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TAKING ADVANTAGE OF PATIENTS IN AN EMERGENCY:
ADDRESSING EXORBITANT AND UNEXPECTED
AMBULANCE BILLS

GEORGE A. NATION III*

I. INTRODUCTION

IMAGINE for a moment that you are working-out at a health club, doing some weightlifting or some cardio. After your workout, you take a shower. You are tired, the locker room was very hot, and by the time you get out front near the entrance to the club, you are feeling lightheaded and pass out. A bystander quickly calls 911 and reports the apparent emergency, and the 911-dispatcher contacts the nearest, or often the only, emergency ambulance service.¹ Minutes later an ambulance arrives staffed by two emergency medical technicians (EMTs).² You are taken three miles to the to the nearest emergency room. How much should you be required to pay for the emergency ambulance service you received but did not contract for?³ The focus of this Article is on developing an appropriate method to answer that question.⁴

The ambulance that took you to the hospital may have been provided by a private for-profit company; a nonprofit such as the local acute care hospital; a public provider, such as the fire department or a separate mu-

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1. See, e.g., Lisa Zamosky, *Who Pays for the Ambulance?*, L.A. TIMES (Aug. 23, 2013), <http://articles.latimes.com/2013/aug/23/business/la-fi-healthcare-watch-20130825> [<https://perma.cc/N4YS-TTKE>] (“In Los Angeles and in many parts of the country, emergency ambulance services—those that show up following a call to 911—don’t hold contracts with insurance companies, so there’s no point worrying about whether you’re being picked up by an in-network provider.”).

2. See *infra* notes 30–81 and accompanying text.

3. See, e.g., Chris Coffey, *Ambulance Rides Leave Patients with Sticker Shock*, NBC 5 CHI. (Apr. 9, 2014), <http://www.nbcchicago.com/investigations/Ambulance-Rides-Leaving-Patients-With-Sticker-Shock-254661651.html> [<https://perma.cc/7LDF-N4HA>] (“The police won’t send you a bill for their help. Firefighters don’t charge you to extinguish flames. After all, those services are covered by property taxes. But most municipalities in greater Chicago *will* charge you for emergency transports. Ambulance fees range between \$365 and \$2,500, depending on the level of care and other factors such as mileage . . .”).

4. The focus of this Article is on emergency ground ambulance transportation; however, the issues discussed here are very similar to those involved in emergency air ambulance transportation and, more broadly, emergency medical treatment of any type. The predominant characteristic in all of these situations is the presence of an emergency, which precludes the ability of the patient to contract for the medical services that they need. As a result, the recommendations included here, while focused specifically on addressing the problems associated with emergency ground ambulance transportation, also serve as a good template for addressing similar problems that arise with respect to emergency air ambulance transportation and emergency medical care in general.

nicipal emergency medical services (EMS) provider; or by a volunteer ambulance company.⁵ The bill you receive for the ambulance service could be anywhere from \$0 to over \$2,500 depending on the identity of the organization that provided the emergency ambulance service.⁶ For example, some volunteer ambulance services and a few municipal providers do not charge at all for their service. However, many fire departments that do not charge for sending a fire truck do charge for sending an ambulance and providing emergency services.⁷ The rates charged by ambulance service providers, just like the prices charged by hospitals, vary widely from one provider to another.⁸ In addition, unpaid ambulance bills, like hospital bills, are sometimes sent quickly to collections even while the patient is trying to appeal the amount of the bill, and this can result in people having their credit ruined as a result of an exorbitant ambulance bill.⁹

Moreover, in the case of emergency services, the patient is often unconscious or otherwise incapacitated due to the medical emergency and therefore unable to agree or to negotiate for the EMS service received.¹⁰ As a result, patients are in a very vulnerable position when it comes to receiving emergency ambulance service.¹¹ EMS service is something that

5. See *infra* notes 60–81 and accompanying text.

6. See Coffey, *supra* note 3. In the case of emergency air ambulance services, the bills are much higher, often in the range of \$50,000–\$100,000. See, e.g., Corin Cates-Carney, *When the Only Ambulance Is a Helicopter*, ATLANTIC (Jan. 22, 2016), <http://www.theatlantic.com/health/archive/2016/01/air-ambulance-helicopter-cost/425061/> [<https://perma.cc/8JNQ-9UKS>] (noting that in case discussed in article, trip from Butte, Montana, to Seattle, Washington, had full charge price of \$69,000, of which patient's insurance company paid \$13,000 originally and then after negotiation agreed to pay additional \$30,000 and provider agreed to waive \$26,000 of original charge). Of course, in the case of emergency medical care in general, the bills are much higher.

7. See *infra* notes 48–51 and accompanying text.

8. See, e.g., Curtis Gilbert, *Ride to the Hospital Now, Pay Later—and Pay and Pay*, MPRNEWS (Mar. 9, 2015), <https://www.mprnews.org/story/2015/03/09/ambulance-fees> [<https://perma.cc/2A8D-R8X5>] (citing survey conducted by Minnesota Ambulance Association that found fees ranging from \$450 to about \$1,900 for basic life support (lowest level of emergency services) in 2012). The article notes that just like hospital list prices, these ambulance fees are often subject to deep discounts. See *id.*

9. See Zamosky, *supra* note 1 (noting that ambulance bills are sent to collections and that some people have their credit ruined even though insurance ultimately pays bill).

10. See, e.g., Alex Medearis, *The Wild West of Ambulance Charges*, PRICEECONOMICS (Dec. 9, 2013), <https://priceeconomics.com/the-wild-west-of-ambulance-charges/> [<https://perma.cc/YWN8-95M>] (“When people need an ambulance, they’re usually not thinking about in-network benefits. In emergencies, the decision may be out of the patient’s control if a bystander calls 911 or if he or she is unconscious. And even when a patient is cost-conscious, there may be only one local provider or the decision may be made by the dispatch system. As the costs of America’s patchwork system vary dramatically, whether a patient receives a manageable bill or a crippling one is ultimately a matter of chance.”).

11. See *id.*

may save a patient's life, but it is also something that may cause financial hardship or ruin.¹² Moreover, emergency ambulance service is also something over which the patient usually has very little or no control.¹³

What makes the current situation intolerable is that many ambulance service providers take advantage of the situation by charging patients grossly inflated fees for their services.¹⁴ As noted, rates for ambulance service at the basic level, referred to as basic life support (BLS), can range from less than \$200 to over \$2,000, and rates for advanced life support (ALS) are higher.¹⁵ This situation is made even worse by the fact that many patients are caught in the middle of billing disputes between insurance companies and emergency service providers. This occurs for two reasons. First, most insurers, both public and private, pay only a small portion of the unreasonably high amount demanded by most ambulance service providers.¹⁶ Second, many emergency ambulance providers refuse to enter into contracts with insurers. As a result, the vast majority of patients are considered "out-of-network" (OON) and are therefore responsible to pay the balance of the bill, which is the difference between the amount reimbursed by the insurer and the amount charged by the service provider.¹⁷ Finally, many ambulance services have either an express or a de facto monopoly.¹⁸ That is, many communities have only one emer-

12. *See id.*

13. *See id.*

14. *See Coffey, supra* note 3 (noting fees ranging from \$365 to \$2,500).

15. *See id.*

16. *See infra* notes 198–228 and accompanying text.

17. *See infra* notes 197–228 and accompanying text for discussion on how insurance coverage for ambulance services works much the same way as for hospital and other medical care. That is, if the patient receives service from an in-network provider, then the patient only owes any deductible, co-pay, and coinsurance amount to the provider. However, if the provider is out-of-network, then the patient is liable to pay the difference between the discounted amount paid by the patient's insurance company and the full charge of the provider. Because many ambulance providers, like many hospitals, set their list prices at exorbitant levels, the balance is substantial. The practice of health care providers suing insured but out-of-network patients for the amount of the providers' full charge that was not paid by the patient's insurance company is known as balance billing. *See* Mary Ann Roser, *Even with Insurance, That EMS Bill Could Cause Sticker Shock*, AUSTIN AM-STATESMEN (Apr. 13, 2014), <https://insuranceneutral.com/oarticle/Even-with-insurance-that-ems-bill-could-cause-sticker-shock-a-489364> [<https://perma.cc/VP3H-PRWG>] (“When you call 911, you get no say in who shows up,” said Stacey Pogue, a senior policy analyst with the Austin-based Center for Public Policy Priorities. “That scenario is exactly why you need protection in an emergency. You have a 100 percent chance in Austin of getting an out-of-network ambulance ride. I think that would be somewhat shocking to a consumer. Balance billing can be crippling for families.”)

18. *See, e.g.,* Michelle Andrews, *Out-of-Network Ambulance Rides Can Bring Out-of-Pocket Expenses*, KAISER HEALTH NEWS (June 14, 2011), <http://khn.org/news/michelle-andrews-on-ambulance-fees/> [<https://perma.cc/L4RS-SG4Q>] (noting that there are no in-network ambulance services in Santa Cruz County where patient being discussed lived, and noting further this patient's experience is not unusual); Ashlee Kieler, *\$164 Per Mile: Surprise Ambulance Bills Are a Growing Problem and*

gency ambulance service that has been granted exclusive status by the local government.¹⁹ This means that if the exclusive emergency ambulance service provider is not in-network with the patient's insurance company (some ambulance providers refuse to go in-network with any insurers), then even patients with knowledge and ability (most patients have neither) cannot arrange for in-network service and are stuck with an enormous bill that they had absolutely no control over incurring.

Legally, emergency ambulance service providers base their claims for payment on quasi-contract and the legal doctrine known as the emergency exception.²⁰ The law recognizes through the equitable doctrine of quasi-contract that where emergency medical services are provided to a patient, the patient becomes responsible to pay the fair value of the services received even though the patient did not agree to pay for the services.²¹ In this context, the law makes the usually reasonable assumption that a patient in need of emergency care would, if the patient were able, agree to pay the reasonable value of such care in order to receive the necessary care.²² In addition, this doctrine encourages physicians and other health care providers to render services to such patients, confident that they will receive reasonable compensation for the services they provide.²³

The problem is that traditionally, courts have determined reasonable value by looking at the usual and customary charges of the provider.²⁴ In the hospital billing context, courts are beginning to recognize that there is a big difference between usual and customary charges and the usual and customary amount that providers actually get paid, and agree to accept as full payment, for their services. The same is true in the context of charges for emergency ambulance services.²⁵ The amounts billed by many provid-

Difficult to Avoid, CONSUMERIST (Feb. 22, 2016), <https://consumerist.com/2016/02/22/164-per-mile-surprise-ambulance-bills-are-a-growing-problem-difficult-to-avoid/> [<https://perma.cc/4FBY-TAJS>] (“[S]ome insurance companies believe ambulance providers choose *not* to contract with insurers because they wouldn’t be able to recoup as much for their services as they can when they bill patients as out-of-network providers.”).

19. *See, e.g.*, Roser, *supra* note 17 (noting “Austin-Travis County Emergency Medical Services is the exclusive emergency ambulance provider in the county” and is not in-network with any insurers because it is partially publicly funded.).

20. *See infra* notes 82–124 and accompanying text.

21. *See infra* notes 86–89 and accompanying text.

22. *See infra* notes 84–86 and accompanying text.

23. *See infra* notes 90–91 and accompanying text.

24. *See infra* notes 92–96 and accompanying text.

25. *See, e.g.*, Howell v. Hamilton Meats & Provisions, Inc., 257 P.3d 1130, 1137 (Cal. 2011) (citing *Malone v. Sierra Ry. Co. of Cal.*, 91 P. 522, 523 (Cal. 1907)) (explaining medical expenses actually paid by or on behalf of patient, not billed charges based on chargemaster rates, is proper measure of medical expenses); *Greenfield v. Manor Care, Inc.*, 705 So. 2d 926, 929 (Fla. Dist. Ct. App. 1997) (holding healthcare agreement to have implied covenant to charge reasonable fee); *Payne v. Humana Hosp. Orange Park*, 661 So. 2d 1239, 1241 (Fla. Dist. Ct. App. 1995) (“A patient may not be bound by unreasonable charges in an agree-

ers are exorbitant and far in excess of what is reasonable based either on costs or usual reimbursements.²⁶ Many emergency ambulance service providers, like many hospitals, charge outrageously inflated prices simply because they can, due to the vulnerable position of patients and the failure of competition to rein in pricing.²⁷ Charging exorbitant amounts for

ment to pay charges in accordance with ‘standard and current rates.’” (quoting *Mercy Hosp. v. Carr*, 297 So. 2d 598, 599 (Fla. Dist. Ct. App. 1974)); *Victory Mem’l Hosp. v. Rice*, 493 N.E.2d 117, 120 (Ill. App. Ct. 1986) (permitting jury question as to whether charges presented by hospital were reasonable); *Butler v. Ind. Dep’t of Ins.*, 904 N.E.2d 198, 202 (Ind. 2009) (explaining medical expenses actually paid by or on behalf of patient, not billed charges based on chargemaster rates, is proper measure of medical expenses); *In re N.J.A.C.*, 979 A.2d 770, 784–85 (N.J. Super. Ct. App. Div. 2009) (presuming regulation of physician fee schedule was reasonable and valid); *Kastick v. U-Haul Co. of W. Mich.*, 292 A.D.2d 797, 798–99 (N.Y. App. Div. 2002) (agreeing with defendants that plaintiff could not recover damages in amount she was never obligated to pay for medical services); *Nassau Anesthesia Assocs. P.C. v. Chin*, 924 N.Y.S.2d 252, 254 (N.Y. Dist. Ct. 2011) (citing *Temple Univ. Hosp. v. Healthcare Mgmt. Alts. Inc.*, 832 A.2d 501, 508–10 (Pa. Super. Ct. 2003)) (agreeing reasonable value of medical services is average amount that provider would have accepted as full payment from third-party payers such as private insurers and federal healthcare programs); *Moorhead v. Crozer Chester Med. Ctr.*, 765 A.2d 786, 789 (Pa. 2001) (holding patient’s recovery for medical expenses in malpractice suit was limited to amount paid and accepted for services, rather than fair and reasonable market value of services), *abrogated by* *Northbrook Life Ins. Co. v. Pennsylvania*, 949 A.2d 333, 337 (Pa. 2008); *Temple Univ. Hosp. v. Healthcare Mgmt. Alts., Inc.*, 832 A.2d 501, 510 (Pa. Super. Ct. 2003) (stating that chargemaster rate “bears no relationship to the amount typically paid for those services”); *Doe v. HCA Health Servs. of Tenn., Inc.*, 46 S.W.3d 191, 198–99 (Tenn. 2001) (affirming lower court holding that patient was obligated to pay reasonable charges for medical services and fair value of goods furnished); *Haygood v. De Escabedo*, 356 S.W.3d 390, 397 (Tex. 2011) (explaining medical expenses actually paid by or on behalf of patient, not billed charges based on chargemaster rates, is proper measure of medical expenses); *Daughters of Charity Health Servs. of Waco v. Linnstaedter*, 226 S.W.3d 409, 411 (Tex. 2007) (finding chargemaster prices are *not* value of medical services in context of hospital lien statute); *cf. Holland v. Trinity Health Care Corp.*, 791 N.W.2d 724, 728 (Mich. Ct. App. 2010) (finding chargemaster rates are “usual and customary”).

26. *See, e.g., Andrews, supra* note 18 (“In Massachusetts, [Blue Cross Blue Shield] says that getting more private EMS providers into its network would reduce costs. ‘This . . . is really about whether individuals, families and employers should pay 80 to 100 million dollars a year because private out-of-network ambulance companies are allowed to charge rates that are three to five times above what Medicare pays them for the very same service,’ says Jay McQuaide, senior vice president of corporate communications for BCBS of Massachusetts.”).

27. *See, e.g., Roser, supra* note 17 (quoting Stacey Pogue, senior policy analyst with Austin-based Center for Public Policy Priorities: “Balance Billing [for emergency ambulance service] can be crippling for families”). Also, when communities grant exclusive EMS rights to providers, prices and balance billing amounts go up. *See id.* (“Negotiated rates for medical care generally entitle private insurance companies to a substantial cut in cost. But EMS providers have no incentive to negotiate discounted rates with insurers, said Douglas Hooten, president of the Texas EMS Alliance and of the Coalition of Advanced Emergency Medical Systems. That’s especially true when there are no other 911 competitors in a community.”). With respect to similar issues in the context of hospital and doctor medical bills, see generally George A. Nation III, *Determining the Fair and Reasonable Value of Medi-*

emergency ambulance services is unfair to all patients and results in significant financial hardship for many.

This Article develops a process for determining the fair and reasonable value of emergency ambulance services.²⁸ It is important to expressly state right at the outset that the only thing worse than being charged an exorbitant rate for ambulance service is having no ambulance services available. Ambulance services are extremely important, and great strides have been made in trauma care and pre-hospital care.²⁹ These critical services cost money and must be paid for. However, that is not an excuse for overcharging individual patients. Part II provides a brief overview and history of ambulance service in the United States. Part III provides an analysis of patients' legal obligation to pay for emergency ambulance services. Part IV discusses a process for determining the fair and reasonable amount that patients should be required to pay. Part V provides recommendations for protecting patients from surprise medical bills for emergency ambulance services. Part VI concludes.

II. BACKGROUND: THE EMS PROBLEM

While some form of ambulance transportation has existed since ancient times, the development and success of cardiopulmonary resuscitation (CPR) in the late 1950s and early 1960s demonstrated that rapid response of trained individuals could save lives.³⁰ The turning point in the United States from mere transportation to pre-hospital EMS and trauma care came in the wake of a report published in 1966 titled, *Accidental Death and Disability: The Neglected Disease of Modern Society*.³¹ This report, commonly referred to as *The White Paper*, was prepared by the Committee on Trauma and the Committee on Shock of the National Academy of Sciences and published by the National Research Council.³² This report concluded that the United States was "insensitive to the magnitude of the problem of accidental death and injury."³³ The report noted the following problems: inter alia, most ambulances were inappropriately designed,

cal Services: The Affordable Care Act, Government Insurers, Private Insurers and Uninsured Patients, 65 BAYLOR L. REV. 425 (2013) [hereinafter Nation, *Determining*]; George A. Nation III, *Healthcare and the Balance-Billing Problem: The Solution Is the Common Law of Contracts and Strengthening the Free Market for Healthcare*, 61 VILL. L. REV. 153 (2016) [hereinafter Nation, *The Balance-Billing Problem*]; George A. Nation III, *Hospital Chargemaster Insanity: Heeling the Healers*, 43 PEPP. L. REV. 745 (2016) [hereinafter Nation, *Chargemaster Insanity*].

28. See *infra* notes 125–271 and accompanying text.

29. See *infra* notes 30–81 and accompanying text.

30. See RYAN CORBETT BELL, *THE AMBULANCE: A HISTORY* 228 (2009) (“[I]nnovations in trauma care produced by two world wars convinced medical profession that there were real gains in life-saving to be made . . .”).

31. See *id.* at 249 (discussing this report).

32. See *id.*

33. See *id.* at 250.

ill-equipped, and staffed with inadequately trained personnel.³⁴ For example, morticians were providing 50% of the nation's ambulance services.³⁵ In most communities, morticians had the only vehicles designed to transport someone lying down. The report led to the design and implementation of the first federally qualified ambulance services and personnel.³⁶

The report recommended, *inter alia*, the state-level adoption of general policies and regulations for ambulance services and the adoption at the district, county, and municipal levels of ways and means of providing ambulance service applicable to local conditions.³⁷ This history explains part of the reason why we have a patchwork of EMS systems across the United States.³⁸ The other part of the reason has to do with funding, or more precisely the lack thereof. Some initial uniformity was established as a result of the passage of the Highway Safety Act of 1966, which created the Department of Transportation (DOT).³⁹ The DOT was given authority over EMS and was charged with improving services by developing and implementing standards with regard to provider training.⁴⁰ States developed regional EMS systems and the Highway Safety Program paid for the costs.⁴¹ Over the next twelve years, the DOT spent more than \$142 million on EMS system development.⁴²

Through the 1970s, additional public funds were allocated to the development of state-level EMS systems.⁴³ In 1973, Title XII to the Public Health Services Act, the Emergency Medical Services Systems Act of 1973 (EMS Act), provided an additional \$300 million of funding for development of regional EMS systems.⁴⁴ By 1978, 304 EMS regions had been identified, and the EMS Act identified various components that each system should have.⁴⁵

However, funding under the EMS Act essentially ended in 1981 with the passage of the Omnibus Budget Reconciliation Act of 1981.⁴⁶ This law consolidated EMS funding into preventative health and health services block grants. As a result, states gained greater flexibility and discretion in

34. *See id.*

35. *See id.* at 246–49.

36. *See id.* at 250.

37. *See id.* at 250–54.

38. *See id.*; *see also id.* at 227–42 (discussing fragmentation of ambulance services leasing during Cold War and outrage of highway deaths).

39. *See id.* at 246.

40. *See* S. REP. NO. 89-1302 (1966); CONF. REP. 89-1920, at 1 (1966) (Conf. Rep.); S. REP. NO. 89-1302, at 1–2.

41. *See supra* note 40.

42. *See* Robert R. Bass, *History of EMS*, in EMERGENCY MEDICAL OVERSIGHT: CLINICAL PRACTICE AND SYSTEMS OVERSIGHT 3 (David C. Cone et al. eds., 2015).

43. *See id.*

44. *See id.* at 4.

45. *See id.* at 5.

46. *See id.* at 9.

funding state EMS activities and regional EMS systems.⁴⁷ Due to a lack of funding that resulted from this law, many of the regional EMS management entities established by federal funding ceased to operate.⁴⁸

Both federal and state public funding for EMS systems remain sporadic. For example, while most fire-related services provided by fire departments are covered by property taxes, most publicly provided EMS systems, even if provided by the fire department, are not paid for by property taxes.⁴⁹ As a result, while a homeowner will not receive a bill for a fire truck coming to put out a fire, the homeowner will receive a bill if the fire department sends an ambulance in response to an emergency.⁵⁰ Today, EMS systems are provided via a patchwork of different entities across the country, and standards and methods of delivery are less than uniform.⁵¹

Over the last twenty or so years, the providing of EMS services and systems has attracted huge amounts of private money as illustrated by the 2005 IPO of Emergency Medical Services, which is the parent of American Medical Response (AMR), a for-profit company and the largest provider of EMS systems in the country.⁵² Prior to the acquisition of AMR by Envision Medical Services, AMR started to sell stock on the New York Stock Exchange and began a nationwide consolidation of the private ambulance industry.⁵³ More recently, further consolidation has occurred with the previously number one and two providers, AMR and Rural/Metro respec-

47. *See id.*

48. *See id.*

49. *See* Elisabeth Rosenthal, *Think the ER Is Expensive? Look at How Much it Costs to Get There*, N.Y. TIMES (Dec. 4, 2013), <http://www.nytimes.com/2013/12/05/health/think-the-er-was-expensive-look-at-the-ambulance-bill.html> [https://perma.cc/5VJM-9WFM] (“Fire departments, which don’t charge for driving to fire alarms, do charge for ambulance runs.”); *see also* Pamela Wood, *Baltimore County to Charge for Ambulance Rides; Charge Could Raise \$26M Annually*, BALT. SUN (July 20, 2015, 7:49 PM), <http://www.baltimoresun.com/news/maryland/baltimore-county/towson/bs-md-co-ambulance-fees-20150720-story.html> [https://perma.cc/85ZP-83CA] (noting that across country it has become standard and acceptable for fire departments to seek payment for ambulance and EMS services); Zamosky, *supra* note 1 (noting common misconception that ambulance transportation and paramedic service is paid for by tax dollars—fire services is but ambulance and EMS services typically are not).

50. *See, e.g.*, *Rizzo v. City of Phila.*, 668 A.2d 236, 238 (Pa. Commw. Ct. 1995) (rejecting suit brought by taxpayers alleging that EMS fees were unlawful revenue-raising tax and holding charges were reasonable and lawfully imposed).

51. *See, e.g.*, Zamosky, *supra* note 1 (noting that “operation and financing of ambulance services are complicated and vary widely throughout the country” and that “ambulance services are operated by any mix of volunteers, ambulance companies, municipal EMS providers or fire departments”).

52. *See EMS Completes IPO of 8.1M Shares*, DENV. BUS. J. (Dec. 21, 2005, 04:36 PM), www.bizjournals.com/denver/stories/2005/12/19/daily40.html https://perma.cc/7M2W-A7ZS] (“Emergency Medical Services Corp. closed its initial public offering of 8.1 million shares . . . at \$14 per share.”).

53. *See American Medical Response, Inc. History*, FUNDING UNIVERSE, www.fundinguniverse.com/company-histories/american-medical-response-inc-history [https://perma.cc/55VM-J5QX] (last visited Oct. 21, 2016) (discussing acquisition by AMR and its initial public offering in August 1992).

tively, now combined under the AMR name and owned by Envision Healthcare Holdings, a Fortune 500 publicly-traded company.⁵⁴ In addition, international EMS provider Falck has established a large and growing presence in the United States. These events provide clear evidence that EMS systems are big business with both public health and huge amounts of money at stake.⁵⁵

EMS systems are defined generally as the providing of out-of-hospital acute medical care or transport to definitive care.⁵⁶ The federal government regulates EMS services at the most basic level by setting minimum standards applicable to all EMS providers.⁵⁷ However, EMS providers are often regulated more strictly by state governments, which typically set higher standards.⁵⁸ In the United States, there are several different models that are used for providing EMS systems.⁵⁹

54. See Dan Levine & Martha Graybow, *Special Report: Dial 911-FOR-PROFIT—Just Don't Tell a Firehouse*, REUTERS (Apr. 15, 2011, 01:04 PM), <http://www.reuters.com/article/us-ambulance/special-report-dial-911-for-profit-just-dont-tell-a-firehouse-idUSTRE73E3D720110415> [<https://perma.cc/VBP7-BM5Z>] (noting that big investors are undaunted, and United States buyout shops are jumping into EMS sector and that AMR's (United States' biggest private ambulance provider) parent Emergency Medical Services Corp. (now Envision Healthcare Holdings) and Rural/Metro Corp. (previously United States' second biggest private ambulance provider) both agreed to be purchased by private equity firms, Clayton Dubilier & Rice and Warburg Pincus, respectively). In 2015, Rural/Metro was purchased by Envision, who now owns both AMR and Rural/Metro. See *Envision Healthcare Announces Closing of Rural/Metro Acquisition*, BUS. WIRE (Oct. 28, 2015, 04:15 PM), <http://www.businesswire.com/news/home/20151028006590/en/Envision-Healthcare-Announces-Closing-RuralMetro-Acquisition> [<https://perma.cc/NG3B-ZBQU>]. Envision entered the Fortune 500 in 2016. See Audrey Shi, *Here Are the 15 New Companies Joining the Fortune 500*, FORTUNE (June 6, 2016), <http://fortune.com/2016/06/06/fortune-500-companies-making-debuts/> [<https://perma.cc/5GRY-TT6A>].

55. See Levine & Graybow, *supra* note 54 (noting that “[i]n United States, estimated 40 million ambulance trips a year are handled by public entities, private providers, hospitals and volunteers” and that total spending on ambulance trips each year is “at least 14 billion”).

56. See *Nat'l EMS Res. Agenda*, NAT'L HIGHWAY TRAFFIC SAFETY ADMIN. (Dec. 31, 2001), www.nhtsa.gov/PEOPLE/INJURY/ems/ems-agenda/definition_of_ems.htm [<https://perma.cc/F28Q-YT5P>] (defining “EMS”).

57. See NAT'L HIGHWAY TRAFFIC SAFETY ADMIN., NATIONAL EMS SCOPE OF PRACTICE MODEL 5 (2007), www.ems.gov/education/EMSScope.pdf [<https://perma.cc/X6UK-FQL4>] (noting concept of “freedom within limits” where there are national standards for personal licensure and minimum competencies while allowing states to set more stringent standards).

58. See *id.* at 8–9.

59. See, e.g., *Emergency Medical Services*, U.S. DEP'T TRANSP. (Mar. 10, 2015), <https://www.transportation.gov/careers/veterans/emergency-medical-services> [<https://perma.cc/S2G7-KV46>] (noting that EMS personnel must be licensed by state in which they work and each state has authority and responsibility to regulate EMS within its borders).

In many communities, EMS systems are municipally operated.⁶⁰ Municipally-based EMS systems may be provided in several different ways. For example, EMS systems may be provided by a local, regional, or state government, and may be funded by service fees, property taxes, or both. If the EMS system is too small to operate independently, it may be organized as a branch of another municipal department, such as the fire department.⁶¹ In communities without a large tax base, community volunteers may provide EMS service.⁶² In these cases, the volunteer squad may receive some funding from municipal taxes but is generally heavily reliant on voluntary donations to cover operating expenses.⁶³ Many municipalities provide EMS systems indirectly under a contractual agreement with a private company, such as Envision's AMR, Falck, or a hospital.⁶⁴ This approach is often taken as a cost-saving measure for the local government.⁶⁵

As noted, significant consolidation in the private ambulance market has been occurring since the 1980s. Today, the private market consists of local ambulance companies, a few large regional companies, and a few multinational companies that offer services in the United States. Private ambulance companies, both for-profit and nonprofit, typically operate either on a fee-for-service basis charged to the patient, or by means of contracts with local municipalities, which often also result in bills sent to patients.⁶⁶ In some cases private ambulance companies agree with local governments that in exchange for exclusive contracts, the ambulance company will provide high quality EMS systems including adequately trained staff, sufficient available resources, and specific response times.⁶⁷

Today, EMS services are provided by a combination of various public providers (local, state, or regional) and private for-profit and nonprofit providers such as hospitals and volunteers.⁶⁸ Different private EMS prov-

60. See, e.g., *Administration and Finance*, CTY. OF MONTEREY HEALTH DEP'T (Sept. 25, 2014), http://www.mtyhd.org/index.php/services/emergency-medical-services/administration-and-finance__trashed/ [https://perma.cc/U64T-JVPT] (noting that Monterey County, California, voters approved special tax in order to fund EMS).

61. See *id.*

62. See, e.g., *MONROE VOLUNTEER AMBULANCE SERVICE, INC.*, www.monroeems.org [https://perma.cc/SJ5C-L3G5] (last visited Oct. 24, 2016).

63. See *id.*

64. See *PRINCIPLES OF EMS SYSTEMS* 149–50 (John A. Brennan & Jon R. Krohmer eds., 3d ed. 2005).

65. See *id.*

66. See, e.g., *Emergency Medical Services*, KERN CTY. PUB. HEALTH SERVS. DEP'T, <http://kernpublichealth.com/ems/> [https://perma.cc/JT9A-CTUL] (last visited Oct. 25, 2016).

67. See, e.g., *Ambulance Rates*, KERN CTY. PUB. HEALTH SERVS. DEP'T, kernpublichealth.com/ems-updates-news/ambulance/ [https://perma.cc/EZL2-8PJZ] (last visited Oct. 25, 2016) (listing ambulance rates for their private providers, Hall Ambulance, Delano Ambulance, and Liberty Ambulance and providing links to Ambulance Performance standards).

68. See *supra* notes 56–65 and accompanying text.

iders (both for-profit and non-profit), like hospitals, set their charges at significantly different levels for the same services.⁶⁹ Moreover, private EMS providers, just like hospitals, accept significantly less than their inflated list prices as full payment for their services from government insurers and private insurers with whom they have contracts.⁷⁰ However, an important difference between private EMS providers and hospitals is that EMS providers overall have contracts with far fewer insurers.⁷¹ In fact, it is not uncommon for EMS providers to have no contracts with any insurers.⁷² In these cases, all privately insured patients are out-of-network and subject to balance billing. Thus, in the case of EMS providers, balance billing is very common. For example, Robin Spring of Corralitos, California, called 911 after becoming short of breath and was taken to the hospital in an ambulance.⁷³ The bill she later received was for \$2,288.⁷⁴ The ambulance was out-of-network and her insurance covered just \$750.⁷⁵ Ms. Spring was responsible for the balance of \$1,538.⁷⁶ However, this was completely unavoidable and predictable because there were no in-network ambulance companies in Santa Cruz County where Ms. Spring lived.⁷⁷ “It made me furious,” she said. “I thought, ‘[t]his is a real setup.’”⁷⁸

Requiring patients who receive emergency ambulance service to pay for the service is neither unfair nor unethical. Moreover, as discussed in the next section, the common law recognizes this fact through the doctrine of quasi-contract and application of the emergency medical care exception. However, the problem arises in the case of emergency ambulance service, just as it does in the case of hospital care, due to the fact that many EMS providers, like many hospitals, are trying to collect an exorbitant amount from privately insured out-of-network patients for the services that they provide.⁷⁹ Also, many EMS providers, again like hospi-

69. See *supra* notes 26–27 and accompanying text.

70. See *supra* notes 5–17 and accompanying text.

71. See, e.g., Andrews, *supra* note 18 (“This Spring, Blue Cross Blue Shield of Massachusetts launched a policy aimed at getting more emergency medical services providers to join its network: It began sending checks for out-of-network private ambulance rides directly to plan members rather than to the EMS providers.”).

72. See, e.g., Zamosky, *supra* note 1 (“In Los Angeles and in many parts of the country, emergency ambulance services—those that show up following a call to 911—don’t hold contracts with insurance companies, so there’s no point worrying about whether you’re being picked up by an in-network provider.”).

73. See Andrews, *supra* note 18 (recounting Robin Spring’s experience).

74. See *id.*

75. See *id.*

76. See *id.*

77. See *id.*

78. *Id.*

79. See *id.* (“This . . . is really about whether individuals, families and employers should pay 80 to 100 million dollars a year because private out-of-network ambulance companies are allowed to charge rates that are three to five times above what Medicare pays them for the very same service,” says Jay McQuaide, a senior vice president of corporate communications for BCBS of Massachusetts.”). For a

tals, use balance billing to demand full payment of their extreme list prices from OON patients. Many EMS providers, again like many hospitals, are also quick to farm out uncollected bills to aggressive collection agencies that often cause great financial and personal hardship for patients who cannot pay the exorbitant bill.⁸⁰ In essence, many EMS providers (also like many hospitals) take advantage of vulnerable patients and use balance billing to force these unfortunate patients to pay excessive rates for emergency ambulance service.⁸¹

III. THE LEGAL REQUIREMENT TO PAY FOR EMERGENCY AMBULANCE SERVICE

In the case of emergency ambulance service, an ambulance company's right to recover payment from the patient is based on the doctrine of quasi-contract, which is also known as an implied-in-law contract or an action for unjust enrichment ("quantum meruit" in Latin, meaning roughly "as much as he deserves" or "what one has earned").⁸² Notwithstanding the fact that the term "contract" is often used to describe this sort of claim, there is no actual contract between the parties.⁸³ Contract law is the law of voluntary agreements and requires the voluntary and knowing agreement of the parties.⁸⁴ Contracts may be either express or implied, that is, stated in words or based on actions, but in both cases, the requirement of a voluntary and knowing agreement remains.⁸⁵ Of course, in the

discussion of the same issues in the context of hospital billing, see generally Nation, *Chargemaster Insanity*, *supra* note 27; Nation, *Determining*, *supra* note 27; Nation, *The Balance-Billing Problem*, *supra* note 27.

80. See, e.g., Anna Gorman, *After the Ambulance Ride to the Hospital Comes the Pain of the Bills*, ORANGE CTY. REG. (Jan. 31, 2016, 08:02 AM), <http://www.ocregister.com/articles/city-701817-gurzi-bill.html> [<https://perma.cc/VEC9-6YAW>] ("[T]he city of La Habra California sent [an eighty-five year old] a \$260 bill for 'paramedic response'—after her insurers already had been billed and paid for the November ambulance ride. . . . One city employee threatened to send her to collections, warning she wouldn't ever be able to get a loan."); Dan Mangan, *Medical Bills Are the Biggest Causes of US Bankruptcies: Study*, CNBC (June 25, 2013, 2:29 PM), www.cnbc.com/id/100840148 [<https://perma.cc/K84U-833H>] (noting that unpaid medical bills are number one cause of bankruptcy filings).

81. See *supra* note 79 and accompanying text.

82. See, e.g., *Hailey v. Med. Corp., Inc.*, No. L-05-1238, 2006 Ohio App. LEXIS 4706, at *2, *18 (Ohio Ct. App. Sept. 15, 2006). Hailey, the plaintiff, was transported via ambulance to a hospital following a car accident and billed \$961. Hailey refused to pay the bill because she believed it to be unreasonable and was sued by the collection agency to which the provider had sold the account. The court noted that the case involves an implied-in-law contract or a quasi-contract, not a true contract. See *id.* at *9.

83. See *id.* at *8–9. The court noted that there was no contract between the parties on these facts because a true contract requires a meeting of the minds as to the essential terms of the agreement. See *id.*

84. See *id.* at *9.

85. See *id.*; see also JOHN D. CALAMARI & JOSEPH M. PERILLO, *THE LAW OF CONTRACTS* § 1-12, at 19–20 (3d ed. 1977) (discussing implied-in-fact, express contracts, and implied-in-law or quasi-contract).

case of emergency ambulance or other emergency medical services, the patient is in no position to agree and often does not even know at the time the services are provided that they are being provided. As a result, there is no contract to be enforced. The parties have never agreed on any of the terms under which the services have been provided, including the price. The ambulance company cannot claim that the patient has agreed to pay a certain price for the services received. The patient has agreed to nothing.

However, the law recognizes that, in the case of necessary emergency ambulance services or other emergency medical services, a reasonable person would desire such services and justice is served by requiring the patient to pay the fair value of the services received.⁸⁶ In the context of emergency medical services, a patient receiving such services would be unjustly enriched unless the patient is required to pay the provider the fair value of the service received.⁸⁷ As a result, the law imposes an obligation on patients who receive emergency medical services, including emergency ambulance services, to pay the fair value of such services to the provider.⁸⁸ The courts' imposition of this obligation prevents an unjust enrichment.⁸⁹ Moreover, the law's recognition of this quasi-contractual obligation serves the important public policy of encouraging such services to be provided when needed.⁹⁰ The word "contract" is associated with this obligation as a result of now obsolete pleading requirements, not because there is any real agreement or true contract between the parties.⁹¹

Because there is no real contract between the parties, the parties have not agreed on the value of the services provided and the court must deter-

86. See *Hailey*, 2006 Ohio App. LEXIS 4706, at *9 (noting that quasi-contracts are legal fictions that create obligations based on equitable principles). The court states: "[A] recipient of emergency medical services may be held liable to the health care provider pursuant to an implied-in-law contract or quasi-contract for the reasonable value of those services." See *id.* at *9-10 (citation omitted).

87. See *id.* at *10 ("One who is severely injured or ill such that he or she becomes unconscious and unable to seek or decline medical services is in need of the protection and assistance such a rule of law offers him. By imposing liability upon him, the law seeks to ensure that he will be provided the necessary services to save his life. Faced with the choice of forcing [the person who was served] to pay the reasonable value of the services he received or forcing those who render emergency medical services in cases such as this to risk doing so as a matter of charity, we must choose the former. Accordingly, [the person who was served] may be held liable in quasi-contract for the reasonable value of the services received by him." (quoting *Morehead v. Conley*, 599 N.E.2d 786, 788-89 (Ohio Ct. App. 1991) (alteration in original))).

88. See *id.* at *18.

89. See *id.*

90. See *id.*

91. See CALAMARI & PERILLO, *supra* note 85, § 1-12, at 20 ("The quasi-contractual label arose from a procedural quirk. Since in the earlier law there was no writ for an obligation of this kind, courts permitted the use of the contractual writ of *assumpsit* and allowed the plaintiff's attorney to plead a fictitious promise. The crux is that a quasi-contract is not a peculiar brand of contract. It is a non-contractual obligation that used to be treated procedurally as *if* it were a contract." (emphasis added)).

mine the fair value of the services.⁹² The problem that has occurred generally in health care, including emergency ambulance services, is that courts, in determining fair value, have traditionally relied on the usual and customary amount *billed* by the provider as a proxy for fair value.⁹³ However, courts are beginning to understand that this is a mistake, because in the context of health care, the odd dynamics of the third-party-payer system and a lack of meaningful retail-level competition have caused the amount usually and customarily *billed* (also referred to as “full charges,” “list prices,” and “chargemaster rates or prices”) by providers to greatly exceed the amount that is usually and customarily *paid* to and accepted by providers as full payment.⁹⁴ That is, the amount billed is typically grossly overstated and greatly exceeds the fair value of the services provided because this price is set to be discounted by third-party payers and not paid.⁹⁵ The amount usually and customarily paid to the provider is a much better measure of fair value for health care than is the amount usually and customarily charged or billed by the provider.⁹⁶

Moreover, there is very little consistency between ambulance companies with regard to the rates that they charge.⁹⁷ In general, ambulance companies have complete discretion in setting their list prices.⁹⁸ Again, this is very similar to the situation with hospitals. Hospitals also charge vastly different amounts for the same procedure.⁹⁹ Hospitals also have complete discretion with regard to setting their billed charges and also use

92. See *Hailey*, 2006 Ohio App. LEXIS 4706, at *10–11 (“The reasonable value of the services must be demonstrated at trial by competent, credible evidence. The party asserting a claim in *quantum meruit* bears the burden of proof. A defending party may raise the issues of the necessity and value of the emergency medical services as a defense to the provider’s claim of nonpayment.” (citations omitted)).

93. See, e.g., *Holland v. Trinity Health Care Corp.*, 791 N.W.2d 724, 729–30 (Mich. Ct. App. 2010) (finding chargemaster rates are usual and customary).

94. See, e.g., Nation, *The Balance-Billing Problem*, *supra* note 27, at 153 (“Courts across the country are beginning to understand that hospital bills based on list or chargemaster prices are excessive and unfair, because they reflect prices that are set to be discounted and not paid.”).

95. See *id.*

96. See *id.* at 187 (arguing that courts should reject usual, customary, and necessary as proxy for fair and reasonable value and substitute usual and customary amount provider is actually paid for services); see also *infra* notes 112–14 and accompanying text that notes the same dilemma applies to ambulance charges with ambulance providers in Minnesota collecting only between \$.42 and \$.65 of each dollar billed.

97. See, e.g., Rosenthal, *supra* note 49 (noting that ambulance “charges as well as insurance coverage, range widely, from zero to tens of thousands of dollars”).

98. See *id.* (“Part of the inconsistency in pricing stems from the fact that ambulance services are variously run by fire departments, hospitals, private companies, and volunteer groups.”).

99. See, e.g., Nation, *Chargemaster Insanity*, *supra* note 27, at 747, 755 (noting “no two hospitals necessarily charge the same amount for the same services” and noting that hospital list prices are “arbitrary and capricious from the point of view of pricing except in one respect—the higher the list price, the higher the hospital’s revenue”).

that discretion to maximize profits.¹⁰⁰ In many cases, billed charges are set by ambulance companies to maximize profits under the odd and often counterintuitive context of various third-party reimbursement schemes.¹⁰¹ In addition, as a result of these third-party reimbursement schemes, the same ambulance company, like the same hospital, will be paid vastly different amounts depending on the identity of the third-party payer.¹⁰² In the hospital context, as I have written about before, the majority of the immediate unfairness of this system is experienced by self-pay patients (the uninsured and those subject to balance billing).¹⁰³ In the long run, however, everyone suffers because this system leads to ever-higher health care costs.¹⁰⁴

In one sense, the problem with regard to emergency ambulance bills is even worse than the problem of exorbitant hospital bills because a higher number of patients are subject to balance billing in the ambulance context due to the fact that ambulance companies tend to contract with fewer, if any, insurers.¹⁰⁵ Thus, a large number of patients that receive emergency ambulance service are subject to balance bills. Also, the balance bills for emergency ground ambulance services, while exorbitant, are more likely to be within the ability of the patient to pay and therefore are more likely to generate profits for the ambulance company. For example, in the hospital context, if a patient receives a \$100,000 or higher bill from the hospital, it is often simply impossible for the patient to pay it. However, in the emergency ambulance service context, even an unconscionably high ambulance bill of \$2,700 or \$5,700 can, often with extreme difficulty, be paid by a much larger number of patients. Moreover, for many patients, it comes down to a choice of either paying the bill, suffer-

100. See *id.* at 760 (“The single most important reason that chargemaster rates remain so high is that competitive forces in the healthcare market have broken down, and as a result, many hospitals may raise their chargemaster rates with impunity. Moreover, such rate increases are associated with increases, albeit much smaller ones, in revenues. Finally, hospitals currently have absolutely no reason to reduce their chargemaster rates—that is, they suffer no competitive disadvantage by setting their rates ever higher.” (citations omitted)).

101. See Rosenthal, *supra* note 49 (noting that emergency dispatchers decide which ambulance to send based on geographic proximity and “[m]ost ambulance companies bill according to the level of the skill of the team on board, rather than the medical needs of the patients they collect”).

102. See, e.g., Medearis, *supra* note 10 (“Many Americans with good insurance will not be overburdened by their ambulance bills. Medicare patients who meet their deductible typically pay 20% of the amount quoted by Medicare. Insured patients who take an in-network ambulance usually pay a fraction of the negotiated amount as well. But the system fails people who happen to take an out-of-network ambulance or don’t have insurance. In that case, the provider is free to charge any amount it sees fit, and the bills are often steep.”).

103. See Nation, *Chargemaster Insanity*, *supra* note 27, at 761–66 (discussing how exorbitant list prices are unfair and even cruel to self-pay patients).

104. See *id.* at 766–69 (discussing how inflated list prices cause higher overall prices for health care).

105. See *supra* notes 71–78 and accompanying text.

ing a damaged credit rating, or paying the cost of hiring an attorney to contest the charge.¹⁰⁶ For many patients, the efficient choice is simply to pay the unreasonable bill.¹⁰⁷ Many ambulance companies take advantage of this situation.¹⁰⁸ As Robin Spring said, “this is a real set up.”¹⁰⁹

In 2015, Kevin Miller, president of the Minnesota Ambulance Association noted that the Association had previously done a survey of its members and “found fees ranging from \$450 to almost \$1,900 for basic life support—the lowest level of emergency medical service.”¹¹⁰ Allina Health Ambulance operates one of the largest ambulance service providers in Minnesota and charges up to \$1,900 for a typical ambulance ride.¹¹¹ Mr. Miller also notes that the fees charged are often subject to deep discounts depending on the patient’s insurance.¹¹² In other words, the amount paid and accepted by providers as full payment is significantly different than the amount billed.¹¹³ According to Mr. Miller, in 2015 across the state of Minnesota, ambulance providers collected anywhere between \$.42 and \$.65 for each dollar billed.¹¹⁴

Many ambulance companies also engage in aggressive billing, as do many hospitals. For example, in 2006, Kim Nuxoll was pregnant and at home with her husband when she realized the baby was coming very quickly.¹¹⁵ She called 911, hoping “she could give birth in the hospital as planned, but her son arrived even faster” than the St. Paul Fire Depart-

106. See Andrews, *supra* note 18 recounting the following:

Negotiating for an in-network rate can often reduce the bill from an out-of-network provider by 30 to 35 percent, says Candice Butcher, president and chief executive of Medical Billing Advocates of America.

Sometimes plan members don’t realize they may have options. Maria and Gerald Kinghorn got an \$800 bill from the ambulance company that transported their 19-year-old son to the hospital a few miles away after he crashed on the interstate near their Utah home and knocked out four teeth. Even though their bill was almost half of the total \$1,700 charge—their automobile and health insurers had paid the rest—they paid it.

“We didn’t want to have our credit ruined for \$800,” says Maria Kinghorn, who says the ambulance company put some pressure on them to pay up. In hindsight, though, “I probably should have checked it and fought it,” she says.

Andrews, *supra* note 18.

107. See *id.*

108. See *id.*; see also *infra* notes 114–18 and accompanying text discussing an ambulance company who was called to assist a woman delivering a baby but arrived after the child was born, transported mother and baby to be examined and charged double—once for the mother and again for the baby.

109. See Andrews, *supra* note 18.

110. See Gilbert, *supra* note 8.

111. See *id.* (noting that ambulance crews usually “don’t mention fees” and “probably don’t even know what they are”).

112. See *id.*

113. See *id.*

114. See *id.*

115. See *id.*

ment that provided the ambulance service.¹¹⁶ “Both mother and the baby seemed fine, but they still needed to be checked out by a doctor.”¹¹⁷ When the paramedics offered to take them to the hospital, Mrs. Nuxoll agreed.¹¹⁸ Sometime later, she found out that the St. Paul Fire Department charged a total of \$2,306 for the ride; \$1,153 for Mrs. Nuxoll and another \$1,153 for the baby!¹¹⁹

According to one commentator, the uninsured and those with high deductible insurance are usually the type of self-pay patient hit with high charges, but in the case of ambulance services, high charges can also hit people with more conventional health insurance.¹²⁰ “Patients who have insurance and means, but use an out-of-network provider, face the highest out-of-pocket costs.”¹²¹ Recall that in the context of emergency ambulance services, the patient usually has no control over which ambulance service is used.¹²² Thus, whether the service used is in or out-of-network is purely up to chance.¹²³ Jay Fitch, the president of Fitch and Associates, the largest emergency medical services consulting firm in the United States, notes that ambulance companies typically collect only 30% to 40% of the amount they bill, and “they often try to charge more for patients with insurance and those who can pay.”¹²⁴

IV. DETERMINING THE FAIR AND REASONABLE VALUE OF EMERGENCY AMBULANCE SERVICE

A. *The Cost of Providing Emergency Ambulance Service*

The cost of providing emergency ambulance service varies greatly for different providers due to both the fact that there are many different types of entities that provide EMS services, and to the nature of emergency ambulance services.¹²⁵ The nature of emergency ambulance service requires that providers be ready to provide service twenty-four hours a day, seven

116. *See id.*

117. *See id.*

118. *See id.*

119. *See id.* (noting that ambulance provider even charged twice for mileage).

120. *See* Medearis, *supra* note 10 (noting “[m]any Americans with good insurance will not be overburdened by their ambulance bills,” but also noting that “ambulance providers often avoid negotiating contracts with insurance companies or charge out-of-network individuals significantly higher rates”).

121. *Id.* (“[T]he system fails people who happen to take out-of-network ambulance or don’t have insurance. In that case, the provider is free to charge any amount it sees fit, and the bills are often steep.”).

122. *See supra* notes 10–13 and accompanying text.

123. *See supra* notes 10–13 and accompanying text.

124. *See* Rosenthal, *supra* note 49.

125. *See generally* U.S. GOV’T ACCOUNTABILITY OFF., GAO-13-6, AMBULANCE PROVIDERS: COSTS AND MEDICARE MARGINS VARIED WIDELY; TRANSPORTS OF BENEFICIARIES HAVE INCREASED (2012), <http://www.gao.gov/assets/650/649018.pdf> [<https://perma.cc/22D6-KC9M>] [hereinafter GAO AMBULANCE REPORT].

days a week.¹²⁶ This creates a very large fixed cost that is known in the industry as the “cost of readiness.”¹²⁷ Providers that deliver a relatively large number of emergency service calls can spread that fixed cost of readiness over all of its service calls and, as a result, will have a much lower cost per call than a provider that provides a significantly lower number of emergency service calls.¹²⁸

In addition to the volume of transports, important cost drivers are the intensity of the transports—that is, the number that are emergency as opposed to nonemergency transports and the relative intensity of the emergency transports (BLS, ALS 1, ALS 2)—and the level of government subsidies that a provider receives.¹²⁹ Volume of transport is inversely related to cost per transport; that is, the larger the number of transports, the lower the cost per transport due to the high fixed cost of readiness. Intensity of service is positively correlated with cost per transport.¹³⁰ That is, it is more expensive to provide emergency service than nonemergency service and more expensive to provide ALS than BLS service.¹³¹ Finally, the level of government subsidies is also positively related to cost per transport; the higher the government subsidy received by a provider, the higher the provider’s cost.¹³² It is suggested that this is because such providers have less pressure to keep their costs under control.¹³³

B. *Value Models*

There are a number of different ways to calculate the reasonable value of emergency ambulance services. For example, value can be based on the cost to provide the service, the Medicare reimbursement rate, or the private insurance company reimbursement rate. If the determination of value were based on cost, then a reasonable profit would need to be added to determine fair and reasonable value.¹³⁴ Another possible approach, although not a good one in the case of emergency ambulance services or other medical services, is to use usual and customary charges of providers in the geographic area where the services in question were provided as a basis for determining reasonable value.¹³⁵ This latter method—

126. *See id.* at 9–18.

127. *See id.*

128. *See id.* at 33.

129. *See id.*

130. *See id.*

131. *See id.*

132. *See id.*

133. *See id.* at 25.

134. It is not reasonable to expect services or products to be supplied at a loss to the provider. However, a cost-based approach lacks the discipline of competitive markets and is likely to result in inefficiencies. *See supra* notes 132–33 and accompanying text.

135. Charges are set solely by the provider, and the lack of any consumer-level price competition results in grossly inflated prices. *See supra* notes 14–19 and accompanying text.

the charge-based method—is the one preferred by providers because it establishes the highest value.¹³⁶ The problem is that the value is too high and is not reasonable.¹³⁷

1. *Usual and Customary Charges*

Traditionally, as noted above, when courts were required to determine the fair and reasonable value of emergency medical services for purposes of applying the doctrine of quasi-contract, they often equated reasonable value with the usual and customary charges common for such services in the area where the services were provided.¹³⁸ Given this history, it is important to explain why the usual and customary charge-based method is no longer valid for determining the fair and reasonable value of emergency ambulance or other medical services.

Necessary to this discussion is an understanding of the various labels commonly used to refer to different types of prices and amounts paid for medical care. For example, “charges” are also known as “full charges,” “billed charges,” “list prices,” or “chargemaster rates,” and represent the highest price for the services in question, similar to the MSRP for a new car.¹³⁹ These terms should be distinguished from the amounts paid by in-network insurance companies, which are referred to as “negotiated rates,” “negotiated charges,” or “discounted charges” (to continue the car analogy, these terms would represent the amount most people actually pay for the new car, although the discount off of list price for medical care is many times greater than for the typical new car), and the amounts paid by government insurers such as Medicare and Medicaid (these prices are set unilaterally by the government).¹⁴⁰ The most common reference concerning government-set rates is to the “Medicare rate.”¹⁴¹

As I have discussed in detail elsewhere, as a result of the third-party reimbursement system for medical care, including emergency ambulance service, charges became anchoring points for either negotiating discounts with various third-party payers or for gaming the Medicare reimbursement system.¹⁴² Eventually, neither Medicare nor private insurers used billed charges to directly determine reimbursement rates.¹⁴³ However, by that time charges were already grossly inflated, and they have since continued to be increased frequently and excessively.¹⁴⁴ This becomes very obvious when charges are compared with actual reimbursements.¹⁴⁵ That is,

136. See *supra* notes 92–104 and accompanying text.

137. See *infra* notes 138–53 and accompanying text.

138. See *supra* notes 82–124 and accompanying text.

139. See Nation, *Chargemaster Insanity*, *supra* note 27, at 746–50.

140. See *id.* at 750–60.

141. See *id.* at 778 (discussing Medicare and Medicaid rates).

142. See *id.* at 766–69.

143. See *id.* (noting that chargemaster rates are still indirectly relevant).

144. See *id.* at 750–60.

145. See *id.*; *supra* notes 105–24 and accompanying text.

throughout health care and including emergency ambulance services, actual reimbursement amounts are only a fraction of billed charges.¹⁴⁶ In other words, while historically charges were a good proxy for actual reimbursements, that is no longer the case today. The amount actually paid to providers today is significantly lower than the amount charged by providers.¹⁴⁷

Today, for a variety of reasons (that I have discussed in detail in other articles and do not wish to repeat here)¹⁴⁸ billed charges remain excessive because they ultimately lead to higher third-party reimbursement rates, or at least have that potential.¹⁴⁹ Moreover, extreme charges carry no downside for the providers because there is very little price competition at the consumer level for health care¹⁵⁰ and none whatsoever with respect to emergency health care and emergency ambulance services.¹⁵¹ Charges are solely within the control of providers and, due to the absence of price competition at the consumer level, there is no market constraint on providers' ability to set charges oppressive levels.¹⁵² Moreover, the process used by providers for setting charges is so heavily influenced by the oddities of the third-party reimbursement system that the charges themselves are arbitrary and capricious from a fair value point of view.¹⁵³ As a result, charges should not be used in any way in the determination of fair and reasonable value.

A contemporary approach that would be equivalent to the traditional approach of basing fair value on usual and customary charges would be to base fair value on the usual and customary reimbursement amount actually received by the provider for the services in question.¹⁵⁴ In other words, the reasonable value of the services provided is equal to the average amount that the provider actually receives as reimbursement for such services.¹⁵⁵ This, in my opinion, is the best method for determining the fair and reasonable value of emergency medical services. However, in the case of emergency ambulance services, data regarding actual reimbursements

146. See *supra* notes 24–27 and accompanying text.

147. Cf. *Temple Univ. Hosp. Inc. v. Healthcare Mgmt. Alts., Inc.*, 832 A.2d 501, 510 (Pa. Super. Ct. 2003) (chargemaster rate “bears no relationship to the amount typically paid for those services”).

148. See *supra* note 27.

149. See Nation, *Chargemaster Insanity*, *supra* note 27, at 766–69.

150. See *id.* at 750–60.

151. See *supra* notes 8–17 and accompanying text.

152. See *supra* notes 119–21 and accompanying text.

153. See *id.* (noting that patients who have insurance and means, but use an out-of-network provider (something over which they have no choice) pay most, not for better service, but simply because of the way the billing and reimbursement system works).

154. See *supra* notes 91–96 and accompanying text.

155. See *supra* notes 110–23 and accompanying text.

is limited, and, as a result, it is necessary to look for other measures that can be independently verified, such as those discussed below.¹⁵⁶

2. Medicare Reimbursement Rates

The Centers for Medicare and Medicaid Services (CMS) pays for ambulance services furnished to patients with Medicare insurance when other forms of transportation would be unacceptable due to the patient's medical condition.¹⁵⁷ Generally, ambulance services are paid according to CMS's Ambulance Fee Schedule (AFS).¹⁵⁸ CMS reimburses for emergency and nonemergency ground ambulance transportation as well as for air ambulance transportation.¹⁵⁹ My focus in this Article is on ground emergency ambulance charges, although, as noted above, the principles governing this discussion are also applicable to emergency air ambulance charges and emergency medical care in general.¹⁶⁰

Two components go into establishing fees for ground-based ambulance service under the AFS. The two components are a base payment,¹⁶¹ discussed further below, and a separate payment for mileage.¹⁶² Under the AFS, fee determination begins with a set dollar amount, which for the year 2015 was \$221.63.¹⁶³ This dollar amount is then adjusted to reflect both the intensity of service (emergency versus nonemergency) and regional differences in the cost of providing service.¹⁶⁴

In 2015, for example, (BLS) emergency service had an intensity of service factor of 1.60, level 1 Advanced Life Support emergency (ALS 1) had an intensity factor of 1.90, and level 2 Advanced Life Support emergency (ALS 2) had an intensity factor of 2.75.¹⁶⁵ A geographic adjustment factor (GAF) is then used to account for "geographic differences in the

156. See, e.g., *supra* notes 124–32 and accompanying text.

157. See 42 U.S.C. § 1861(s)(7) (2012); 42 C.F.R. § 410.40(d) (2013).

158. For information regarding the AFS, see 42 U.S.C. § 410(B); 42 U.S.C. § 1834(1); 42 C.F.R. § 414(H); CENTER FOR MEDICARE & MEDICAID SERVICES, MEDICARE CLAIMS PROCESSING MANUAL CHAPTER 15 (2016); CENTER FOR MEDICARE & MEDICAID SERVICES, MEDICARE BENEFIT POLICY MANUAL CHAPTER 10 (2016).

159. See CENTER FOR MEDICARE & MEDICAID SERVICES, MEDICARE BENEFIT POLICY MANUAL CHAPTER 10 (2016).

160. See *supra* note 4.

161. See *id.*

162. See *id.*

163. See MEDICARE PAYMENT ADVISORY COMM'N, AMBULANCE SERVICES PAYMENT SYSTEM, at tbl. 1 (2015), www.medpac.gov/docs/default-source/payment-basics/ambulance-services-payment-system-15.pdf?sfvrsn=0 [<https://perma.cc/K8PX-4MF8>].

164. See *id.*

165. See U.S. DEP'T OF HEALTH & HUM. SERVS., REPORT TO CONGRESS: EVALUATIONS OF HOSPITALS' AMBULANCE DATA ON MEDICARE COST REPORTS AND FEASIBILITY OF OBTAINING COST DATA FROM ALL AMBULANCE PROVIDERS AND SUPPLIERS II (2015) <https://www.cms.gov/medicare/medicare-fee-for-service-payment/ambulancefees/schedule/downloads/Report-To-Congress-September-2015.pdf> [<https://perma.cc/5S98-JBLU>] [hereinafter HHS REPORT TO CONGRESS].

cost of providing ambulance services.”¹⁶⁶ The GAF is based on the non-facility practice expense (PE) component of the geographic practice cost index (GPCI).¹⁶⁷ The PE GPCI is designed to account for geographic variation in the price of physician services.¹⁶⁸ “There are currently 89 different localities defined by CMS.”¹⁶⁹ The ZIP Code in which the Medicare insured patient is picked up by the ambulance establishes which localities PE GPCI is applied to determine the base payment.¹⁷⁰ The PE GPCI is applied only to the labor-related portion of the ambulance service.¹⁷¹ For ground transports, this portion is 70% of the base payment; the remaining 30% of the base payment is unmodified by the GAF.¹⁷²

The mileage payment component of the AFS is determined by multiplying loaded miles by the mileage rate.¹⁷³ Loaded miles are the miles the ambulance travels with the patient on-board from the point-of-pick-up to the appropriate facility.¹⁷⁴ Finally, the AFS also incorporates two permanent add-on payments for transports that originate in rural areas—one for ground transports and one for air transports.¹⁷⁵ The standard mileage rate is increased by 50% for the first seventeen miles for ground ambulance transports that originate in a rural ZIP Code.¹⁷⁶ There are also three temporary add-on payments that are in force until December 31, 2017.¹⁷⁷ These temporary policies increase rural ground billing payments by 3% of both the base payment and the mileage rate if the point-of-pickup is rural, by 2% if the point-of-pickup is urban, and by 22.6% if the point-of-pickup is considered super-rural.¹⁷⁸

“Medicare paid approximately \$5.3 billion to over 11,000 entities for ambulance services in 2011.”¹⁷⁹ “According to the Medicare Payment Advisory Commission (MedPAC), ambulance service use per [patient or] beneficiary, Medicare spending on ambulance services, and the volume of Medicare-participating ambulance entities all increased between 2007 and 2011.”¹⁸⁰ It is important to note that Medicare requires participating ambulance service providers to accept the Medicare-allowed charge, based on the AFS, as payment in full and to not bill or collect from the beneficiary any amount other than any unmet Part B deductible and the Part B coin-

166. *See id.*

167. *See id.*

168. *See id.*

169. *Id.* at 11 n.17.

170. *See id.* at 12.

171. *See id.*

172. *See id.*

173. *See id.*

174. *See id.*

175. *See id.* at 13.

176. *See id.* at 13 tbl. 2.3: Add-On Payments to the AFS.

177. *See id.*

178. *See id.*

179. *See id.* at 9.

180. *Id.*

surance amounts.¹⁸¹ In other words, ambulance service providers are prohibited from balance billing patients for the difference between the provider's charge and the AFS-based payment from Medicare.¹⁸²

An important question in the context of this Article is whether Medicare rates should be used to determine the fair and reasonable value of emergency ambulance services. To see how much Medicare pays under the AFS, consider the following example. As an illustration, I have assumed a ten-mile emergency ambulance trip in 2015 in the Philadelphia metropolitan area. Medicare's reimbursement for this hypothetical trip would be between \$450 and \$681.¹⁸³ The range reflects various intensity levels of emergency service.¹⁸⁴ That is, BLS service would be reimbursed at about \$450, ALS 1 service (most emergency transports fall into this category)¹⁸⁵ is paid at about \$518, and ALS 2 at about \$681.¹⁸⁶ These numbers include a mileage reimbursement of \$71.30 for the ten-mile trip. That is, for 2015, Medicare's base rate for mileage was \$7.13 per fully-loaded mile.¹⁸⁷

While data for the industry is limited, in 2012 a report from the General Accounting Office (GAO) found that in 2010, the median cost per transport for ground ambulance service providers was \$429, but the range was from a low of \$224 per transport to a high of \$2,204 per transport.¹⁸⁸ The median cost was for all transports and was not broken out between emergency and nonemergency transports.¹⁸⁹ The GAO report also found that the median Medicare margin, including add-on payments, was about +2% in 2010.¹⁹⁰ That is, providers' Medicare payments per transport exceeded their overall costs per transport by 2%.¹⁹¹ However, just as in the case of costs per transport, margins varied widely for those providers.¹⁹² Median Medicare margins with add-on payments ranged from about -2% to +9%.¹⁹³ As a comparison, the hypothetical trip discussed in the previ-

181. See 42 U.S.C. § 1834(1) (2012); 42 C.F.R. § 410.40(a) (2012) (requiring mandatory assignment for all ambulance services, meaning that ambulance providers and suppliers must accept Medicare-allowed charges as payment in full and not bill or collect from beneficiary any amount other than any unmet Part B deductible and Part B coinsurance amounts).

182. See 42 U.S.C. § 1834(1); 42 C.F.R. § 410.40(a).

183. See HHS REPORT TO CONGRESS, *supra* note 164, at 10–11.

184. See *id.*

185. See GAO AMBULANCE REPORT, *supra* note 124, at 33.

186. See HHS REPORT TO CONGRESS, *supra* note 164, at 10–11.

187. See *id.*

188. See GAO AMBULANCE REPORT, *supra* note 124, at 10.

189. See *id.*

190. See *id.* at 18.

191. See *id.*

192. See *id.*

193. See *id.* at 22.

ous paragraph would have been paid by Medicare at 2010 rates at about \$431 for BLS, \$498 for ALS 1, and \$692 for ALS 2.¹⁹⁴

How do Medicare rates measure up to the industry? Again, data for the industry is limited, but in looking at anecdotal information, it seems that ambulance companies are often playing the same games as those responsible for hospital billing. The game is: How high can we set our rates? For example, an industry newsletter from Comstar Ambulance Billing Service states: “A question I routinely receive from clients is, ‘how high can I set my rates?’”¹⁹⁵ The newsletter goes on to provide the following advice:

There is no appropriate definitive answer to this question. The OIG guidance on this matter is to set rates to cover your costs . . . False. One thing I can do is provide general information on the rate setting patterns of Comstar’s 200+ municipal client base. To that end, I have analyzed the current ambulance billing rates set by Comstar’s clients. Below is the average rates for the highest 50 Comstar clients:

BLS-E \$1,205,

ALS 1 \$1,950,

ALS 2 \$3,101,

SCT \$3,462, [and]

Mileage \$32.13 per loaded mile[.]

Please note, Comstar is successfully billing and collecting the fees set by highest 50 Comstar clients in full (less applicable co-pays . . .) without issue from non-contracted insurance carriers.

If your current rates are above the averages above, you do not have an issue. If your rates are below the averages above, you have a potential opportunity for revenue increase.¹⁹⁶

I cannot vouch for the accuracy of the information quoted above, but it certainly does illustrate a mindset consistent with the way in which hospital chargemaster rates are set, and it also illustrates why charges cannot be used as a basis for determining the fair and reasonable value of emergency ambulance services. The Medicare rates certainly provide a better starting point for determining fair and reasonable value.

3. *Private Insurance Reimbursement Rates*

With regard to private insurance, there are two issues that affect reimbursement for ambulance services. The first is whether the ambulance

194. See *supra* notes 157–87 and accompanying text for an explanation of how to calculate AFS reimbursements.

195. See Rick Martin, *CMS Ambulance Fee Schedule Update*, COMSTAR AMBULANCE BILLING SERVICE, at 2, (Jan. 15, 2015) https://comstarbilling.com/wp-content/uploads/2015/01/newsletter_01_2015.pdf [<https://perma.cc/G9U2-5NPB>].

196. See *id.*

services received are covered.¹⁹⁷ This typically depends on whether the insurance company determines that it was necessary.¹⁹⁸ In the case of emergency ambulance services, this is not usually a concern and is not my focus here.¹⁹⁹ The second issue concerns the amount that the insurer will pay for the ambulance services provided to the insured.

In general, in-network insurance companies pay more than the Medicare rate but less, often much less, than the amount charged by the providers.²⁰⁰ The amount paid by in-network insurance companies is negotiated between the provider and the company and set forth in the contract between them, which also typically states that the provider will accept the insurance company's reimbursement as payment in full and prohibits the provider from balance billing patients insured by that insurer.

In the case of emergency ambulance services provided by an out-of-network company, some private insurers will reimburse the out-of-network provider at the in-network rate but may pay less.²⁰¹ The reason that receiving service from an out-of-network provider is so significant is that out-of-network providers have not agreed with the insurance company to accept the insurance company's reimbursement as payment in full.²⁰² Thus, in these cases the provider is free to bill the patient for the difference between the amount paid by the insurance company and the full charges billed by the provider; that is, the balance owing after the insurance company has made payment.²⁰³ This sets the stage for balance billing of patients insured by out-of-network insurers.²⁰⁴

197. See, e.g., Zamosky, *supra* note 1 (noting that both Medicare and private insurance generally cover cost of ambulance rides, but they rely on medical necessity when determining reimbursement).

198. See *id.* ("Ambulance trips are considered medically necessary in cases of sudden emergency . . .").

199. See *id.*

200. See, e.g., Andrews, *supra* note 18 (citing Robert E. O'Connor, chair of Department of Emergency Medicine at University of Virginia School of Medicine, as saying that sometimes in-network reimbursements are just 50% of provider's charges (list prices) and recounting example of patient whose insurance covered in-network emergency ambulance bills at 80% of charges, but coverage for out-of-network provider maxed out at \$750). The patient's ambulance bill was \$2,288. See *id.*

201. See *id.*

202. In the case of government insurers Medicare or Medicaid, for example, providers are required to accept the payment as payment in full and are prohibited from balance billing. See *supra* notes 180–81 and accompanying text.

203. Balance-billing refers to billing the insured but out-of-network patient directly for the difference between the provider's charges and the insurance reimbursement. For example, in the case mentioned in above, the patient was billed for the difference between the \$2,288 of charges and the insurance companies' reimbursement of \$750; the patient was billed \$1,538. See *supra* note 199.

204. For a discussion of balance-billing in the health care context, see generally Nation, *Healthcare and the Balance Billing Problem*, *supra* note 27.

Private insurance reimbursement rates, like the charges of ambulance companies, vary greatly from one insurer to another.²⁰⁵ Moreover, “‘There are significant numbers of patients who have no coverage for this, and the number of self-pay patients has climbed’ since the recession, said Jay Fitch, president of Fitch and Associates, the largest emergency medical services consulting firm in the United States.”²⁰⁶ In addition, Mr. Fitch notes that ambulance companies typically collect only 30% to 40% of the amount they bill,²⁰⁷ and as a result, they often try to charge more for patients with insurance and those who can pay.²⁰⁸ This is why many ambulance companies find it profitable to refuse to go in-network with any insurance companies.²⁰⁹ That is, by being out-of-network, they can balance bill all of their patients except those that are covered by Medicare.²¹⁰ As noted above, ambulance services are variously provided by fire departments, hospitals, private companies, and volunteer groups, which contribute to the inconsistent pricing.²¹¹ Also, while some providers are included in insurance networks, others are not. “‘There’s a saying that if you’ve seen one emergency medical system, you’ve seen one emergency medical system—no two are alike,’ said Dr. Robert E. O’Connor, a vice president of the American College of Emergency Medicine and chairman of the department at the University of Virginia.”²¹² According to O’Connor, charges and payments “are all over the place.”²¹³

Under the Affordable Care Act (ACA), qualified health insurance policies are required to include some coverage for emergency care, including ambulance services, as an essential benefit.²¹⁴ However, the ACA does not prevent balance billing by out-of-network providers.²¹⁵ In addition, even if the patient is lucky and an in-network provider happens to have been called by the 911 dispatcher, “the ambulance ride and the care are billed separately.”²¹⁶ As a result, lower-tier plans under the ACA often require

205. See Rosenthal, *supra* note 49, (quoting Robert E. O’Connor’s observation that charges for ambulance services “are all over the place”).

206. *Id.*

207. See *id.* As discussed *supra*, this statistic can be interpreted in a variety of ways. The interpretation that I think is most often correct is that these low collection rates are an indication of excessive pricing. That is, the level of billed charges is completely within the discretion of the provider, and the provider’s ability to go after patients via balance-billing for that exorbitant balance is an incentive to set prices at unreasonably high levels.

208. See *id.*

209. See *supra* notes 71–78 and accompanying text.

210. See *id.*

211. See Rosenthal, *supra* note 49.

212. *Id.*

213. *Id.*

214. See *id.*

215. See Nation, *Healthcare and the Balance Billing Problem*, *supra* note 27, at 165–67 (noting that in fact ACA encourages balance billing).

216. See Rosenthal, *supra* note 49.

patients to pay an initial copay of \$250 for the emergency room and \$250 more for the transport.²¹⁷

Insurance reimbursements are often based on Medicare's Ambulance Fee Schedule.²¹⁸ However, the range is broad with some insurers reimbursing more or less than the applicable AFS amount.²¹⁹ As discussed above, the average Medicare payment is just 2% more than the median provider cost per transport.²²⁰ This means that many providers fail to fully recover their costs and in fact lose money transporting Medicare patients.²²¹

Providers may also be losing money or just about breaking even on their in-network insurance reimbursements, although that seems very unlikely. According to O'Connor, in-network reimbursements often cover just 50% of charges.²²² However, I must observe that ambulance providers voluntarily enter into contracts with in-network insurers, and it seems very unlikely that they would agree to reimbursements that were unprofitable for them. Also, some studies have indicated that the profit margin for the ambulance industry overall is about 7.5%.²²³ This suggests that the reason reimbursements often cover just 50% of charges is that charges are set exorbitantly high. O'Connor also notes that, if the EMS company does not join the network, reimbursement may not be much improved. "It's [the rate paid to providers by out-of-network insurers] often at a rate that they [the insurers] decide unilaterally, and is very low relative to the charge."²²⁴ However, as noted above, the big benefit to not being in-network is not the reimbursement received from the insurance company, it is the legal right of the ambulance provider to balance bill the patient.²²⁵

Since margins are thin for Medicare and in-network patients, ambulance providers often avoid negotiating contracts with insurance companies or charge out-of-network individuals significantly higher rates in order to compensate But the system fails people who happen to take an out-of-network ambulance or don't have insurance. In that case, the provider is free to charge any amount it sees fit, and the bills are often steep.²²⁶

217. *See id.*

218. *See, e.g.,* Andrews, *supra* note 18 ("In-network reimbursements are sometimes just 50 percent of the charges or a percentage of the Medicare reimbursement rate."). If the emergency ambulance provider does not join the network, then reimbursement from private insurance is set unilaterally by the insurance company, but the patient is liable for the balance. *See id.*

219. *See id.*

220. *See supra* notes 188–94 and accompanying text.

221. *See id.*

222. *See* Andrews, *supra* note 18.

223. *See* KELSEY OLIVER, IBIS WORLD INDUSTRY REPORT 62191: AMBULANCE SERVICES IN THE U.S., IBISWORLD 4, 6, 8 (Jan. 2017) [hereinafter IBIS REPORT].

224. *Id.*

225. *See supra* notes 14–20 and accompanying text.

226. *See* Medearis, *supra* note 10.

In addition, according to Candice Butcher, president and chief executive of Medical Billing Advocates of America, in-network rates are often 65% to 70% of charges.²²⁷ In other words, ambulance providers voluntarily enter into contracts with insurance companies in which they agree to accept 65% to 75% of their list prices as payment in full. Again, I think it is very unlikely that providers would voluntarily enter into agreements that provided for reimbursement without a reasonable profit margin. This, coupled with an average overall profit margin for the ambulance industry of 7.5%²²⁸ indicates that charges are exorbitant.

C. *Determining the Reasonable Value of Emergency Ambulance Service*

It is clear that the charges demanded by many ambulance service providers are exorbitant and do not represent the fair and reasonable value of the services that they provide.²²⁹ This begs the question: What is the fair and reasonable value of emergency ambulance services? Based on the data discussed above, the Medicare reimbursement rates reflected in the AFS are a much better place to start determining fair value than are the exaggerated charges demanded by providers.²³⁰ However, it seems quite possible that the reimbursement amounts established in the AFS are too low to be used unadjusted to determine the fair and reasonable value of emergency ambulance services.²³¹ Recall that these reimbursement rates with the add-on provisions only exceed the median provider's costs by 2%.²³² As a result, I suggest that the AFS amounts be adjusted upward in order to arrive at a fair and reasonable value.²³³ The question then becomes: By how much should the AFS amount be adjusted?

1. *Fair Rates*

Before we discuss the appropriate adjustment to be made to the AFS amount, it is important to discuss a broader issue. The issue is whether it is justified to overcharge some patients because other patients are not paying their fair share. In some ways, emergency ambulance service providers, like many hospitals, have taken the Willie Sutton approach to billing. Willie Sutton reputedly replied to a reporter's inquiry as to why he robbed banks by saying "because that's where the money is."²³⁴ In the case of ambulance services, patients who have insurance and means, but happen

227. See Andrews, *supra* note 18 (negotiating for in-network rate can reduce bill from out-of-network provider by 30–35%).

228. See IBIS REPORT, *supra* note 222, at 4, 6, 8.

229. See *supra* notes 125–56 and accompanying text.

230. See *supra* notes 157–96 and accompanying text.

231. See *supra* notes 188–94 and accompanying text.

232. See *supra* notes 189–93 and accompanying text.

233. See *infra* notes 253–71 and accompanying text.

234. See Quote by Willie Sutton—"That's Where the Money Is," SNOPEs, <http://www.snopes.com/quotes/sutton.asp> [<https://perma.cc/YUU4-VNWF>] (last visited Dec. 2, 2016).

to be transported by an out-of-network provider, face the highest out-of-pocket costs.²³⁵ Put simply, this is because these patients can afford to pay and, in spite of the unfairness, often find that paying the exorbitant bill is the least costly alternative for them. For example, an ambulance company transported Maria and Gerald Kinghorn's "son to the hospital a few miles away after he crashed on the interstate near their Utah home and knocked out four teeth."²³⁶ The charge was \$1,700,²³⁷ or roughly three times the applicable AFS amount.²³⁸ The Kinghorn's automobile and health insurers had paid \$900, but the ambulance company balance billed the Kinghorns for the \$800 balance.²³⁹ Notwithstanding the excessive bill, Maria decided to pay up: "We didn't want to have our credit ruined for \$800," she told Kaiser Health News.²⁴⁰

It is a fact that some patients lack insurance coverage, the ability to pay their bill, or both. Chief paramedic Josh Nultemeier of King American Ambulance in San Francisco states that: "[Fifty] percent of the calls we go on we don't get any reimbursement for."²⁴¹ One estimate puts the collection rate (the percentage of ambulance charges that are actually paid) in San Diego County at just 33%.²⁴² As noted above, this could be an indication that billed charges are extreme, or it could also be an indication that ambulance companies recover less than their cost from some patients. It seems very likely that both interpretations are correct. That is, charges are extreme and in some cases the ambulance company does not even cover their costs.

When first responders respond to a call, they do not know whether they are picking up a customer who can pay or not. Of course, some might say that this situation is not unique to emergency ambulance service. For example, when a store sells on credit, it never knows whether the customer will in fact make full payment. It is also true that everyone who shops in a store that sells on credit pays higher prices to cover the amounts not paid by customers who default on their credit obligations. Likewise, non-shoplifting customers also pay the costs caused by those who shoplift. However, there is an important distinction in the case of emergency ambulance services and that is this: the patient has no choice with respect to which ambulance service they use.²⁴³ This is very different than the situation involving retail shoppers. For example, if a particular store's prices

235. See Medearis, *supra* note 10.

236. See Andrews, *supra* note 18.

237. See *id.*

238. See Rosenthal, *supra* note 49 (noting that Medicare rates for 2011 ranged between \$289 and \$481; thus, \$1,700 charge represented 350% of Medicare's high rate).

239. See Andrews, *supra* note 18.

240. See *id.*

241. See Medearis, *supra* note 10.

242. See *id.*

243. See *supra* notes 85–91 and accompanying text.

are very high because it makes poor credit decisions or fails to adequately control shoplifting, customers have the freedom to decide that prices are too high and to shop elsewhere. This is not the case with respect to emergency ambulance services.²⁴⁴ That is, patients have no choice over which ambulance service they use.²⁴⁵ As a result, while I sympathize with the fact that some ambulance service providers struggle to make ends meet, that is not, in my estimation, a sufficient justification for grossly overcharging those who can pay.²⁴⁶

Amanda Brewer, a working mother from Carrollton, Mississippi, who lacks health insurance, faced a struggle with medical bankruptcy after her son broke his femur in her backyard.²⁴⁷ The ambulance charge was \$2,448.50.²⁴⁸ Though Brewer initially negotiated to pay the charge in installments, the collection agency demanded the payment in full several months later.²⁴⁹ The agency only relented when Brewer asked whether they would prefer that she declare medical bankruptcy.²⁵⁰ But while Brewer avoided bankruptcy, many others do not.²⁵¹ A recent study found that medical bills are the largest source of bankruptcies in the United States.²⁵²

2. *Fair and Reasonable Price Range*

Based on the information discussed in the preceding section, it is clear that Medicare reimbursements based on the AFS should be the basis of the courts' determination of the fair and reasonable value of emergency ambulance services.²⁵³ However, the AFS rate should be adjusted upward in the range of 15% to 65% to arrive at a fair and reasonable reimbursement amount.²⁵⁴ I believe that a good estimate of the fair and reasonable value of emergency ambulance services lies somewhere in the range of 115% to 165% of the AFS reimbursement amount.²⁵⁵

244. See Medearis, *supra* note 10 (“The fundamental problem with the economics of ambulance transport is that patients have almost no ability to make an informed choice.”).

245. See *id.* (“As the costs of America’s patchwork system vary dramatically, whether a patient receives a manageable bill or a crippling one is ultimately a matter of chance.”).

246. Moreover, the vast difference in provider costs per trip (\$224–\$2,204) show that there is no intrinsic reason that costs must be so high. See GAO AMBULANCE REPORT, *supra* note 124, at 10. Competition in the industry is needed to create the economies of scale that will bring down the per trip cost of readiness.

247. See Medearis, *supra* note 10.

248. See *id.*

249. See *id.*

250. See *id.*

251. See *id.*

252. See *supra* note 80 and accompanying text.

253. See *supra* notes 10–13 and accompanying text.

254. See *infra* notes 266–67 and accompanying text.

255. See *id.*

Notwithstanding the limitations of the GAO data,²⁵⁶ I have used that data along with other available data²⁵⁷ and anecdotal information²⁵⁸ to arrive at this range of fair value. Based on the GAO data for 2010, 90% of providers had costs per transport between \$253 and \$924.²⁵⁹ Also for 2010, average Medicare reimbursement for ground ambulance transports was about \$464.²⁶⁰ A very rough average of the cost is \$589, calculated by simply taking the average of \$253 and \$924.²⁶¹ The middle of the range that I suggest would produce a reimbursement of \$650 for 2010.²⁶² This provides for about a 10% profit if average costs are \$589, which is in the ballpark of indications of the industry profit of a little over 8%.²⁶³ However, the quality of the data do not support such fine-tuned analysis, which is why I suggest a range of fair value. In addition, the GAO data makes no distinction between emergency and nonemergency service, and the focus in this Article is exclusively on emergency service, which has a higher cost associated with it than nonemergency service.²⁶⁴

At the low end of the cost range, the low fair price that I suggest of 115% of the average Medicare reimbursement rate would produce a payment of \$534, which, based on the GAO numbers, would produce a profit margin of 111% for low-cost providers.²⁶⁵ On the other hand, for high-cost providers, the high range of reimbursement that I suggest of 165% of the Medicare rate would produce a payment of \$766, which would produce a \$158 loss or about a -17% margin.²⁶⁶ I think it is a good idea to reward providers who can keep their costs low and to push high-

256. See GAO AMBULANCE REPORT, *supra* note 125, at 5–6 (discussing limitations of study).

257. See, e.g., HHS REPORT TO CONGRESS, *supra* note 164, at 22–32; IBIS REPORT, *supra* note 222, at 33.

258. See, e.g., Andrews, *supra* note 18 (containing story recounting experience of individuals with emergency ambulance service bills); Coffey, *supra* note 3 (same); Gilbert, *supra* note 8 (same); Kieler, *supra* note 18 (same); Medearis, *supra* note 10 (same); Rosenthal, *supra* note 49 (same); Roser, *supra* note 17 (same); Zamosky, *supra* note 1 (same).

259. See GAO AMBULANCE REPORT, *supra* note 124, at 10.

260. See *id.* at 22.

261. See *id.* at 10 ($(253 + 924) / 2 = 588.5 \cong 589$).

262. That is, 140% of $464 = 650$.

263. That is, $(650-589) / 589 = .1036$.

264. See GAO AMBULANCE REPORT, *supra* note 124, at 13 n.29 (noting that providers' costs increase with intensity level (emergency versus non-emergency and ALS versus BIS) of transport, although this finding is contrary to findings in 2007 GAO report).

265. That is, $1.15 \times 464 = \$534$, and low cost for 90% of providers based on the GAO numbers is 253 for a *profit* of $534-253 = 281$ and $281/253 = 1.11$. See *id.* at 10.

266. That is, $1.65 \times 464 = \$766$, and high cost for 90% of providers based on the GAO numbers is 924 for a loss of $766-924 = -158$ or $-158/924 = -.17$. See *id.*

cost providers to lower their costs.²⁶⁷ Finally, let me reiterate that I would prefer to base fair and reasonable value on the actual contracted-for reimbursements that the provider receives.²⁶⁸ In addition, as I have discussed elsewhere, it may be appropriate to increase the average private reimbursement rate to reflect the benefits that private insurers provide to ambulance companies.²⁶⁹ Although, in the case of emergency ambulance services, these benefits are limited to quick and assured payment.²⁷⁰ However, based on my research, this data seems unlikely to be widely available, and therefore it will often be necessary to rely on Medicare's AFS as a basis for determining fair and reasonable value.²⁷¹

V. RECOMMENDATIONS FOR PROTECTING PATIENTS FROM SURPRISE
MEDICAL BILLS FOR EMERGENCY AMBULANCE SERVICES

In the case of emergency ambulance services, patients are often taken advantage of because of the vulnerable position in which they happen to find themselves, through no fault of their own.²⁷² Patients have no control over which ambulance service is called in an emergency and often are not even aware that they are receiving services at the time they are provided.²⁷³ This is why, as noted above, the law of quasi-contract, and not the law of real contracts, governs the relationship between ambulance companies and patients in the case of emergency ambulance service.²⁷⁴ Moreover, even if the patient is conscious when the ambulance arrives, patients typically and logically defer to the suggestions of the medical personnel present and, as a result, often accept the service not because they think they need it but because they are encouraged to do so by the EMS providers on the scene.²⁷⁵ In addition, even when the ambulance bills are unreasonably high, they often remain within the realm of possible payment for many patients, and even though the amount demanded is unfair, many patients, as noted above, find that they are left with no other practical choice than to pay the unfair amount demanded by the ambulance company.²⁷⁶ The choice often comes down to paying the unfair bill, risk-

267. This will encourage efficiency and the GAO Report notes that generous government reimbursements have the opposite effect. *See id.* at 15 (noting that as government subsidies decrease, so do costs).

268. *Cf.* Nation, *Determining*, *supra* note 27, at 460–65 (discussing benefits of using market-determined rate when possible).

269. *See id.* at 449–51.

270. *See id.* at 461–65.

271. *See, e.g.,* Medearis, *supra* note 10 (“Charges for ambulance transportation vary dramatically across the U.S. and from provider to provider.”).

272. *See supra* notes 10–13 and accompanying text.

273. *See id.*

274. *See supra* notes 82–123 and accompanying text.

275. *See* Rosenthal, *supra* note 49 (“[W]hen an ambulance arrives, sick patients or injured people . . . often feel they have little choice but to get in, unaware of the potential price tag.”).

276. *See supra* notes 105–09 and accompanying text.

ing damage to one's credit rating by simply refusing to pay or by paying only a portion of the bill, or hiring an attorney to challenge the bill.²⁷⁷ Unfortunately, under the United States legal system, attorneys' fees are generally not awarded as part of damages absent either a statutory requirement or a contrary agreement between the parties.²⁷⁸ As a result, even a successful lawsuit challenging the bill may leave the patient out-of-pocket in an amount equal to or greater than the bill itself. Thus, it is not surprising that many patients who can pay do pay.²⁷⁹ As one patient succinctly put it: "[T]his is a real set up."²⁸⁰

A. *The Role of the Courts*

The courts can provide some immediate relief to this problem in cases where patients have refused to pay and are sued by the ambulance service providers by requiring the ambulance service providers to prove the reasonableness of their charges. That is, in any action filed by providers, or by bill collectors acting in their place, to collect payment for emergency ambulance services courts, as discussed above should refuse to accept the reasonable and customary amount charged as a proxy for the reasonable value of the services provided.²⁸¹ Instead, courts should require proof from the provider or bill collector that the charges are fair and reasonable. Specifically, I would encourage courts to begin from the position that about 115% of the Medicare reimbursement amount established by the AFS is the fair and reasonable value of the services provided, unless the provider can establish by clear and convincing evidence that this amount is not fair and reasonable by, for example, showing that it routinely receives a higher amount as payment for the same services pursuant to contracts with insurance companies.²⁸²

Court decisions establishing 115% of the AFS as a benchmark for determining the fair and reasonable value of emergency ambulance services will help to alleviate the problem of patients being taken advantage of by unconscionable emergency ambulance charges. This will not, however, help those who can pay the exorbitant charges and pay them because they fear damage to their credit rating or fear having to pay legal fees on top of the steep ambulance charges if they lose in court.²⁸³ Thus, as discussed in

277. See *supra* notes 118–24 and accompanying text.

278. See CALAMARI & PERILLO, *supra* note 85, at 569 (noting in United States, award of damages does not ordinarily include reimbursement of successful party's attorneys' fees).

279. See *supra* notes 71–81 and accompanying text.

280. See *id.*

281. See *supra* notes 138–56 and accompanying text.

282. For this purpose, it is important to distinguish between out-of-network insurers and in-network insurers; only in-network rates should be used because these are rates agreed to by both parties.

283. See *supra* notes 276–80 and accompanying text.

the next section, the legislature must also play a role in addressing this issue.

B. *Legislative Action*

There is currently no federal protection from balance bills for insured patients who receive emergency or nonemergency medical care out-of-network.²⁸⁴ The ACA, while it does protect members of non-grandfathered plans from increased cost sharing between in-network and out-of-network providers with respect to emergency care services, does not protect patients from balance billing even for emergency services, including emergency ambulance services.²⁸⁵ However, a few state legislatures are providing statutory solutions to the problem of surprise medical bills in either the emergency or nonemergency context.²⁸⁶ Surprise billing occurs when a patient has gone to an in-network facility but is treated by out-of-network physicians or others.²⁸⁷

C. *Legislation Addressing Surprise Balance Billing*

Legislation in this area is motivated, *inter alia*, by the recognition that when insurance companies and providers disagree regarding payment amounts, patients unfairly get caught in the middle.²⁸⁸ For example, in some cases, insurance providers have decided to send checks directly to patients rather than to the providers, in order to force the providers to go through the more difficult process of obtaining payment from the patient.²⁸⁹ This is often done because insurers feel that ambulance companies have acted unreasonably in refusing to become part of the network.²⁹⁰

284. *See, e.g.*, JACK HOADLEY ET AL., *BALANCE BILLING: HOW ARE STATES PROTECTING CONSUMERS FROM UNEXPECTED CHARGES?*, THE CENTER ON HEALTH INSURANCE REFORMS, GEORGETOWN UNIVERSITY HEALTH POLICY INSTITUTE 3 (2015), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2015/rwjf420966 [<https://perma.cc/8SXX-EJWM>].

285. *See* Karen Pollitz, *Surprise Medical Bills*, HENRY J. KAISER FAM. FOUND. (Mar. 17, 2016), <http://files.kff.org/attachment/issue-brief-surprise-medical-bills> [<https://perma.cc/C4L5-5XWR>].

286. *See* HOADLEY ET AL., *supra* note 284, at 7–11 (noting that under federal law (Employer Retirement Income Security Act or ERISA), employer-sponsored plans that are self-funded by employer are generally exempt from state regulation and as a result patients with self-funded employer health plans are not protected from balance bills even in few states that provide statutory protection).

287. *See id.* at 4 (describing “Scenario 3: Surprise Billing Situation in a Network Hospital”).

288. *See id.*

289. *See, e.g.*, Andrews, *supra* note 18 (discussing Maryland law that “requires insurers to send ambulance reimbursement for 911 calls directly to the provider . . . but also prohibits providers from billing consumers for balances beyond the reimbursed amount”).

290. *See id.*

Legislation addressing this type of problem can take several different forms, but in all cases it is designed to ensure the consumers are not liable for charges that are outside of their control.²⁹¹ Most of this legislation is focused on protecting patients from surprise balance bills from hospitals and doctors in a variety of different contexts, rather than being focused specifically on bills for emergency ambulance services.²⁹² However, some legislation in this area is likely to apply to emergency ambulance billing even if it is not referenced specifically, and in some cases emergency ambulance billing is referenced specifically.²⁹³ For example, in Maryland, legislation provides that out-of-network insurance companies must pay directly to ambulance service providers for covered services but also prohibits providers that receive direct reimbursement from an insurer from balance billing out-of-network patients (other than to collect any copayment, deductible, or coinsurance amount applicable).²⁹⁴ In other words, insurers must pay directly to providers, and providers can only sue the insurance company for more money—not patients.²⁹⁵

2. *Balancing the Interests of Providers and Insurers*

From the perspective of patients, this is an excellent solution that takes the patient out of the dispute between insurance companies and EMS providers over the correct level of payments. However, care in drafting such legislation must be taken to balance the interests of both providers and insurers. States that have passed legislation in this area have taken one of two different approaches to protecting consumers, and each of these approaches affects insurers and providers differently.²⁹⁶ One approach is to require that insurers hold their members harmless from balance bills in the context of, for example, emergency treatment.²⁹⁷ The other approach is to prohibit providers from balance billing in situations,

291. See HOADLEY ET AL., *supra* note 284, at 14. (noting that shared goal of this legislation is ensuring that consumers are not liable for charges that are mostly outside of their control).

292. See *id.* (noting that only a few states have acted through legislation to protect consumers against unexpected charges that result when providers send balance bills to their patients and noting even those states enacting protections typically limit scope to scenarios in which consumers have limited control, and sometimes protections apply only to certain types of insurance, for example, some states apply protections to HMOs but not to PPOs).

293. See *id.* at 4 (noting that one scenario in which this legislation applies concerns emergency settings and suggesting that ambulance services may also fall under this scenario).

294. See, e.g., Andrews, *supra* note 18 (discussing Maryland law that “requires insurers to send payment for 911 calls directly to the provider . . . but also prohibits providers from billing consumers for balances beyond the reimbursed amount”).

295. See *id.*

296. See HOADLEY ET AL., *supra* note 284, at 5–11 (discussing various approaches states have taken to protecting consumers from balance billing).

297. See *id.*

such as emergency treatment, where the statute applies.²⁹⁸ In those states taking the hold-harmless approach, the financial risk is borne by the insurance company, as they may be forced to pay providers' unilaterally determined list prices even if they believe them to be unreasonably high, because the statute requires that they hold their members harmless from any financial liability to the provider.²⁹⁹ On the other hand, in states that prohibit balance billing in certain contexts, the financial risk is placed on providers.³⁰⁰ The provider may be forced to accept the payment amount unilaterally determined by the insurance company even though the provider thinks that it is unreasonably small.³⁰¹ This is because the insurance company has a contract with the patient and not with the provider (unless the insurance company is in-network with the provider, in which case the balance-billing problem does not arise). As a result, there is no contract claim that the provider may bring against the insurer, because the insurance company owes no contractual obligation to the ambulance provider.³⁰² This is why balance billing claims are brought against the patient rather than the insurance company.³⁰³ Thus, if the ambulance provider feels as though the reimbursement amount paid and unilaterally established by the insurance company is too small, the ambulance company would have no right legally to contest the insurance company's determination.³⁰⁴

Most of the states that have passed legislation in this area have addressed this problem in one of two ways: either by setting repayment levels directly or by establishing formulas to be used to arrive at fair repayment amounts or, more commonly, by providing for some type of dispute resolution system.³⁰⁵ In both cases, the intent is to protect the interests of both insurers and providers.³⁰⁶

For example, California has taken the approach of prohibiting physicians from balance billing in emergency cases, but also requires that insur-

298. *See id.*

299. *See id.*

300. *See id.*

301. *See id.*

302. *See supra* notes 14–20 and accompanying text.

303. *See supra* notes 14–17 and accompanying text.

304. *Cf.* Crain's New York Business, *New York Law to Curb Surprise Billing Shows Promising Results*, MOD. HEALTHCARE (Apr. 7, 2016), <http://www.modernhealthcare.com/article/20160407/NEWS/304079996> [<https://perma.cc/6QF2-5V5M>] (discussing New York legislation and its process for resolving disputes between insurers and providers); Harris Meyer, *Florida Governor Signs Law Shielding Patients from Surprise Medical Bills*, MOD. HEALTHCARE (Apr. 14, 2016), <http://www.modernhealthcare.com/article/20160414/NEWS/160419946> (discussing similar law for Florida); Harris Meyer, *Passage of California Surprise-Bill Legislation Could Spur Other States to Act*, MOD. HEALTHCARE (Sept. 1, 2016), <http://www.modernhealthcare.com/article/20160901/NEWS/160909980> [<https://perma.cc/5VYE-J8FV>] (discussing similar legislation for California).

305. *See* HOADLEY ET AL., *supra* note 284, at 7–11.

306. *See id.* at 6–7.

ance plans pay providers a “reasonable and customary” payment rate. However, California requires that reasonable and customary rates be based on statistically credible and up-to-date information.³⁰⁷ California also provides a voluntary, nonbinding independent dispute resolution process, although so far it has been little used.³⁰⁸

Colorado, on the other hand, requires insurance plans hold their members harmless in both emergency and nonemergency surprise billing situations.³⁰⁹ As a result, in Colorado, this often results in insurers having to pay providers’ full billed charges.³¹⁰

In New York, balance billing in emergency situations is prohibited and it is also prohibited in surprise billing situations as long as the patient assigns insurance benefits to the provider.³¹¹ New York also provides an independent dispute resolution system that uses licensed physicians in active practice and allows them to, inter alia, choose either the provider’s original billed charge or the insurance plan’s original payment amount, but not any other amount.³¹² This is a very interesting provision that is intended to have the desirable effect of encouraging both providers and insurers to set reasonable rates. That is, if either party sets an unreasonable rate, that party risks having it rejected in favor of the other party’s rate rather than some middle ground between the two prices. The closer the two parties’ prices are set to begin with, the less likely the parties will be to resort to the dispute resolution system.

While only a handful of states have provided legislative solutions so far, this approach is very promising.³¹³ It certainly seems reasonable to assume that insurers and providers can work out reasonable payment amounts given that these parties have the information, ability, and, in the presence of well-drafted legislation, the incentive to deal effectively with one another.

VI. CONCLUSION

In many ways, the problems associated with overcharging for emergency ambulance services are similar to the problems associated with excessive charges for emergency health care in general. In both cases, the

307. *See id.*

308. *See id.*

309. *See id.*

310. *See id.* at 7.

311. *See id.* at 8 (noting this is important to providers because it means that they will receive payment, albeit not their full list charges, quickly rather than having to acquire payment directly from patient).

312. *See id.* at 8–9.

313. It is important to note that the plans that have been passed so far by the states, while similar, also have significant differences. For example, application of the provisions in some cases depends on the type of insurance, HMO, EPO, or PPO. In addition, passing such legislation can be politically difficult. A detailed discussion of these various approaches is beyond the scope of this paper.

problems manifest themselves through the practice of balance billing insured but out-of-network patients³¹⁴ in order to collect the full amount of the extortionate list prices demanded by hospitals, doctors, ambulance companies, and other health care providers. In both cases, Medicare patients and patients with good health insurance (i.e., broad networks and low deductibles, co-payments, and co-insurance rates) that is in the provider's network (so the patient is considered to be in-network) are protected from the problem of balance billing. In both cases, the burden falls most heavily on self-pay patients including those who are uninsured, underinsured, or insured but out-of-network and therefore subject to balance billing.³¹⁵ However, and also in both cases, the greedy list prices ultimately contribute to the ever-increasing price of health care and, as a result, adversely affect all patients, including those who are not directly subject to balance billing.³¹⁶ Finally, the root causes of both problems are also the same, and they are the odd characteristics of health insurance reimbursement schemes (past and present) coupled with the lack of meaningful price competition for health care at the consumer level.³¹⁷ These are the causes of the current highly inflated list prices for all types of health care.

However, while the problems are similar, they are not the same. The most important distinction between the problems of extreme charges for emergency medical care including ambulance service and extreme charges for health care in general is that the nature of emergency health care precludes the possibility of ever having meaningful consumer-level price competition.³¹⁸ Another important difference is that many ambulance companies are not in-network with any insurers and, as a result, balance billing for emergency ambulance services is more common than it is for health care billing in general.³¹⁹ With regard to the balance-billing problem in the context of hospital billing, I have argued elsewhere for adopting measures designed to create robust consumer-level price competition in order to rein in exorbitant chargemaster-based prices.³²⁰ In the ambulance balance billing context, this approach will not work because patients are in need of acute and immediate medical care, and therefore consumers will never be able to choose their emergency ambulance service provider based on competitive market forces. As a result, a legislative solution is necessary to properly solve the emergency health care (including emergency ambulance services) balance-billing problem.³²¹

314. The uninsured and underinsured also bear the brunt of these problems. See, e.g., Nation, *Hospital Chargemaster Insanity*, *supra* note 27, at 761–66.

315. See *id.*

316. See *id.* at 766–70.

317. See *id.* at 750–60.

318. See *supra* notes 10–13 and accompanying text.

319. See *supra* notes 105–17 and accompanying text.

320. See Nation, *The Balance-Billing Problem*, *supra* note 27, at 168–74.

321. See *supra* notes 284–314 and accompanying text.

The legislative solution that I suggest, as noted above, is similar to what several states have already done, and takes the consumer out of the middle of the dispute between the insurance company and the ambulance company concerning the appropriate fee to be paid for the services provided.³²² Also as noted, such legislation must provide balance between the interests of both insurers and providers in establishing a fair and reasonable price.³²³

While we await a legislative solution, and perhaps even after the legislation is passed in the case of the uninsured, the courts have an important role to play in reining in the abuses associated with billing for emergency ambulance services just as they do in reining in similar billing abuses for health care in general.³²⁴ The most important contribution the courts can make to solve these problems is to reject the traditional approach to establishing the fair value of medical services in general, including emergency ambulance services, that has been based on the usual and customary charges of providers in the same geographic area where the services were provided.³²⁵ As noted, list prices or billed charges have become greatly inflated and completely unrelated to value due to the combined effects of insurance reimbursement schemes and a lack of consumer-level price competition.³²⁶ As a result, charges no longer serve as a good proxy for fair value.³²⁷ Rather, the best measure of fair value is the amount that is actually paid and accepted as full payment by providers in the area where the services were rendered. However, in the case of emergency ground services this data is limited and, as a result, I suggest that courts use Medicare's AFS as a starting point and then adjust that amount upward in the range of 15% to 65% in order to arrive at a fair and reasonable value for emergency ground ambulance services.³²⁸ Taking the steps recommended here, both legislative and judicial, will help to protect vulnerable patients from being taken advantage of and also help to control the overall cost of health care.

322. *See id.*

323. *See id.*

324. *See supra* notes 281–83 and accompanying text.

325. *See id.*

326. *See id.*

327. *See id.*

328. *See supra* notes 253–71 and accompanying text.