance bill is more than $1,000.\textsuperscript{39}

These extra charges add up. Patients end up paying $129 million every year on surprise bills from ground ambulances.\textsuperscript{40}

To further exacerbate the problem, prices for emergency transportation services are increasing. The prices that providers charged health plans for advanced life support ambulance trips increased more than 22\% between 2017 and 2020, landing at an average of almost $1,300.\textsuperscript{41} Insurers have to pay at least a portion of that ambulance bill – a portion that is almost always more expensive than what the in-network rate would have been. And health plans are paying a much higher amount on those bills. Average payments by plans to ambulances increased 56\% between 2017 and 2020, from $486 to $758.\textsuperscript{42}

Higher payments by insurers means added costs for health plans which insurers can shift to patients through higher premiums, driving up consumer health spending.\textsuperscript{43} For example, some patients have co-insurance payments, meaning their co-pay is based on a percentage of a bill.

The impact of these higher prices puts consumers in financial jeopardy. In 2019, the Federal Reserve found that nearly 4 in 10 adults would have difficulty covering an emergency expense of $400 (even less than the median ambulance surprise bill of $450).\textsuperscript{44}

To be effective in addressing the cost impact of surprise medical bills, solutions must both protect the patient from surprise bills and be designed to hold charges down to prevent cost-shifting to patients in the form of higher co-insurance obligations and higher insurance premiums.
Federal No Surprises Act sets strong patient protections, but did not include ambulances

**IN JANUARY 2022, THE FEDERAL NO SURPRISES ACT** went into effect, protecting insured patients from surprise bills from out-of-network providers at in-network facilities, out-of-network emergency care and air ambulances. The new law, however, does not protect patients from surprise bills from ground ambulances.

The No Surprises Act did acknowledge that ground ambulance surprise bills were still a problem and called for the establishment of an Advisory Committee on Ground Ambulances and Patient Billing (“Advisory Committee”). The Advisory Committee is tasked with submitting “a report that includes recommendations with respect to disclosure of charges and fees for ground ambulance services and insurance coverage, consumer protection and enforcement authorities of the Departments of Labor, Health and Human Services, and the Treasury and State authorities, and the prevention of balance billing to consumers.” [Emphasis added.]
State-level consumer protections from ambulance surprise bills

PRIOR TO AND SINCE PASSAGE OF THE federal law, almost half of the states enacted surprise billing protections for consumers insured by state-regulated plans.\textsuperscript{47} And 10 of those states included ground ambulances in their prohibition of surprise out-of-network charges.\textsuperscript{48}

NOTE: These state laws can serve to protect only a small portion of their insured populations because approximately 60% of insured individuals receive their health insurance through employer-sponsored self-funded health plans. These self-funded plans are exempt from state regulation.\textsuperscript{49}

As the Advisory Committee devises its plan for federal ground ambulance policies, it should analyze the success of solutions implemented in these ten states with existing ground ambulance protections.

State laws protecting patients from ground ambulance surprise bills have two primary components, similar to those in the federal No Surprises Act. First, the patient-focused part of the laws protects patients from being obligated to pay out-of-network surprise ambulance bills. The second part focuses on how those out-of-network ambulances will be paid by the health plans insuring the patient. The analysis below is a compilation of the state research cited in Appendix A, which is found at the end of this report.

10 states have protections from ambulance surprise bills

COLORADO  DELAWARE  FLORIDA  ILLINOIS  MAINE  MARYLAND  NEW YORK  OHIO  VERMONT  WEST VIRGINIA
What does the patient owe?
Each of these states cap the amount patients pay for a ground ambulance ride at what they would have paid if the ambulance company was in their insurance network. As such, patients are “held harmless” to balance billing by out-of-network ground ambulance companies.

Most states have gone a step further by explicitly prohibiting out-of-network ground ambulances from sending patients a balance bill. By making it illegal for ambulances to send a bill to a patient for anything the insurance company doesn’t pay, these laws eliminate the burden on patients to identify unlawful out-of-network ambulance charges. When a state stops short of a ban on balance billing, and merely hold patients harmless from surprise bills, the onus is on the patient to identify those illegal charges if they are billed.

Which ambulances are covered by the surprise billing protections?
State laws do vary on which ambulance business models are subject to the surprise billing protections. For example, Maryland laws only apply to publicly owned ambulances while Colorado laws only apply to privately owned ambulances.
How are out-of-network ambulances paid?

The mechanism used to settle payment disputes between out-of-network providers and insurers can help generate cost-savings for consumers. Some states designed systems in a way to minimize the addition of excessive administrative costs and the goal of achieving payments that better reflected that of a competitive market. State surprise billing laws have utilized two ways of establishing the rate paid to out-of-network ambulances: a payment standard or an arbitration system.

**Using a payment standard or benchmark**

A payment standard sets a fixed amount that health plans pay to providers for ground ambulance rides. Each state, however, uses different techniques to set this fixed payment amount. For example, Colorado requires state-regulated insurers to pay 275% of Medicare rates for out-of-network ambulance transportation. Ohio’s law requires state-regulated insurance companies to pay providers whichever of the following rates is
the highest: the Medicare rate, the insurance plan’s out-of-network rate, or the median in-network rate for the service as negotiated with other providers in the region.\textsuperscript{51}

A payment standard essentially establishes an upper limit on what an insurance company will pay. It can result in two outcomes. First, if there is a ceiling to payments, and there is no ability to balance bill the patients, ground ambulances might no longer resist joining insurance networks.\textsuperscript{52} Setting a payment standard avoids the added costs of negotiation and arbitration.\textsuperscript{53}

The challenge to this approach, however, is establishing a reasonable payment standard on which to base ambulance services. States have looked to Medicare rates, billed charges, and in-network negotiated rates.\textsuperscript{54} There is a chance that using the median in-network rate (the basis of some payment standards) would lock in place the high costs of ambulance service.\textsuperscript{55}

Well-designed payment standards can ensure a speedy and fair payment system. Poorly designed standards could either result either in standardized over-payments reflecting a non-competitive market or under-payments causing the contraction of ground ambulance services. The challenge of policymakers is to strike a balance between these two poles.

Using an arbitration system

An arbitration system allows out-of-network ambulances and providers to negotiate for an appropriate payment. If the two parties cannot agree, then they can initiate arbitration, where an arbitrator decides what a fair price for the service is. Three of the 10 states with ground ambulance surprise billing protections — Delaware, Maine and West Virginia — use an arbitration system to determine payment disputes. Arbitration systems vary from state to state but state laws often define parameters for the arbitrator to consider when deciding what the final payment will be. For example, in Maine, arbiters may consider the median in-network rate for the service, the doctor’s experience, and if the provider was previously in the insurance company’s network.\textsuperscript{56}

One challenge with using an arbitration system to settle payment disputes is that each claim that is arbitrated adds administrative costs to the system.\textsuperscript{57} Both the provider and the insurer incur the costs of preparing for and going through the process. Another added cost is the arbitrator’s fee. Fixed fees for arbitrators in Texas range from $400-$4,750.\textsuperscript{58} These costs add up and may also be passed on to insured individuals through higher premiums.

If the arbiters are not given clear guidelines (such as a payment standard) to consider, individual arbitrators may come to very different decisions. Wide variations could make it more likely that providers will use arbitration more frequently in attempts to win outsized payment decisions. Alternatively, consistent arbitration decisions create an expectation for a payment amount in most situations and only outlier cases would be brought to arbitration, keeping those added costs out of the system. Well-designed arbitrator guidelines are essential to avoid these overuse of arbitration with their inherent costs.
Recommendations

**EMERGENCY TRANSPORTATION PLAYS AN important role in helping people get the health care they need in a timely manner.** Ground ambulances can save lives. But as in other parts of the health care system, prices for this emergency care are rising. Too often, insured patients find they are paying a large part of that cost out-of-pocket because the ambulance that provided their care did not belong to their health plan’s network.

The Advisory Committee on Ground Ambulances and Patient Billing is tasked with analyzing the data and recommending solutions to protect consumers from these expensive bills that they have no way to avoid. Here are suggestions for this committee to consider:

**Ban surprise billing from ground ambulances**

The best way to protect patients in all 50 states from ground ambulance surprise bills is through federal legislation. The No Surprises Act, in effect for less than one year, has already prevented providers from doling out more than 9 million surprise medical bills for many situations. But the unrestrained ground ambulance industry is still sending surprise bills to unprotected patients.

Congress should amend the No Surprises Act to include ground ambulances in the prohibition on surprise medical billing and limit patient expenses to in-network cost-sharing.

**Collect data to determine reasonable payments for ambulance services**

A key element of any surprise billing solution is to assure that payments made to out-of-network ambulances reflect the prices of a competitive market. Out-of-network ambulances should be paid using fair market prices to ensure ground ambulance services around the country can operate efficiently. The Advisory Committee needs to collect data which represents all elements of our complex ambulance services industry and quantify the costs to operate an efficient, cost-effective emergency transportation network. Data from multiple sources should be used to inform a comprehensive financial assessment from which to make recommendations for ambulance services payment standards. Sources might include information from the Centers for Medicare and Medicaid Services (CMS). In 2018, CMS was given the power to collect data from ambulance companies that had billed Medicare. In addition, the No Surprises Act requires providers and insurers to provide data to better explain air ambulance billing, charges and costs. Similar data should be collected from the ground ambulance industry.

The federal government should mandate data collection from plans, issuers and providers of ground ambulances relating to charges and billing, as well as medical and operational costs and profits, to provide a clear financial picture of the ground ambulance industry across the U.S.
Learn from state ambulance surprise billing protection laws
The Advisory Committee should study the impact of related state laws to determine the effectiveness of out-of-network payment dispute processes. Variations in the states’ approaches give sufficient indication of which systems encourage overuse of arbitration and result in inflated payments; both outcomes add unnecessary costs to the overall health care system.

Establish a clear benchmark payment standard rate for ambulance services sufficient to support operations. Those rates should be determined through analysis of data on costs, not billed charges. If arbitration is considered, tight guardrails should be established to ensure consistent, predictable payments that reflect fair market prices.
The Road Forward

**SURPRISE BILLS HAVE BURDENED AMERICANS** for too long, adding financial stress at times when individuals are struggling with serious health challenges. The No Surprises Act offers a fix that was long overdue. Now, state and federal decision makers have the chance to take an additional step to protect consumers from ground ambulances — the missing link for comprehensive protection of surprise medical bills.

Ten states have proven that consumer protection is not only possible but necessary. Each year, 3 million insured people use ground ambulances. Half of them will be exposed to an expensive out-of-network medical bill they had no way to avoid. We must implement a solution to this problem while still supporting the ground ambulance industry that saves lives every day.

*Credit: camilo jimenez/Unsplash*
Appendix A

TEN STATES HAVE ADOPTED POLICIES TO protect consumers from ambulance surprise bills.

NOTE: These state laws can serve to protect only a small portion of their insured populations because approximately 60% of insured individuals receive their health insurance through employer-sponsored self-funded health plans. These self-funded plans are exempt from state regulation.62

Colorado63,64
- **Exemptions:** Taxpayer-funded ambulance providers.*
- **Consumer Protections:** Bans balance billing
- **Resolution of provider-insurer payment disputes:** Payment standard.
  - Health plans must reimburse out-of-network ground ambulances at 275% of Medicare rates.65

*Private ambulance providers may also be exempt if they have a contract with a municipal authority. In those cases, the terms of that contract take precedence over state law.

Delaware66,67
- **Exemptions:** Volunteer fire departments,68 Non-emergency ambulance rides.
- **Consumer Protections:** Bans balance billing
- **Resolution of provider-insurer payment disputes:** Arbitration.
  - **Factors:** Arbitrator can consider amounts within a prescribed range in the law. The range for payment depends on whether the ambulance had previously been part of the plan’s network. For ambulances which were previously in-network with that insurer, the range is between the highest in-network charge allowed during its most recent participation in-network and the highest charge paid to that out-of-network ambulance by any health plan. For ambulances that have never been in-network with that carrier, the allowable range is between the highest charge allowed by the carrier for any other network or non-network emergency care provider during the previous 12 months and the highest charge paid to that out-of-network ambulance by any health plan.
Florida\textsuperscript{69,70}

- **Exemptions:** None, law applies to both public and private providers.

- **Consumer Protections:** Bans balance billing

- **Resolution of provider-insurer payment disputes:** Arbitration.

  - **Factors:** Arbiters can consider the lesser of these three amounts: what the provider charges, the “usual charge” for a similar service in that region, or a mutually-agreed-upon charge.\textsuperscript{71}

Illinois\textsuperscript{72,73}

- **Exemptions:** None, law applies to both public and private providers

- **Consumer Protections:** Bans balance billing

- **Resolution of provider-insurer payment disputes:** Arbitration.

  - **Factors:** 2022 amendments of Illinois state law specifically state that the arbitrator should give the qualifying payment amount (QPA) (defined as median in-network rate in that geographic area) a rebuttable presumption when deciding the total amount owed to the provider.\textsuperscript{74}

Maine\textsuperscript{75,76}

- **Exemptions:** Non-emergency ambulance rides

- **Consumer Protections:** Bans balance billing

- **Resolution of provider-insurer payment disputes:** Arbitration. Through 2023, must reimburse at provider rate or 180% of Medicare rates.\textsuperscript{77}

  - **Factors:** Provider experience, previously contracted rate, median in-network rate\textsuperscript{78}

Maryland\textsuperscript{79,80}

- **Exemptions:** Private ambulance services, unless it has a contract with a municipal authority.

- **Consumer Protections:** Bans balance billing

New York\textsuperscript{81,82}

- **Exemptions:** Interfacility transportation (non-emergency)

- **Consumer Protections:** Bans balance billing

- **Resolution of provider-insurer payment disputes:** Payment standard: Insurers must pay the out-of-network ambulance based on “usual and customary rate, which cannot be excessive or unreasonable.”\textsuperscript{83}

Ohio\textsuperscript{84,85}

- **Exemptions:** Non-emergency ambulance rides.

- **Consumer Protections:** Bans balance billing

- **Resolution of provider-insurer payment disputes:** Payment standard: Health plans must reimburse out-of-network ground ambulances at whichever of the following is highest: median in-network rate, out-of-network rate based on “usual, customary and reasonable amount” or the Medicare rate.\textsuperscript{86}

Vermont\textsuperscript{87,88}

- **Exemptions:** Non-emergency ambulance rides

- **Consumer Protections:** Holds patients harmless

- **Resolution of provider-insurer payment disputes:** None

- **Factors:** Some Vermont ACOs may participate in the state’s All-Payer Rate Setting system.\textsuperscript{89}
West Virginia\textsuperscript{90,91}

- **Exemptions**: Non-emergency ambulance rides

- **Consumer Protections**: Holds patients harmless

- **Resolution of provider-insurer payment disputes**: \textbf{Arbitration} using No Surprises Act system.
Notes


2 See note 1.


5 See note 1.


7 California, Massachusetts, Minnesota. See note 6, appendix 8.

8 See note 6.


10 See note 9.


12 See note 1.

13 See note 1.


15 See note 6.


19 See note 14.


21 See note 20.

22 See note 14, p. 756.

23 See note 1.

24 See note 1.

25 See note 14, p. 754.

26 See note 14, p. 756.


See note 14, p. 1916.


Alabama, Indiana, Kentucky. See note 1.

In California, the median cost is $1209. In Minnesota, the median cost is $1,133. In Massachusetts, the median cost is $1024. See note 6, appendix 8.


See note 41.


62 See note 11.


67 See note 64.


70 See note 64.


73 See note 64.

74 See note 72.


76 See note 64.


80 See note 64.

81 See note 64.

82 See note 68.

83 Ohio Code Sec. 3902.50 et seq., 30 September 2021, accessible at https://codes.ohio.gov/ohio-revised-code/section-3902.50.


85 See note 64.

86 See note 64.


88 See note 64.


91 See note 64.