AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 207
(A-23)

Introduced by: Medical Student Section

Subject: Ground Ambulance Services and Surprise Billing

Referred to: Reference Committee B

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1 Whereas, Emergency Medical Services (EMS) and ground ambulance services play a critical
2 role in the network of healthcare in each community[1]; and
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4 Whereas, People insured under Medicare or Medicaid are not at risk for surprise billing[2]; and
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6 Whereas, Ten percent of emergency room visits for privately insured individuals require an
7 ambulance ride to the hospital[3]; and
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9 Whereas, Anywhere from 71-86% of ground ambulance rides involve potential surprise bills with
10 patients being charged an aggregate of $129 million per year due to out-of-network charges[1,4];
11 and
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13 Whereas, 39% of Americans would struggle to cover an unexpected expense of just $400[5]; and
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15 Whereas, Eight percent of all medical debt stems from ambulance charges[6]; and
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17 Whereas, Medical debt disproportionately impacts poor and minority communities, with 80% of
18 medical debt being held by households with zero or negative net worth, and 27% of Black
19 households holding medical debt compared to only 17% of non-black households[7]; and
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21 Whereas, EMS and ambulance service reimbursement from governmental sources is inadequate
22 and subject to significant year-to-year fluctuations[4]; and
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24 Whereas, Patients bear a disproportionate and unintentional financial burden due to out-of-
25 network ambulance service charges[8]; and
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27 Whereas, Financial concerns have been linked to reduced utilization of ground ambulance
28 services, increasing risk of morbidity and mortality[9]; and
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30 Whereas, Low-income patients are 160% more likely to utilize emergency medical services when
31 cost concerns are eliminated[10]; and
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33 Whereas, Only Colorado, Delaware, Florida, Illinois, Maine, Maryland, New York, Ohio, Vermont,
34 West Virginia have protections against ground ambulance surprise billing[11]; and
35
36 Whereas, The No Surprises Act supplements existing state surprise billing laws to protect patients
37 from receiving surprise medical bills by requiring private health plans to cover eligible out-of-
38 network costs, and by prohibiting covered healthcare providers from billing more than the in-
39 network cost-sharing amount[12-14]; and

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Whereas, The No Surprises Act called for the creation of a “Ground Ambulance and Patient Billing” advisory committee in January 2022 to develop recommendations on how to address surprise billing in the context of ground ambulance services, but has neither chosen representing members nor published a meeting date[11,15]; and

Whereas, The No Surprises Act addresses air ambulance services by including “medical transport by helicopter” and “medical transport by airplane”, but does not include ground ambulance services[16-17]; therefore be it

RESOLVED, That our American Medical Association oppose surprise billing practices for ground ambulance services. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 3/27/23

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RELEVANT AMA POLICY

Out-of-Network Care H-285.904
1. Our AMA adopts the following principles related to unanticipated out-of-network care:
A. Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider.
B. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. State regulators should enforce such standards through active regulation of health insurance company plans.
C. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur.
D. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians.
E. Patients who are seeking emergency care should be protected under the "prudent layperson" legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.
F. Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company.
G. Minimum coverage standards for unanticipated out-of-network services should be identified. Minimum coverage standards should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization.
H. Independent Dispute Resolution (IDR) should be allowed in all circumstances as an option or alternative to come to payment resolution between insurers and physicians.
2. Our AMA will advocate for the principles delineated in Policy H-285.904 for all health plans, including ERISA plans.
3. Our AMA will advocate that any legislation addressing surprise out of network medical bills use an independent, non-conflicted database of commercial charges.
Citation: Res. 108, A-17; Reaffirmation: A-18; Appended: Res. 104, A-18; Reaffirmed in lieu of: Res. 225, I-18; Reaffirmation: A-19; Reaffirmed: Res. 210, A-19; Appended: Res. 211, A-19; Reaffirmed: CMS Rep. 5, A-21; Modified: Res. 236, A-22;

Billing Procedures for Emergency Care H-130.978
(1) Our AMA urges physicians rendering emergency care to ensure that the services they provide are accurately and completely described and coded on the appropriate claim forms. (2) In the interest of high quality care, patients who seek medical attention on an emergency basis should have the benefit of an immediate evaluation of any indicated diagnostic studies. The physician who provides such evaluation is entitled to adequate compensation for his or her services. When such evaluations are provided as an integral part of and in conjunction with other routine services rendered by the emergency physician, ideally an inclusive charge, commensurate with the services provided, should be made. Where the carrier collapses or eliminates CPT-4 coding for payment purposes, the physician may be left with no realistic alternative other than to itemize. Such an itemized bill should not be higher than the amount which would be paid if the appropriate inclusive charge were recognized. The interpretation of diagnostic procedures by a consulting specialist, as a separate and independent service provided the emergency patient, is equally important to good patient care. Physicians who provide such interpretations are also entitled to adequate compensation for their services. (3) Our AMA encourages state and local organizations representing the specialty of emergency medicine to work with both private and public payers in their area to implement payment practices and coding procedures which assure that payment to physicians rendering emergency care adequately reflects the extent of services provided.
Citation: (CMS Rep. J, I-86; Reaffirmed by Res. 118, I-95; Reaffirmation A-00; Reaffirmed: BOT Rep. 6, I-01; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed in lieu of Res. 808, I-15

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Advocacy Efforts to Persuade All Health Payers to Pay for EMTALA-Mandated Services D-130.975
Our AMA will incorporate into any existing or future legislative efforts regarding EMTALA and/or balance billing, language which would require all insurers to assign payments directly to any health care provider who has provided EMTALA-mandated emergency care, regardless of in-network and out-of-network status.
Citation: BOT Rep. 2, I-05; Reaffirmation A-07; Reaffirmed: CMS Rep. 01, A-17;

Balance Billing for All Physicians D-380.996
1. Our AMA will devote the necessary political and financial resources to introduce national legislation at the appropriate time to bring about implementation of Medicare balance billing and to introduce legislation to end the budget neutral restrictions inherent in the current Medicare physician payment structure that interferes with patient access to care.
2. This national legislation will be designed to pre-empt state laws that prohibit balance billing and prohibit inappropriate inclusion of balance billing bans in insurance-physician contracts.
3. Our AMA will develop model language for physicians to incorporate into any insurance contracts that attempt to restrict a physician's right to balance bill any insured patient.
4. Our AMA Board of Trustees will report back to our AMA House of Delegates electronically by March 15, 2008 and at every HOD meeting its progress toward the completion of all of these goals.
Citation: Res. 925, I-07; Reaffirmed: BOT Rep. 22, A-17;

Medicare Balance Billing D-390.986
Our American Medical Association: (1) advocate that physicians be allowed to balance bill Medicare recipients to the full amount of their normal charge with the patient responsible for the difference between the Medicare payment and the physician charges; (2) seek introduction of national legislation to bring about implementation of balance billing of Medicare recipients; and (3) further advocate that such federal laws and regulations pre-empt state laws that prohibit balance billing.
Citation: Res. 713, I-02; Reaffirmation A-04; Reaffirmation A-06; Reaffirmed per BOT Action in response to referred for decision Res. 236, A-06; Reaffirmed: CMS Rep. 5, I-12; Reaffirmed: BOT Rep. 9, A-22;

Balance Billing H-385.991
Our AMA supports the right of the physician to balance bill a patient for any care given, regardless of method of payment, where permissible by law or contractual agreement.
Citation: Sub. Res. 128, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: Sub. Res. 704, A-01; Reaffirmation A-04; Reaffirmation A-05; Reaffirmation A-06; Reaffirmed per BOT Action in response to referred for decision Res. 236, A-06; Reaffirmed: CMS Rep. 01, A-16;

Freedom of Choice H-390.854
(1) The AMA will seek appropriate cases to challenge the legality and constitutionality of Medicare restrictions on non-participating physicians' medical practice and on patient freedom of choice by such mechanisms as limitations on balance billing and prohibitions on private "opt out" arrangements between physicians and patients. (2) The AMA will strongly resist such restrictions being extended to other payers in national health care reform legislation.
Citation: Res. 117, I-92; Reaffirmed: CMS Rep. 10, A-03; Renumbered: CMS Rep. 7, I-05; Reaffirmation A-06; Reaffirmed: CMS Rep. 01, A-16;

Medicare's Ambulance Service Regulations H-240.978
1. Our AMA supports changes in Medicare regulations governing ambulance service coverage guidelines that would expand the term "appropriate facility" to allow full payment for transport to the most appropriate facility based on the patients needs and the determination made by physician medical direction; and expand the list of eligible transport locations from the current three sites of care (nearest hospital, critical access hospital, or skilled nursing facility) based upon the onsite evaluation and physician medical direction.
2. Our AMA will work with the Centers for Medicare & Medicaid Services (CMS) to pay emergency medical services providers for the evaluation and transport of patients to the most appropriate site of care not limited to the current CMS defined transport locations.
Citation: Res. 37, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08; Modified: Res. 124, A-17;

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